MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7009 1410 0000 2303 7465

April 15, 2010

Elizabeth Nyuemah, Administrator
Global Gospel Garden Social SV
2560 Vierling Drive
Shakopee, MN 55379

Re: Results of State Licensing Survey

Dear Ms. Nyuemah:

The above agency was surveyed on March 22, 23, and 24, 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 7465

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:	ELIZABETH NYEMAH	DATE: April 15, 2010
PROVIDER:	GLOBAL GOSPEL GARDEN SOCIAL SV	COUNTY: HENNEPIN
ADDRESS:	2560 VIERLING DRIVE SHAKOPEE, MN 55379	HFID: 26632

On March 22, 23 and 24, 2010, a surveyor 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 4668.0070 Subp. 3

Based on record review and interview, the licensee failed to ensure a job description was developed for one of one licensed staff (A) reviewed. The findings include:

Employee A, a registered nurse (RN), was hired February 26, 2010. There was no job description available for the registered nurse.

When interviewed March 23, 2010, the program director confirmed she did not have a job description for the RN, and that she was in the process of developing one.

TO COMPLY: The licensee shall maintain current job descriptions, including qualifications, responsibilities, and identification of supervisors, if any, for each job classification.

TIME PERIOD FOR CORRECTION: Thirty (30) days

2. MN Rule 4668.0100 Subp. 2

Based on interview and record review, the licensee failed to ensure that unlicensed staff who administered medications were instructed by the registered nurse (RN) in medication administration and demonstrated competency to the RN their ability to perform the procedure for one of one client's (#1) record reviewed. The findings include:

Client #1 began receiving services from the licensee on November 23, 2009, which included assistance with medication administration twice a day.

When interviewed March 23, 2010, the program director stated that there were three unlicensed staff who were not trained in medication administration by the RN, employees D, E and F. The program director stated because they were not trained in medication administration, she set up the client's medications whenever the three unlicensed staff persons were working, by crushing and prepackaging the client's medications for the unlicensed staff to administer at a later date and time. The program director confirmed employees D, E and F administered the medications to client #1 that were set-up by her prior to administration. The program director indicated she thought this was acceptable until they were trained by the RN.

When interviewed March 23, 2010, the current RN stated she was not aware that some unlicensed staff were not trained in medication administration and stated she was under the impression that all of the existing staff were trained in medication administration by the previous RN.

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

3. MN Rule 4668.0100 Subp. 9

Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted supervisory visits every fourteen days for one of one client's (#1) record reviewed. The findings include:

Client #1 began receiving services on November 23, 2009, which included delegated nursing tasks of twice daily assistance with medication administration and daily blood glucose monitoring. These delegated nursing tasks required RN supervisory visits to be conducted every fourteen days. The client's record contained three RN supervisory visits, December 23, 2009 and January 14 and 20, 2010. There were no further RN supervisory visits or licensed practical nurse monitoring visits documented.

When interviewed March 23, 2010, the program director stated the visits on December 23, 2009 and January 14 and 20, 2010 were the only visits the previously employed RN provided.

When interviewed March 23, 2010, the current RN stated she had not conducted any supervisory visits since she was hired February 26, 2010.

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

4. MN Rule 4668.0140 Subp. 2

Based on interview and record review, the licensee failed to ensure that service agreements were complete for one of one client's (#1) record reviewed. The findings include:

Client #1's service agreement, dated October 28, 2009, indicated the client received assistance with personal care and assistance with medication administration. The service agreement did not include the frequency of the services, the identification of the persons or categories of persons who provided the services, the schedule or frequency of supervision of the services, the fees for the services, nor did it include a plan for contingency action.

When interviewed March 23, 2010, the program director confirmed the lack of completeness of client #1's service agreement and indicated she was not aware of this requirement.

