MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 1380 0003 8091 0969

June 24, 2009

Jenifer Malobe, Administrator
Tender Care Home Servicers Inc
9700 45th Avenue N STE 122
Plymouth, MN 55442

Re: Results of State Licensing Survey

Dear Ms. Malobe:

The above agency was surveyed on May 28, 29, 30, 31, and June 1, 2, 3, 4, and 8, 2009, 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
Deb Peterson, Office of the Attorney General
Stella French, Office of Health Facility Complaints

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: TENDER CARE HOME SERVICES INC

HFID #: 25353

Dates of Survey: May 28, 29, 30, 31, and June 1, 2, 3, 4 and 8, 2009

Project #: QL25353003

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

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

1. MN Rule 4668.0012 Subp. 17

INDICATOR OF COMPLIANCE: # 7

Based on observation and interview, the licensee failed to provide a current copy of their Class A license. The findings include:

On May 28, 2009, a copy of a Class A Home Care license was observed posted on the wall in the business office of the agency. The expiration date on the license was August 5, 2008.

When interviewed May 28, 2009, a current copy of the Class A license was requested from the owner. On May 29, 2009 the owner provided a copy of the same Class A license that was posted on the wall in the business office. A current copy of the licensee's Class A license was never made available for review.

2. MN Rule 4668.0016 Subp. 8

Waiver 09-04: requirement not met

INDICATOR OF COMPLIANCE: # 8
INDICATOR OF COMPLIANCE: # 5

Based on observation, interview and record review, the agency failed to follow the conditions of Information Bulletin 09-04: Tuberculosis Prevention and Control Guidelines: Home Care which was approved by the Minnesota Department of Health in February 2009. 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 waiver to MN Rule 4668.0065 Subp. 1 and Subp. 2 by Information Bulletin 09-04. The agency failed to follow the requirement of MN Rule 4668.0065 Subp. 1 as of March 9, 2009, and are therefore subject to the waiver requirements of Information Bulletin 09-04 in that the agency failed to ensure that the results of baseline TB screening of all paid and unpaid healthcare workers were documented and assure all reports or copies of tuberculin skin tests (TSTs), IGRAs/TB blood tests for *M. tuberculosis*, medical evaluation, and chest radiograph results were maintained in the healthcare worker's file. The findings include:

Employee B was hired by the licensee on January 28, 2009 as a licensed nurse. The employee's record did not contain evidence of a tuberculosis screening.

When interviewed June 3, 2009, the owner stated the tuberculosis screening "should be" in the employee's file. The owner was unable to provide documentation of the tuberculosis screening.

3. MN Rule 4668.0060 Subp. 3

INDICATOR OF COMPLIANCE: # 1

Based on observations, record review and interview, the licensee failed to ensure all services required by the client's service agreement were provided for three of three client (#2, #3 and #4) records reviewed. The findings include:

The owner provided a service agreement for client #2, dated September 8, 2008. The service agreement indicated the client was to receive "home health aide services, 8 hours daily; skilled nursing visits (LPN) 7.75 hours daily; skilled nursing visits (RN) 7.75 hours daily." The client's record lacked documentation to support that the services were provided as noted in the service agreement.

When interviewed on May 28 and 29, 2009 client #2 stated, "We aren't getting the care we are supposed to here. The only reason she (employee D was present in the apartment) is up here now, is because I'm moving and she's helping me pack. We don't have aides at night…..My son had to put me on the commode." Client #2 stated that the last three nights her son had to put her on the commode during the night. She stated she phoned downstairs for help, but the phone kept ringing and no one answered the phone.

Client #2's nursing time cards and the personal care attendant time sheets for May 2009 were requested from the owner on May 28, 29, and June 3 and 4, 2009. They were never provided for review so the amount of documented services for the client could not be determined.

