Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1350 0003 0567 0261

August 31, 2007

Ron Eriksmoen, Administrator
Healthcare Resources
1204 Aspen Drive
Burnsville, MN 55337

Re: Licensing Follow Up visit

Dear Mr. Eriksmoen:

This is to inform you of the results of a facility visit conducted by staff of the Minnesota Department of Health, Case Mix Review Program, on August 14, 15, 16, and 17, 2007.

The documents checked below are enclosed.

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

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

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

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

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

Sincerely,

Jean M. Johnston

Jean Johnston, Program Manager
Case Mix Review Program

Enclosure(s)

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

01/07 CMR1000

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1350 0003 0567 0261

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

August 31, 2007

Ron Eriksmoen, Administrator
Healthcare Resources
1204 Aspen Drive
Burnsville, MN 55337

RE: QL24247002

Dear Mr. Eriksmoen:

On August 14, 15, 16, and 17, 2007, a reinspection of the above provider was made by the survey staff of the Minnesota Department of Health, to determine the status of correction orders issued during an survey completed on January 30, 31, and February 1, 2, 5, and 6, 2007, with correction orders received by you on March 21, 2007.

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

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

Based on observations, record review, and interview, the licensee failed to ensure that clients received care and services according to accepted nursing standards for two of five current clients' (1 and C2) records reviewed. The findings include:

Client 1 began receiving services July 12, 2006, which included medication administration by the unlicensed staff. During a home visit on February 1, 2007, the client's responsible party stated that he set up the client's medications in medi-set containers one time a week, and then the unlicensed staff gave the medications to client 1 at the appropriate times throughout the day from the medi-set container. When interviewed February 1, 2007, an unlicensed staff who cared for client 1 stated that she had no idea what medications she was giving the client, and that sometimes there were a different number of medications in the box, or a different color/shaped medication. She stated she only "hoped" they were the correct medications. When interviewed February 2, 2007, the registered nurse confirmed that nursing staff from the agency did not set up client 1's medications, but rather the client's responsible party did. The registered nurse confirmed that she was uncomfortable with the client's responsible party setting the medications up, and the agency staff administering the medications, but that was the way it had been since the client started services.

September 6, 2007

During a home visit February 1, 2007 at Cottage C, clients C1 and C2 were observed to be seated at the table in the dining area, and were being assisted to eat their breakfast. A paper cup was observed sitting on the table which contained several pills in it. Employee DB was observed to pick up the paper cup. Employee DB put some yogurt in it, and hand the paper cup to another unlicensed staff who was feeding client C2. Employee DB directed the other unlicensed staff to feed the yogurt with the pills in it, to client C2. The other employee fed the yogurt with the pills in it to client C2. Employee DA, who was the unlicensed employee who was responsible for setting up and administering the clients' medications that day, entered the dining area, and noted that the pills that were in the paper cup that were given to client C2 were actually client C1's medications. When interviewed February 1, 2007, employee DA stated that she had set up all four clients medications into paper cups that morning, and placed the cups by the client's place settings at the table. She stated that is what she usually did. Employee DA stated that for some reason, employee DB took client C1's medications and gave them to client C2 by mistake. When interviewed on February 2, 2007 the registered nurse stated that the correct method for the personal care attendants to follow when administering medications was to set up a client's medications, and then immediately administer the medication to the client.

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.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $250.00.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), **the total amount you are assessed is**: **$250.00.** This amount is to be paid by check made payable to the **Commissioner of Finance, Treasury Division MN Department of Health,** and sent to the Licensing and Certification Section of the MN Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 within 15 days of this notice.

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

FAILURE TO CORRECT: In accordance with Minnesota Rule 4668.0800, Subp.7, if, upon subsequent re-inspection after a fine has been imposed under MN Rule 4668.0800 Subp. 6, the (correction order has/the correction orders have) not been corrected, another fine may be assessed. This fine shall be double the amount of the previous fine.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided in the section entitled "TO COMPLY." Where a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance on re-inspection with any item of a multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection has been corrected.