TO COMPLY: The service agreement required by subpart 1 must include:

A. a description of the services to be provided, and their frequency;

B. identification of the persons or categories of persons who are to provide the services;

C. the schedule or frequency of sessions of supervision or monitoring required, if any;

D. fees for services;

E. a plan for contingency action that includes:

(1) the action to be taken by the licensee, client, and responsible persons, if scheduled services cannot be provided;

(2) the method for a client or responsible person to contact a representative of the licensee whenever staff are providing services;

(3) who to contact in case of an emergency or significant adverse change in the client's condition;

(4) the method for the licensee to contact a responsible person of the client, if any; and

(5) circumstances in which emergency medical services are not to be summoned, consistent with the Adult Health Care Decisions Act, Minnesota Statutes, chapter 145B, and declarations made by the client under that act.

Class C licensees need not comply with items B and C and this item, subitems (2) and (5). Subitems (3) and (5) are not required for clients receiving only home management services.

TIME PERIOD FOR CORRECTION: Thirty (30) days

5. MN Rule 4668.0150 Subp. 6

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

Client #1 began receiving services November 23, 2009, which included assistance with medication administration. The client's record did not include a renewal of the client's medications since the client began receiving services in November 2009.

When interviewed March 23, 2010, the program director confirmed the client's medications were not renewed and indicated she was not aware of this requirement.

When interviewed March 23, 2010, the current registered nurse stated she had not sent a listing of the client's medications to her physician for renewal since she started with the agency on February 26, 2010.

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

TIME PERIOD FOR CORRECTION: Fourteen (14) days

6. MN Rule 4668.0160 Subp. 6

Based on interview and record review, the licensee failed to ensure that notes summarizing each contact with the client were entered into the record no later than two weeks after contact for one of one client's (#1) record reviewed. The findings include:

Client #1 began receiving services from the licensee on November 23, 2009. The client's record was reviewed on March 22, 2010, and the record did not contain any nursing progress notes, or supervisory visits by the nurse.

When interviewed March 22, 2010, regarding the lack of nursing progress notes and supervisory visits, the program director stated that the previous registered nurse (RN) had a file of documentation for client #1 that he kept with him and that she would contact him to obtain this information. The program director stated the previous RN was employed from November 2009 until the end of February 2010.

On March 23, 2010, the program director produced two nursing notes for client #1, dated December 21, 2009, and January 23, 2010. The program director stated the previous RN electronically sent these documents to her March 22, 2010.

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: Thirty (30) days

7. MN Statute §144A.44 Subd. 1(2)

Based on observation, interview and record review, the licensee failed to ensure that nursing directed the care for one of one client's (#1) record reviewed. The findings include:

Client #1 began receiving services from the licensee on November 23, 2009, which included assistance with medication administration and assistance with activities of daily living. Client #1 had a diagnosis of Asthma and had prescriber's orders for Proair HFA 90 mcg (Albuterol) inhaler, inhale one to two puffs with comfort seal mask by mouth every four hours as needed for wheezing, uncomfortable breathing and/or asthma attack. The client also had a prescriber's order for Duoneb 2.5-.5 milligrams/3 milliliters nebulize 3 milliliters (1 vial) per nebulizer every four hours as needed.

Documentation by the program director, an unlicensed staff person, in the client's health progress notes, dated March 15, 2010, indicated the following, "(the client's name) had an asthma attack two time last not and was not responding. So staff use the Nebulizer 3 ml(1 vial) after the meds was out she seem relax. But for the whole night she was confuse by taking off her clothes, covers, calling all her dead family people names, saying let go and putting her leg out of bed. She wasn't sleep at all."(sic)

Documentation on the client's medication administration record (MAR) for March 2010 indicated the program director administered Proair HFA 90 mcg inhaler at 8:00 p.m. and again at 9:00 p.m. on March 15, 2010. The reason for giving the inhaler as documented on the MAR was "For asthma attack, was not responding after use - two times." The client's MAR indicated at 10:00 p.m. on March 15, 2010, the program director administered a nebulizer treatment.