Apartment #412 was entered on May 28, 2009. Three clients (#2, #3 and #4) were residing in the apartment. A sign posted on the wall in the living room noted, "Entire apartment must be clean and tidy at all times." The following conditions were observed in the apartment on May 28, 2009: The carpet in the adjoining living room, dining room, office and hallway were heavily soiled with visible dirt and numerous large dark stains with multiple smaller stains scattered throughout the carpet. Debris such as pieces of paper, and a card from a deck of cards were scattered on the carpet especially in the dining room/office area. The toilet in the bathroom across the hall from client #4's room was soiled with a darkened ring of residue around the base of the toilet; staining in the toilet bowl; and what appeared to be dried urine streams running down from the front rim of the toilet to the front surface of the toilet to the floor. The toilet seat and the area where the seat was attached to the toilet had numerous dark yellow areas of residue. The toilet paper holder was broken and half of the holder was missing. A drinking cup was observed on the floor by the toilet between a wastepaper basket and plunger. The bathtub was soiled with dried hair on the bottom of the tub. There was dark residue staining around the drain and the entire inside lower circumference of the tub. There was a cigarette butt laying next to a men's electric shaver on the vanity countertop. The kitchen countertop had a dust pan lying next to the toaster. The toaster crumb tray was covered with crumbs. The majority of the microwave exhaust vents were encrusted with a darkened brownish-yellow film. The refrigerator door had prefilled insulin syringes in a zippered baggie. There were two pieces of meat stored uncovered on a plate which appeared dried out and hard.

The odor of urine permeated the air when apartment #412 was entered on May 30, 2009. The smell of urine was coming from the vacant room of former client #4, who was discharged the previous day. There was a mattress on the floor of the room, which was grossly soiled and the mattress center was concave. On a subsequent visit to the apartment on June 3, 2009, the mattress was no longer in the room and it was observed that a piece of carpet was cut out of the carpeted floor. The carpet along the bedroom interior wall adjacent to hallway was severely discolored and darkly stained in an area approximately four feet long by one to two feet wide. There were numerous other lightly colored stains scattered throughout the carpet.

When interviewed June 3, 2009, the owner stated the personal care attendants were responsible for cleaning the clients' (#2, #3 and #4) apartment #412.

4. MN Rule 4668.0070 Subp. 3

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to ensure that there were job descriptions for four of five employees (A, B, D and E) reviewed. The findings include:

Employees A and E were hired on August 28, 2008 and April 7, 2009, respectively. Employee A, E and D (the owner) all worked as personal care attendants. There were no job descriptions available for review for this job classification.

Employee B was hired January 28, 2009 as a licensed practical nurse. A job description for this job classification was not available for review.

When interviewed June 3, 2009, the owner verified that there were no job descriptions for either job classification.

5. MN Rule 4668.0100 Subp. 2

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the licensee failed to document in the client's record the procedure for administering medications for one of one client (#2) reviewed. The findings include:

Client #2's medications were centrally stored and administered by unlicensed staff. Client #2 was also an insulin dependent diabetic, and had physician orders for the daily use of a Spiriva Inhaler daily, and use of Lotrimin cream and nystatin Powder. On May 28, 2009, an unlicensed employee was observed handing the client a prefilled insulin syringe for the client to self-administer. The client's record did not contain any procedures for the staff to follow regarding the administration of the client's medications and assistance with insulin.

The policy and procedure book for the agency was provided by the owner. The procedure book did not contain a procedure for administration of oral, cream and powder medications, and the handling of prefilled insulin syringes.

When interviewed June 3, 2009, the owner was queried regarding the completeness of the policy and procedure book, since the book provided contained only five procedures (suctioning, perineal care, eye meds, nebulizer therapy and medication with and inhaler and space). The owner stated "that's all."

6. MN Rule 4668.0100 Subp. 4

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to ensure a registered nurse specified in writing specific instructions for performing procedures and that the procedures were documented in one of one client (#2) record reviewed. The findings include:

Client #2 was an insulin dependent diabetic and had physician ordered Accu-Cheks (blood sugar monitoring) four times per day. The client's record did not contain specific instructions for unlicensed staff to follow when performing the Accu-Chek for the client.