September 6, 2007

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

If you have any questions, please feel free to give me a call at 651-201-4301.

Sincerely,

Jean M. Johnston

Jean Johnston
Program Manager
Case Mix Review Program

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

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

INFORMATIONAL MEMORANDUM

PROVIDER: HEALTHCARE RESOURCES

DATE OF SURVEY: August 14, 15, 16, and 17, 2007

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

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

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

NAME (S) AND TITLE (S) OF PERSONS INTERVIEWED:
Ron Eriksmoen, Owner/Administrator
Linda Eriksomoen, LPN
Alice Brun, RN
Nicholas Boakye, PCA-Burncrest
Mavis Agyei, PCA-Burnscrest
Jennifer Steinhorst, PCA-Commonwealth
Liz Eriksmoen, PCA-Commonwealth
Allison Eriksmoen, PCA-Bryant

SUBJECT: Licensing Survey _____ Licensing Order Follow Up: #1___

ITEMS NOTED AND DISCUSSED:

1) An unannounced visit was made to follow-up on the status of state licensing orders issued as a result of a visit made on January 30, 31, and February 1, 2, 5, and 6, 2007. The results of the survey were delineated during the exit conference. Refer to Exit Conference Attendance Sheet for the names of individuals attending the exit conference.

   The status of the correction orders issued as a result of a visit made on January 30, 31, and February 1, 2, 5, and 6, 2007 is as follows:

   1. **MN Rule 4668.0030 Subp. 2** **Corrected**
   2. **MN Rule 4668.0040 Subp. 2** **Corrected**
   3. **MN Rule 4668.0065 Subp. 1** **Corrected**
   4. **MN Rule 4668.0075 Subp. 1** **Corrected**
   5. **MN Rule 4668.0100 Subp. 1** **Corrected**
   6. **MN Rule 4668.0100 Subp. 2** **Corrected**
   7. **MN Rule 4668.0100 Subp. 4** **Corrected**

8. MN Rule 4668.0100 Subp. 9	**Corrected**	
9. MN Rule 4668.0140 Subp. 1	**Corrected**	
10. MN Rule 4668.0150 Subp. 3	**Corrected**	
11. MN Rule 4668.0150 Subp. 6	**Corrected**	
12. MN Rule 4668.0160 Subp. 2	**Corrected**	
13. MN Rule 4668.0160 Subp. 5	**Corrected**	
14. MN Rule 4668.0160 Subp. 6	**Corrected**	
15. MN Statute §144A.44 Subd. 1(2)	**Not Corrected**	**$250**

Based on observation, record review and interview, the licensee failed to ensure that clients received care and services according to accepted nursing standards for four of eight current clients' (B1, B3, C1 and C2) records reviewed. The findings include:

During a visit at Cottage B on August 15, 2007 at 12:30 p.m., the medication administration record for clients B1 and B3 did not have their 8:00 a.m. medications signed out as administered. When interviewed, August 15, 2007, employees BB and BC stated that the clients' 8:00 a.m. medications had not been administered because they each thought the other staff person was going to administer them. At 12:30 p.m., on August 15, 2007, employee BC administered the clients' medications that were omitted at 8:00 a.m., except for the medications noted below, which were already scheduled to be given again at 12:00 noon. Client B1 did not receive her 8:00 a.m. baclofen 10 milligrams and potassium chloride 1080 milligrams because she was due for additional doses of these medications at 12:00 noon. Client B3 did not receive her 8:00 a.m. baclofen 20 milligrams and Tylenol Arthritis 650 milligrams because she was due for additional doses of these medications at 12:00 noon.