When interviewed March 23, 2010 regarding the client's asthma attack and the reason the client's inhaler was administered within one hour of the previous dose, not four hours as ordered, the program

director stated that she was called to come in by the staff on duty because the client was having an asthma attack. The program director stated she administered the first dose of the inhaler and it did not help, so she administered another dose, which didn't help, so she administered the nebulizer treatment. When questioned whether the current registered nurse (RN) was notified of the client's asthma attack or the client's physician, the program director stated that she called the RN and the RN instructed her to call the client's physician. The program director stated she called the client's physician, and the physician instructed her to give the inhaler within an hour, and the nebulizer after that. The client's record did not contain any physician's order to administer the inhaler at a frequency less than every four hours nor did the client's record indicate that the nurse or the physician had been consulted regarding the client's asthma attack. There were no vital signs documented regarding the client's status during the asthma attack other than the client had restlessness and confusion throughout the night.

Although the program director indicated she notified the current RN of the client's asthma attack on March 15, 2010, when interviewed March 23, 2010, the current RN stated she was not aware of the client's asthma attack until she came to the facility the following day, March 16, 2010. The RN also stated she was not aware that the client was administered her inhaler within one hour of the previous dose or that she received a nebulizer treatment. The RN confirmed she had not called or received an order from the client's physician regarding the client's inhaler frequency. The RN stated she was told on March 16, 2010, that the client had an "anxiety attack" the previous night.

Client #1's service agreement dated October 28, 2009 indicated the client received assistance with medication administration. Client #1's medications were sometimes set-up by an unlicensed staff person which were then administered at a later date and time by another unlicensed staff person. The definition of assistance with self-administration of medications under MN Rule 4668.0003 Subp. 2a, states medications may be set-up by a nurse, physician or pharmacist.

The client's MAR indicated she received assistance with medication administration twice a day by unlicensed staff. The client received the medications Aspirin, Amlodipine, Zocor, Atenolol and Metformin on a scheduled basis. The client's MAR for March of 2010 indicated the initials, "PP" above the initials of the person who administered the client's medications on March 3, 6, 13 and 20, 2010.

When interviewed March 22, 2010 regarding why there were two sets of initials on the mentioned days in March, the program director stated the initials PP stood for "prepackaged." The program director stated that she needed to prepackage the client's medications on the days that there was an unlicensed staff person on duty who had not been trained in medication administration. When questioned by the surveyor as to what was meant by prepackaging the client's medications, the program director demonstrated the following to the surveyor. The program director stated she would punch the client's medications out of a 30 day bubble pack card and/or labeled medication bottle for the specified time period, and put the medications in a pill crusher and crush the client's medications. She would then place the crushed medications in a small plastic bag and place the bag in a med-set container for the designated day and time to be administered. The unlicensed staff would then administer the client's medications on the designated day and time.

When interviewed March 23, 2010, regarding the practice of an unlicensed staff person prepackaging medications for another unlicensed staff person to administer at a later day and time, the current RN stated she was not aware this practice was occurring and stated she was under the impression that all of the existing staff were trained in medication administration by the previous RN.

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: Fourteen (14) days

8. MN Statute §626.557 Subd. 14(b)

Based on observation, interview and record review, the licensee failed to ensure that an individualized assessment of the client's susceptibility to abuse and a plan to minimize the risk of abuse to that person was developed for one of one client's (#1) record reviewed. The findings include:

Client #1 began receiving services from the licensee on November 23, 2009. The client received assistance with medication administration and assistance with all of her activities of daily living, including eating and drinking, and was unable to communicate her needs using the English language. The client required all of her liquids to be thickened due to the risk of choking on thin liquids. The client's health progress notes dated November 26, 2009 identified an incident where the client was administered liquids by a visitor that was not thickened, which caused the client to choke. The client was transferred to the hospital. The client's health progress notes also identified disagreements among family members concerning the care of the client, and guardianship was being pursued. The client was observed on all days of the survey to not be able to communicate to staff in English. The program director was observed to interpret for the client. There was no individualized assessment of the client's risk of abuse by other individuals, nor was there a plan developed to assist in minimizing the risk of abuse to the client.

When interviewed March 23, 2010, the program director confirmed there was not an individual abuse prevention plan developed for client #1.

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: Fourteen (14) days

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