When interviewed, May 28 and 29, 2009, client #2 stated that the personal care assistants had completed her Accu-Cheks in the morning of both the 28th and 29th.

The policy and procedure book for the agency was provided by the owner. The procedure book did not contain a procedure for Accu-Cheks.

When interviewed June 3, 2009, the owner was queried regarding the completeness of the policy and procedure book, since the book provided only contained five procedures. The owner stated "that's all."

7. MN Rule 4668.0100 Subp. 8

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to ensure that a registered nurse (RN) oriented each unlicensed person, who performed home health aide tasks, to each client prior to providing services for one of one client (#2) record reviewed. The findings include:

On May 29, 2009, unlicensed employee A provided the reviewer the care plan she could refer to if she needed to know what to do for client #2. The care plan, dated October 1, 2007, was the most current care plan contained in the PCA (personal care attendant) folder for client #2. The care plan did not include tasks that were noted on the supervisory visits as tasks being performed by the PCAs for the client, such as blood glucose monitoring, suctioning and medication administration. The PCA care plan was undated and unsigned, and in the area on the form labeled, "RN signature," the space was blank.

When interviewed June 3, 2009, the owner stated that PCA care plans were provided for each client and the personal care attendants were to follow the PCA care plan for the care of each client.

8. MN Rule 4668.0140 Subp. 2

INDICATOR OF COMPLIANCE: # 1

Based on observation, record review and interview, the licensee failed to provide a complete service agreement for one of one client (#2) record reviewed. The findings include:

Client #2's service agreement, dated September 8, 2008, was provided by the agency owner. The services noted on the service agreement were "home health aide services, 8 hours daily; skilled nursing visits (LPN) 7.75 hours daily; skilled nursing visits (RN) 7.75 hours daily." The service agreement lacked a description of the services to be provided by the licensee.

When interviewed May 28, 2009, the client stated her Accu-Cheks (blood sugar monitoring) were to be completed four times per day and her medications were administered to her by staff. None of these services were listed on the client's service agreement. On May 28, 2009, the client's medications were observed to be centrally stored in a locked file cabinet. The central storage of the client's medications was not noted on the service agreement**.**

9. MN Rule 4668.0150 Subp. 2

INDICATOR OF COMPLIANCE: # 6

Based on observation, record review and interview, the licensee failed to ensure medications and treatments were administered as ordered and properly documented for three of three client (#1, #2 and #3) records reviewed. The findings include:

On May 28, 2009, client #2's medication container was observed, and it contained six medications in the evening slot and one medication in the hour of sleep (HS) slot from Tuesday, May 26, 2009. The medications were theophylline 300 milligrams (mg.), docusate sodium 100 mg, Oyster shell 500 mg, Mucinex 600 mg, Seroquel 300 mg., metoprolol 25 mg. and Zocor 20 mg. When interviewed May 28, 2009, the registered nurse stated if the pills were still in the container, it meant the pills were not administered to the client as ordered on May 26, 2009.

Client #2's physician ordered sliding scale coverage for blood sugar readings as follows: 150-200=2units; 201-250=4 units; 251-300=6 units; 301-350=8 units; 351-400=10 units and greater than 400=12 units. Documentation in the client's nursing notes, medication administration record (MAR) and insulin flow sheet indicated the client did not receive sliding scale insulin coverage for blood sugars as ordered by the physician on the following days: 05/01/09 12 noon, blood sugar (BS) 298; 05/04/09 8:55 a.m., BS 310; 05/04/09 12 noon, BS 448; 5/13/09 9:30 a.m., BS 252; 5/13/09 2:02 p.m., BS 268; 5/15/09 12 noon, BS 232; 5/22/09 10:45 a.m., BS 242; 5/22/09 1:49 p.m., BS 386; 5/23/09 10:26 a.m., BS 298; 05/23/09 1:22 p.m., BS 309; 05/24/09 11:25 a.m., BS 338; 5/24/09 1:01 p.m., BS 284; 5/25/09 10:52 a.m., BS 332; 5/25/09 2:18 p.m., BS 241; 5/27/09 1:19 p.m., BS 545; and 5/27/09 9:35 p.m., BS 570.