During a visit at Cottage C on August 15, 2007 at 8:15 a.m., clients C2 and C3 were seated at the breakfast table. Employee CA was observed to take two envelopes out of the medication cupboard that were labeled with clients C2 and C3s' names, and "8:00 a.m." Employee CA stated that she had set these clients' medications up earlier, because she anticipated it being a "busy" morning, with a client needing to leave for an appointment, and another client leaving for an outing. The registered nurse (RN) arrived at the Cottage on August 15, 2007, at approximately the same time, and observed the practice. The RN indicated that the practice of setting the medications up prior to administration was not part of the agency's protocol. She stated the correct method for the personal care attendants to follow when administering medications was to set up a client's medications, and then immediately administer the medication to the client. The RN indicated that this was how she had trained the unlicensed staff.

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7005 0390 0006 1220 3442

March 14, 2007

Ron Eriksmoen, Administrator
Healthcare Resources
1204 Aspen Drive
Burnsville, MN 55337

Re: Results of State Licensing Survey

Dear Mr. Eriksmoen:

The above agency was surveyed on January 30, 31, and February 1, 2, 5, and 6, 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: Dakota County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman

1/07 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: HEALTHCARE RESOURCES

HFID #: 24274

Date(s) of Survey: January 30, 31, and February 1, 2, 5, and 6, 2007

Project #: QL24274002

Indicators of Compliance	Outcomes Observed	Comments
1. The provider accepts and retains clients for whom it can meet the needs. **Focus Survey** • MN Rule 4668.0140 **Expanded Survey** • MN Rule 4668.0050 • MN Rule 4668.0060 Subp. 3, 4 and 5 • MN Rule 4668.0180 Subp. 8	• Clients are accepted based on the availability of staff, sufficient in qualifications and numbers, to adequately provide the services agreed to in the service agreement. • Service plans accurately describe the needs and services and contain all the required information. • Services agreed to are provided Clients are provided referral assistance.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met _X_Correction Order(s) issued _X_Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided

Indicators of Compliance	Outcomes Observed	Comments
2. The provider promotes client rights. **Focus Survey** • MN Rule 4668.0030 • MN Statute §144A.44 **Expanded Survey** • MN Rule 4668.0040 • MN Rule 4668.0170	• Clients' are aware of and have their rights honored. • Clients' are informed of and afforded the right to file a complaint.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met _X_Correction Order(s) issued X___Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided
3. The provider promotes and protects each client's safety, property, and well-being. **Focus Survey** • MN Statutes §144A.46 Subd. 5(b) • MN Statute §626.556 • MN Statutes §626.557 **Expanded Survey** • MN Rule 4668.0035	• Client's person, finances and property are safe and secure. • All criminal background checks are performed as required. • Clients are free from maltreatment. • There is a system for reporting and investigating any incidents of maltreatment. • Maltreatment assessments and prevention plans are accurate and current.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met _X_Correction Order(s) issued X___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** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____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.]		_X_ Correction Order(s) issued _X_ Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided
5. The provider employs and/or contracts with qualified and trained staff. **Focus Survey** • MN Rule 4668.0100 • [Except Subp. 2] • MN Rule 4668.0065 **Expanded Survey** • MN Rule 4668.0060 Subp. 1 • MN Rule 4668.0070 • MN Rule 4668.0075 • MN Rule 4668.0080 • MN Rule 4668.0130 • MN Statute §144A.45 Subd. 5 [Note: See Informational Bulletin 99-7 for Class A variance in a Housing With Services Setting. Non-compliance with this variance will result in a correction order issued under 4668.0016.]	• Staff, employed or contracted, have received all the required training. • Staff, employed or contracted, meet the Tuberculosis and all other infection control guidelines. • Personnel records are maintained and retained. • Licensee and all staff have received the required Orientation to Home Care. • Staff, employed or contracted, are registered and licensed as required by law. • Documentation of medication administration procedures are available. • Supervision is provided as required.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met _X_ Correction Order(s) issued _X_ Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided
6. The provider obtains and keeps current all medication and treatment orders [if applicable]. **Focus Survey** • MN Rule 4668.0150 **Expanded Survey** • MN Rule 4668.0100 Subp. 2 [Note: See Informational Bulletin 99-7 and 04-12 for Class A variance in a Housing With 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 ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met _X_ Correction Order(s) issued _X_ Education Provided **Follow-up Survey** #___ ____New Correction

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** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded X__Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided
8. The provider is in compliance with MDH waivers and variances. **Expanded Survey** • MN Rule 4668.0016	• Licensee provides services within the scope of applicable MDH waivers and variances	*This area does not apply to a Focus Survey.* **Expanded Survey** ____Survey not Expanded X__Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided

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

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

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

1. MN Rule 4668.0030 Subp. 2

INDICATOR OF COMPLIANCE: # 2

Based on record review and interview, the licensee failed to provide the current Minnesota Home Care Bill of Rights to in five of five current clients' (1, A1, B1, C1, and D1) records reviewed. The findings include:

Clients 1, A1, B1, C1 and D1 began receiving services July of 2006, June of 2005, December of 2006, May of 2005, and March of 2006 respectively. There was no evidence in the clients' records that they had received a copy of the Minnesota Home Care Bill of Rights. When interviewed on January 31, 2007, the owner/administrator stated that he thought he had given a copy of the Minnesota Home Care Bill of Rights to the clients at the start of services, but later stated that he was mistaken, and that the information he gave to the clients at the start of care was information pertained to reporting incidents of abuse and neglect.

2. MN Rule 4668.0040 Subp. 2

INDICATOR OF COMPLIANCE: # 2

Based on record review and interview, the licensee failed to provide clients with a written procedure for making a complaint for five current clients' (1, A1, B1, C1, and D1) records reviewed. The findings include:

The licensee provided an "Individual Grievance Procedure" which did not include information pertaining to the right to complain to the Minnesota Department of Health, Office of Health Facility Complaints. There was no evidence that clients' 1, A1, B1, C1, and D1 received anything in writing from the licensee on how to make a complaint. When interviewed January 31, 2007 the owner/administrator acknowledged that the agency's Individual Grievance Procedure was not provided to the clients and that it did not contain all the required information.

3. MN Rule 4668.0065 Subp. 1

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to ensure that tuberculosis screening was completed for six of seven employees (B, C, AA, BA, CA, and DA) reviewed. The findings include:

Employees C, AA, BA, CA, and DA began having direct client contact September of 2006, May of 2004, August of 2006, June of 2006 and June of 2003 respectively. There was no evidence in the records that they had received tuberculosis screening. When interviewed January 31, 2007, the owner/administrator stated that tuberculosis screening was not routinely being done for the employees.

Employee B began having direct client contact August of 2006. There was no evidence in her record of tuberculosis screening. When interviewed February 2, 2007, employee B stated she had received a Mantoux test when she started with the licensee, but could not recall the date of the Mantoux test. Employee B confirmed there was no documentation of her Mantoux test in her record.

4. MN Rule 4668.0075 Subp. 1

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to ensure orientation to the home care requirements for seven of seven employees' (B, C, AA, BA, CA, CB, and DA) records reviewed. The findings include:

Employees B, C, AA, BA, CA, CB, and DAs' personnel files did not include evidence of orientation to home care. When interviewed on January 31, 2007, and February 2, 2007, the administrator/owner and registered nurse confirmed that an orientation to the home care requirements had not been completed for any employees because they were unaware of this requirement.

5. MN Rule 4668.0100 Subp. 1

INDICATOR OF COMPLIANCE: # 5

Based on interview and record review, the licensee failed to ensure that delegated nursing tasks were performed by employees that had received training prior to providing delegated nursing for six of six unlicensed employees' (C, AA, BA, CA, CB, and DA) records reviewed. The findings include:

Employees, C, AA, BA, CA, CB, and DA, were unlicensed care attendants who provided personal care to clients 1, A1, B1, C1 and D1 including, dressing, grooming, bathing, transferring, positioning and range of motion exercises. There was no evidence the care attendants' were trained to perform these tasks as required in MN Rule 4668.0100 Subpart 5. When interviewed January 31, 2007 and February 2, 2007, the administrator/owner confirmed that the above mentioned employees had not received the training as required in this chapter. He stated they were unaware of this requirement.