Documentation in the personal care attendant (PCA) notes, dated May 25, 2009, noted, "H.S. Blood sugar was 200, she never got her 60 units The Lantus was missing." The client had a physician's order to receive 60 units of Lantus insulin every night.

Treatment orders signed and dated by client #2's physician on March 2, 2009, were as follows: check oxygen saturation every shift; monitor lower extremity edema every shift; assist with ambulation daily; rinse BiPAP canister at the end of every shift; change oxygen tubing once weekly; change BiPAP tubing and accessories once weekly; monitor lung sounds every shift; monitor vital signs every shift; change trach tube once monthly; and change inner cannula once daily.

The May 2009 treatment records in the client's file were entirely blank in the areas where completed treatments would be documented. The aforementioned treatments were entered on the treatment record, but the record lacked documentation indicating any of the treatments had been completed as ordered. Narrative documentation in the nurses' notes for the month of May 2009 indicated some treatments were provided on some days. The following treatments were documented as provided: the client's oxygen saturations were checked on May 7 and 20; the client's lower extremity edema was monitored on May 2 and 5; lung sounds were monitored on May 7 and 20; vital signs were done on May 4, 5, 7, 11, 20 and 28, 2009; trach care was completed on May 5 and 11 and the inner cannula was changed on May 5, 2009.

Client #2 had physician orders for 1% Lotrimin cream and nystatin powder to be applied twice per day. The aforementioned treatments were entered on the treatment record, but there was no documentation on the record indicating any of the treatments had been administered as ordered. Documentation in the nurses' notes indicated the client refused the cream on May 5, 2009.

Client #2 was observed receiving her morning medications at 12:50 p.m. on May 28, 2009. The client's medications were emptied from a medi-set (medication) container by unlicensed employee D directly on the table next to the client. The client was observed taking each one of her pills which included aspirin 81 mg., Norvasc 5 mg., prilosec 20 mg., Lasix 20 mg., potassium chloride 20 mEq, theophylline 300 mg., Oyster shell 500 mg., Mucinex 600 mg., Seroquel 300 mg., and metoprolol 25 mg. The reviewer did not observe employee D document the administration of the medications after she gave them to the client.

A document labeled, PCA Medication Administration Charting, with the client's name was observed on May 29, 2009. Employee A's initials were entered 18 times in the 8:00 a.m. time slot for the month of May 2009, otherwise the form was blank.

When interviewed May 29, 2009, employee A stated she entered her initials on the form each time she administered client #2's medications. She stated she did not know why no one else had entered their initials on the form.

When interviewed May 28, 2009, the registered nurse stated medications were set up by a licensed nurse in a medi-set container for a week supply at a time. The procedure for the nurse setting up the medications was to document on the MAR each medication that was set up by the nurse into the medi-set container.

Client #2's MAR lacked documentation of a medication set up for all of the clients' physician prescribed medications from May 21 through May 26, 2009. The physician ordered aspirin was not documented on the MAR as set up for May 27 and 28, 2009 and the client's Lasix and potassium chloride were not documented as set up for May 19 and 20, 2009.

Client #1's MAR for May 2009 indicated Accu-Cheks (blood sugar monitoring) were to be done daily at alternative times. There was no evidence the May 31, 2009, 12:00 p.m. that the Accu-Chek was done. When interviewed May 31, 2009 at 5:45 p.m., the LPN confirmed the Accu-Chek had not been documented as being completed. She could not determine if it had been done or not.