6. MN Rule 4668.0100 Subp. 2

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the licensee failed to ensure that unlicensed staff administering medications to clients, were instructed by a registered nurse (RN) in medication administration, and demonstrated to the RN, competency to follow the procedure for six of six unlicensed staff (C, AA, BA, CA, CB, and DA) records reviewed. The findings include:

Employees C, AA, BA, CA, DA and CB administered medications to clients 1, A1, B1, C1, and D1 on a routine basis. Employees C, AA, BA, CA and CBs' records included a "medication training" packet which was taught by a licensed practical nurse, not a registered nurse as required. Employee DA's record did not indicate any medication training. When interviewed February 1, 2007, employee DA stated she received medication training from another agency.

When interviewed on February 2, 2007, the administrator/owner and RN confirmed that employees C, AA, BA, CA, and CB were instructed in medication administration by a licensed practical nurse, and that there was no evidence of medication training/competency for employee DA in her record.

7. MN Rule 4668.0100 Subp. 4

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to ensure that unlicensed staff who were performing delegated nursing procedures that are not included in the required curriculum were instructed by the registered nurse (RN) prior to performing the procedure, and demonstrated their ability to perform the procedure to the RN for six of six unlicensed staff (C, AA, BA, CA, CB, and DA). The findings include:

Employee C provided delegated nursing procedures to client #1 such as, administration of gastric tube feedings and water flushes, colostomy care, and urinary catheter care. There was no evidence in employee C's record that the RN had instructed the employee in these procedures, nor was there evidence that the employee had demonstrated to the RN her competency to perform these procedures. When interviewed February 1, 2007, employee C stated that she was instructed and trained on how to perform these procedures by another personal care attendant.

Employee AA provided blood glucose monitoring to client A1 once daily during her shift. There was no evidence in employee AA's record that the RN had instructed the employee in blood glucose monitoring nor that she had demonstrated to the RN her competency to perform this procedure. Employee AA was interviewed on February 1, 2007, and stated she was instructed by the agency licensed practical nurse on how to conduct blood glucose monitoring.

Employee BA provided urinary catheter care to client B1. There was no evidence in employee BA's record that the RN had instructed the employee on how to care for client B1's catheter. Employee BA was interviewed on February 1, 2007 and stated that she was instructed by the agency's licensed practical nurse on how to perform catheter care.

Employees CA and CB provided delegated nursing procedures to client D1 such as, administration of gastric tube feedings and water flushes, nebulizer treatments, and urinary catheter care. There was no evidence in employees CA and CBs' records that the RN had instructed the employees on how to perform these procedures, nor was there evidence that the employees had demonstrated to the RN their competency to perform these procedures. When interviewed February 1, 2007, employee CB stated he remembered being instructed by a nurse, but could not recall if it was a RN or a licensed practical nurse.

Employee DA provided water flushes via a gastric tube, and provided urinary catheter care to client C1. There was no evidence in employee DA's record that the RN had instructed employee DA on how to perform these procedures, nor was there evidence that the employee had demonstrated to the RN her competency to perform these procedures. When interviewed February 1, 2007, employee DA stated she had been instructed by the licensed practical nurse on how to perform these procedures.

When interviewed February 2, 2007, the registered nurse stated she started with the licensee in August of 2006, and that most of the training had been done by a licensed practical nurse. She confirmed the lack of documentation of training and competencies for the above mentioned employees.

8. MN Rule 4668.0100 Subp. 9

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to ensure that a registered nurse (RN) supervised unlicensed personnel who performed services that required supervision for five of five current client (1, A1, B1, C1, and D1) records reviewed. The findings include:

Clients' 1, A1, B1, C1, and D1 received assistance with medication administration from unlicensed personnel in addition to other delegated nursing tasks such as, assistance with administration of gastric tube feedings, colostomy care, urinary catheter care and nebulizer treatments. The clients' records did not include evidence of supervisory visits of the home health aide tasks. There were no notations by a nurse in client 1's record since home care services began July of 2006. The nursing visit notes in clients A1, B1, C1 and D1s' records, did not indicate supervision of unlicensed staff. Instead the notes described an assessment of the client's status on that day.

When interviewed January 31, 2007, the RN confirmed the notes in the client's records were "visit notes" and did not include supervision of the tasks being performed by the unlicensed staff. The RN stated she was not aware of this requirement.

9. MN Rule 4668.0140 Subp. 1

INDICATOR OF COMPLIANCE: # 1

Based on record review and interview, the licensee failed to establish a written service agreement with the client or the client's responsible party for five of five current clients' (1, A1, B1, C1, and D1) records reviewed. The findings include:

Client 1 began receiving home care services July of 2006. Interviews with the client and personal care attendants indicated the client received assistance with her activities of daily living, administration of medications, administration of a gastric tube feedings, urinary catheter care, and colostomy care. There was no evidence of a written service agreement in the client's record. During a home visit on February 1, 2007, a family member was interviewed and when questioned regarding a service agreement, he stated that he thought the licensee was working on it, and that it was "in process."

Client A1 began receiving home care services June of 2005. Interviews with the personal care attendants indicated the client received assistance with her activities of daily living, administration of medications, and blood glucose monitoring twice a day. There was no evidence of a written service agreement in the client's record.

Client B1 began receiving home care services December of 2006. Interviews with the client and personal care attendants indicated the client received assistance with activities of daily living, administration of her medications, range of motion exercises, and urinary catheter care. There was no evidence of a written service agreement in the client's record.

Client C1 began receiving home care services May of 2005. Interviews with the client and personal care attendants indicated the client received assistance with activities of daily living, administration of medications, urinary catheter care, and assistance with water flushes through her gastric feeding tube.

There was no evidence of a written service agreement in the client's record.

Client D1 began receiving home care services March of 2006. Interview with the personal care attendants indicated the client received assistance with his activities of daily living, administration of medications, nebulizer treatments, tracheostomy care, urinary catheter care, range of motion exercises, and administration of gastric tube feedings. There was no evidence of a written service agreement in the client's record
When interviewed February 2, 2007, the administrator/owner confirmed that clients 1, A1, B1, C1, and D1 did not have written service agreements signed by the client or the client's responsible party.

10. MN Rule 4668.0150 Subp. 3

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the licensee failed to ensure there were physician's orders for medications and/or treatments that were being administered for four of five current clients' (1, A1, B1, and C1) records reviewed. The findings include:

Client 1 began receiving home care services July of 2006, which included medication administration. There were no physician's orders for the medications the personal care attendants were administering. In addition, the personal care attendants were administering the client's gastric tube feeding, assisting with colostomy care and range of motion exercises. There were no physician's orders for these treatments. When interviewed on February 2, 2007, the registered nurse (RN) confirmed there were no physician's orders for client 1, indicating that she thought because nursing was not involved in the client's care, that they did not need physician's orders.

Client A1 began receiving services June of 2005. Staff interviews indicated that client A1 received blood glucose monitoring twice a day. Client A1's record did not contain a physician's order to conduct blood glucose monitoring. When interviewed February 2, 2007, the RN confirmed there was no physician's order to do this testing.

Client B1 started receiving home care services December of 2006 which included medication administration. Client B1's record contained a physician's order dated December of 2006 for Ultram prn. The medication record for January and February, 2007 indicated that Ultram 50 milligrams (1/2) tablet was being administered every twelve hours routinely. There was no physician's order for this frequency change. Client B1 had a physician's order dated December of 2006 for Baclofen 30 milligrams three times a day, although the February 2007 medication record indicated that the client was receiving Baclofen 15 milligrams four times a day. There was no physician's order for the frequency and dosage change for the client's Baclofen in the client's record. Client B1 also received Docusate Na 100 milligrams every day. There was no physician's order for this medication. The client was also receiving Beta Serum injections .3 milligrams subcutaneously every other day in January of 2007, although a physician's order dated January of 2007 indicated the client was to receive Beta Serum 0.0625 milligrams injections every other day increased to 0.25 milligrams over an eight week period. When interviewed February 2, 2007, the RN stated that she was sure that another provider involved in client B1's care had the physician's order changes for the Baclofen and the new order for the Docusate, but indicated she was not aware of the Beta Serum order change or the Ultram.