Client #3's "PCA Medication Administration Charting" for May 2009 lacked evidence client #3 received his medications as ordered by the physician on May 2, 3, 5, 12, 14, 16, 17, 19, 21, 26, and 28, 2009, at 8:00 a.m. and on May 1 to 28, 2009, at 4:00 p.m. and 9:00 p.m. When interviewed May 31, 2009, employee F confirmed the medications were not signed off as given.

On May 31, 2009 at 4:42 p.m., the reviewer observed client #3's medication box and the client's 4:00 p.m. medications remained in the box. When interviewed May 31, 2009, employee F stated that she came to work late and thought the 4:00 p.m. medications had already been given. Employee F confirmed the 4:00 p.m. medications remained in the box. At 5:19 p.m. the medications remained in client #3's medication box, and had not been administered.

10. MN Rule 4668.0160 Subp. 5

INDICATOR OF COMPLIANCE: # 4

Based on record review, the licensee failed to ensure that entries in the client record were authenticated with the name and title of the person making the entry for one of one client (#2) record reviewed. The findings include:

Client #2's record contained an employee signature verification record with five names listed, but the names lacked the title of the employees.

The initials of F and J on the medication administration record and initials of SZ and HO on the blood glucose monitoring record were not listed on the signature verification record. There were no other identifying signature verification documents made available for review.

11. MN Rule 4668.0160 Subp. 6

INDICATOR OF COMPLIANCE: # 4

Based on record review and interviews, the licensee failed to provide notes summarizing each contact with a client and enter notes into the record no later than two weeks after contact for one of one client (#2) record reviewed. The findings include:

The client's record did not contain documentation of the services provided. According to the client #2's service agreement, dated September 3, 2008, the frequency of the client's services was 23.5 hours per day which included both nursing and personal care attendant services (PCA). The personal care attendant (PCA) time sheets for the client were requested from the owner on May 28. The owner was unable to provide the time sheets on May 28, 2009, stating the PCA time sheets were at her attorney's office, but she would provide them the following day. On May 29, 2009, the "PCA Time and Activity

Documentation" sheets provided from the owner were from 2008 with the most current time sheet dated October 12, 2008.

When interviewed on May 29, 2009 the owner was informed the PCA time sheets provided were not current. The owner stated she had stopped by her attorney's office and collected the files, but she didn't get a chance to look through them before she provided them to the reviewer.

The PCA time sheets and nursing time sheets for May 2009 were requested from the owner again on June 3, 2009. The owner informed the reviewer the time sheets were at her attorney's office and she didn't know if she could get anyone to fax the time sheets from her attorney's office to her business office.

When interviewed on June 4, 2009, the owner stated the PCAs fill out the time sheet required to be used by the Department of Human Services at the end of each shift, and the client signs the sheet weekly verifying the hours and services provided. The PCA and nursing time sheets for May 2009 for client #2 were requested, and the owner stated she would fax the sheets to the fax number on the reviewer's business card. The requested time sheets were never received.

12. MN Statute §144A.46 Subd. 5(b)

INDICATOR OF COMPLIANCE: # 3

Based on observation and interview the licensee failed to ensure that persons disqualified from having direct contact with clients followed the provisions of their disqualification (person C) and that background studies were completed for three of five (B, E, and G) employees reviewed. The findings include:

Person C had been disqualified from any position allowing direct contact with or access to, persons receiving services from programs licensed by the Minnesota Department of Health. Information obtained from the Office of Health Facility Complaints indicated that person C received letters from the Minnesota Department of Human Services, dated November 14, 2007, and March 20, 2008, regarding the disqualification.

Client #1, who is in a vegetative state, resides in apartment 122 (which is also the agency office). When interviewed May 28, 2009, employee B stated that person C came into apartment 122, picked "things" up and dropped off supplies.

During an interview on May 29, 2009 at 11:47 a.m. employee A stated person C has been in apartment 122 at times doing paperwork or delivering supplies. She indicated that she thought he would be in the apartment around 11:42 a.m. on May 29, 2009 while she delivered a phone to apartment 412.

Employee B, E and G were hired by the licensee on January 28, 2009, April 7, 2009 and July 19, 2007, respectively. The employees' records did not contain any evidence that a background study had been completed.

When interviewed June 3, 2009, the owner stated she had noticed that the employees did not have a background study and she had been waiting for the studies to come in the mail. She stated she needed to call for the results of the study.

13. MN Statute §626.557 Subd. 14(b)

INDICATOR OF COMPLIANCE: # 3

Based on record review and interview, the licensee failed to ensure that an individualized assessment of the client's susceptibility to abuse was completed and measures to minimize the risk of abuse were developed for one of one client (#2) reviewed. The findings include:

On May 28, 2009, client #2's complete record was requested from the owner.

When interviewed June 4, 2009, the owner stated the nurses do the vulnerable adult assessments and file it in the client file. The owner stated she would need to locate the assessment. No assessment was provided to for review during the survey**.**

A draft copy of this completed form was faxed to Jennifer Malobe on June 8, 2009. Any correction orders 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).

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

June 19, 2008

Jennifer Malobe, Administrator
Tender Care Home Services Inc HFID 25353
9700 45th Avenue N Ste 122
Plymouth, MN 55442

Re: Telephone Interview

Dear Ms. Malobe,

The information discussed during a telephone interview conducted by staff of the Minnesota Department of Health, Case Mix Review Program, on June 4, 2008, is summarized in the enclosed documents listed below:

Telephone Interview and Education Assessment form
A summary of the items discussed during the phone interview and a listing of the education provided during the interview

Resource Sheet for Home Care Providers
A listing of web-sites and documents useful to home care providers in assuring compliance with home care regulations

Please note, it is your responsibility to share the information contained in this letter and the information from this interview with your direct care staff and the President of your facility's Governing Body.

If you have any questions, please feel free to call our office at (651) 201-4301.

Sincerely,

Jean M. Johnston

Jean Johnston, Program Manager
Case Mix Review Program

Enclosure(s)

CMR TELEPHONE 03/08

Class A and Class F Home Care

Telephone Interview and Education Assessment

Registered nurses from the Minnesota Department of Health (MDH) use this form to document telephone interviews and education of newly licensed Class F and Class A (licensed only) Home Care Providers as well as other providers who have not been surveyed by Case Mix Review staff.

Licensing requirements listed below were reviewed during a telephone interview. Information from this interview along with other data will be considered when making decisions regarding the timing of an on site survey. The noted topics were discussed during the telephone interview and education was provided in the checked areas.

Name of Home Care Licensee: TENDER CARE HOME SERVICES INC

HFID #: 25353 Type of License: Class A Home Care

Date of Interview: June 4, 2008, and had not begun providing care with this license

Interview Topic	Item Discussed	Education Provided
Access to information	☒ Home Care Rules and Statutes	☐ Web address for Home Care Rules and Statutes was sent (MN Statute §144A and MN Rule 4668) ☐ Web address for Vulnerable Adult Act was sent (MN Statute §626.557) ☐ Web address for Maltreatment of Minors Act was sent (MN Statute §626.556) ☐ Board of Nursing web address was sent Sent via: E-mail ☒ Basic Education Provided
Client Needs	☒ Care needs of clients	☐ Home Care licensee is required to have staff sufficient in qualifications and numbers to meet client needs (MN Rule 4668.0050) ☒ Basic Education Provided