Client C1 began receiving home care services May of 2005, which included medication administration. Client C1's medication administration record for February 2007 indicated that Furosemide 20 milligrams one – to- two tablets were administered every noon. Client C1's physician's order for the Furosemide, dated February of 2006, indicated Furosemide of milligrams was to be administered every noon as needed for swelling. There was no order present for daily Furosemide in client C1's record. When interviewed February 2, 2007, the RN was unable to clarify the discrepancy.

11. MN Rule 4668.0150 Subp. 6

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the licensee failed to ensure that all physician's orders were renewed at least every three months for four of four clients' (A1, B1, C1 and D1) records reviewed who had physician's orders. The findings include:

Clients, A1, B1, C1 and D1 began receiving home care services which included assistance with medication administration June of 2005, December of 2006, May of 2005, and March of 2006 respectively. There was no evidence that the physician's orders were renewed at least every three months. When interviewed January 31, and February 2, 2007, the registered nurse confirmed the clients' physician's orders had not been renewed every three months, stating she was not aware of the requirement.

12. MN Rule 4668.0160 Subp. 2

INDICATOR OF COMPLIANCE: # 4

Based on observations and interview, the licensee failed to establish written procedures to control the use and removal of records from the licensee's offices and security of the client's records. The findings include:

During the survey, it was observed that portions of client records were removed from the office and taken to other offices, and/or to client's homes. When interviewed February 2, 2007, the owner/administrator indicated there were no written procedures to control the use and removal of records from the provider's offices and for security of the client's records.

13. MN Rule 4668.0160 Subp. 5

INDICATOR OF COMPLIANCE: # 4

Based on record review and interview, the licensee failed to ensure that entries in the client's record were authenticated with the name and title of the person making the entry for one of six current clients' (1) records reviewed. The findings include:

Client 1's personal care attendant notes, located in the client's home, contained seven entries of medication administration starting January 11, 2007. The entries did not contain the name and title of the person making the entries. When interviewed February 1, 2007, employee CA, a personal care attendant who made entries in the client's record confirmed the entries were not signed. She stated that was a good idea to sign them. When interviewed February 2, 2007, the registered nurse stated that the

form the personal care attendants used did not have a place for the person to sign their name and title, so the staff must have forgotten to sign the entries.

14. MN Rule 4668.0160 Subp. 6

INDICATOR OF COMPLIANCE: # 4

Based on record review and interview, the licensee failed to ensure that a note summarizing each contact with the client was made for five of five current clients' (1, A1, B1, C1, and D1) records reviewed. In addition, the licensee failed to ensure that upon termination of services, a summary was documented for one of one client (A2) whose services were terminated. The findings include:

Client 1 began receiving home care services July of 2006. "Personal Care Attendants" (PCA) the agency unlicensed staff were in the client's home one to two shifts a day since start of services, and provided medication administration, administration of gastric tube feeding, assistance with activities of daily living, urinary catheter care, colostomy care and range of motion exercises. Documentation in the client's record revealed only seven entries of the care provided by the PCA's. The first documentation was dated January of 2007. When interviewed February 2, 2007, the registered nurse (RN) stated that she had recently developed a form for the PCA's to document the care provided. She confirmed that there should have been more entries in the record.