Interview Topic	Item Discussed	Education Provided
Home Care Bill of Rights	☒ Bill of Rights given to clients	☐ Current and appropriate version of home care bill of rights required Minnesota Dept. of Health web-site ☒ Basic Education Provided
Advertising	☒ Advertising should reflect services provided	☐ Includes all forms of advertising MN Rule 4668.0019 ☒ Basic Education Provided
Unlicensed personnel (ULP) who provide direct care	☒ Training needed for ULP to be qualified to provide direct care ☒ Ongoing education needed for unlicensed personnel	☐ Initial training needed MN Rule 4668.0100 Subp. 5 (Class A) ☐ Competency testing required MN Rule 4668.0130 Subp.3 (Class A) ☐ Inservice training MN Rule 4668.0100 Subp. 6 (Class A) ☐ Ongoing infection control training needed MN Rule 4668.0065 Subp. 3 ☒ Basic Education Provided
Unlicensed personnel (ULP) and medication administration	☒ Training required ☒ Insulin administration by unlicensed personnel	☐ Difference between medication administration and assistance with medication administration. MN Rule 4668.0003 Subp. 2a and Subp. 21a ☐ Medication reminders – a visual or verbal cue only. MN Rule 4668.0003 Subp. 21b ☐ ULP limitations with insulin administration MN Rule 4668.0100 Subp. 3 (Class A) ☐ Prescriber orders required MN Rule 4668.0150 Subp. 3 (Class A) ☒ Basic Education Provided

Interview Topic	Item Discussed	Education Provided
Role of registered nurse (RN) and licensed practical nurse (LPN)	☒ Need to verify licenses of nurses ☒ RN does assessments ☒ LPN does monitoring	☐ Difference between RN and LPN role MN Rule 4668.0180 Subp. 5 (Class A) and Minnesota Nurse Practice Act ☐ Points at which RN assessment is needed - Class F requirements ☐ RN assessment and change in condition MN Rule 4668.0100 Subp. 9 (Class A) ☒ Basic Education Provided
Supervision of unlicensed personnel (ULP)	☒ Requirements for supervision and monitoring of unlicensed personnel	☐ RN supervision and LPN monitoring of unlicensed personnel ☐ Timing of supervision and monitoring MN Rule 4668.0100 Subp. 9 (Class A) ☒ Basic Education Provided
Service plan or agreement	☒ Contents of Service Plan or Agreement ☒ Person who prepares service plan	☐ Differentiate between licensee service plan and county service plan ☐ Required components of service plan ☐ Need to review service plan ☒ Basic Education Provided MN Rule 4668.0140 (Class A)
Protection of health, safety and well being of clients	☒ Background studies for all staff ☒ Assessment of vulnerability for all clients	☐ Background studies not transferable ☐ Only DHS background study accepted MN Statute §144A.46 Subd. 5 ☐ Plan to address identified vulnerabilities required MN Statute §626.557 Subd. 14b ☒ Basic Education Provided
Infection control	☒ Tuberculosis screening prior to direct client contact	☐ System for follow up on TB status after hire MN Rule 4668.0065 Subps. 1 & 2 ☐ Yearly infection control inservice required for all staff including nurses MN Rule 4668.0065 Subp. 3 ☒ Basic Education Provided

Interview Topic	Item Discussed	Education Provided
Assisted Living	☒ Arranged providers for assisted living required to follow 144G	☐ Uniform Consumer Information Guide must be given to all prospective clients MN Statute 144G.03 Subd. 2b9 ☒ Basic Education Provided

The data used to complete this form was reviewed with Jennifer Malobe, Administrator during a telephone interview on June 4, 2008,. A copy of this Telephone Interview and Education Assessment form will be sent to the licensee. Any questions about this Telephone Interview and Education Assessment form should be directed to the Minnesota Department of Health, (651) 201-4301. This form will be posted on the MDH web-site. Home care provider general information is available by going to the following web address and clicking on the appropriate home care provider link:

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

Statutes and rules can be viewed on the internet:
http://www.revisor.leg.state.mn.us/stats - for Minnesota Statutes

http://www.revisor.leg.state.mn.us/arule/ - for Minnesota Rules