Clients A1, B1, C1, and D1 received home care services by the personal care attendants including but not limited to, medication administration, assistance with activities of daily living, administration of gastric tube feedings, colostomy care, urinary catheter care, and range of motion exercises on a daily basis. Clients A1, B1, C1, and D1s' records did not contain documentation by the personal care attendants summarizing each contact with the client. The documentation only included what medications were administered to the clients. When interviewed February 2, 2007, the administrator/owner confirmed the lack of documentation by the personal care attendants for each contact with the client, and stated that they were in the process of developing something that would correct this problem.

Client A2 began receiving home care services December of 2002, and discontinued services October 30, 2006. The last entry in the client's record dated October of 2006 stated that the client was "admitted to the hospital yesterday." There was no summary following the termination of services that included the reason for initiation and termination of services or the condition of the client at termination of services. When interviewed February 2, 2007, the registered nurse confirmed there was not a summary following termination of services. She stated she did not know that it was a requirement.

15. MN Statute §144A.44 Subd. 1(2)

INDICATOR OF COMPLIANCE: # 2

Based on observations, record review, and interview, the licensee failed to ensure that clients received care and services according to accepted nursing standards for two of five current clients' (1 and C2) records reviewed. The findings include:

Client 1 began receiving services July of 2006, which included medication administration by the unlicensed staff. During a home visit on February 1, 2007, the client's responsible party stated that he set up the client's medications in medi-set containers one time a week, and then the unlicensed staff

gave the medications to client 1 at the appropriate times throughout the day from the medi-set container. When interviewed February 1, 2007, an unlicensed staff who cared for client 1 stated that she had no idea what medications she was giving the client, and that sometimes there were a different number of medications in the box, or a different color/shaped medication. She stated she only "hoped" they were the correct medications. When interviewed February 2, 2007, the registered nurse confirmed that nursing staff from the agency did not set up client 1's medications, but rather the client's responsible party did. The registered nurse confirmed that she was uncomfortable with the client's responsible party setting the medications up, and the agency staff administering the medications, but that was the way it had been since the client started services.

During a home visit February 1, 2007 at Cottage C, clients C1 and C2 were observed to be seated at the table in the dining area, and were being assisted to eat their breakfast. A paper cup was observed sitting on the table which contained several pills in it. Employee DB was observed to pick up the paper cup. Employee DB put some yogurt in it, and hand the paper cup to another unlicensed staff who was feeding client C2. Employee DB directed the other unlicensed staff to feed the yogurt with the pills in it, to client C2. The other employee fed the yogurt with the pills in it to client C2. Employee DA, who was the unlicensed employee who was responsible for setting up and administering the clients' medications that day, entered the dining area, and noted that the pills that were in the paper cup that were given to client C2 were actually client C1's medications. When interviewed February 1, 2007, employee DA stated that she had set up all four clients medications into paper cups that morning, and placed the cups by the client's place settings at the table. She stated that is what she usually did. Employee DA stated that for some reason, employee DB took client C1's medications and gave them to client C2 by mistake. When interviewed on February 2, 2007 the registered nurse stated that the correct method for the personal care attendants to follow when administering medications was to set up a client's medications, and then immediately administer the medication to the client.

16. MN Statute §144A.46 Subd. 5(b)

INDICATOR OF COMPLIANCE: # 3

Based on record review and interview, the licensee failed to ensure that a background study was completed by the Minnesota Department of Human Services (DHS) for two of seven employees' (B and CA) records reviewed. The findings include:

Employee B was hired August of 2006 to provide home care services. Employee B's record did not contain a background study conducted by DHS. When interviewed February 2, 2007, the administrator/owner confirmed that he had not submitted a background study on employee B.

Employee CA was hired June of 2006 to provide home care services. Employee CA's record did not contain a background study conducted by the DHS. When interviewed February 2, 2007, the owner stated he was sure that he had submitted a background study on employee CA, but was unable to locate the background study results. On February 15, 2007 the DHS background study section was contacted. They stated there was no record of the agency submitting a background study request for employee CA.

A draft copy of this completed form was left with Ron Ericksmoen at an exit conference on February 6, 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).