MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
Inver Grove Heights WP LLC
9056 Buchanan Trail
Inver Grove Heights, Minnesota 55077
Dakota County

Report#: HL26132011

Date: January 11, 2016

Date of Visit: November 3, 2015
Time of Visit: 10:00 a.m. – 4:00 p.m.

By: Lisa Jacobsen, RN, Special Investigator

Type of Facility: ☐ Nursing Home ☐ HHA ☒ Home Care Provider
☐ SLF ☐ ICF/IID
☐ Hospital ☐ Other: _____

☒ Facility Self Report ☐ Complaint

Allegation(s): **It is alleged** that a client was neglected when the staff, alleged perpetrator (AP) failed to test the client's blood sugar level and did not administer the client's insulin over the course of two days. The client became confused, was vomiting, had rapid respirations and was hospitalized.

An unannounced visit was made at this facility and an investigation was conducted under:

☐ Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
☐ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
☐ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
☐ Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
☐ Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
☒ Federal Regulations for EMTALA (42 CFR Part 489)
☐ State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)

☐ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
☐ State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
☐ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)
☐ State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
☑ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
☑ State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☐ Abuse ☑ Neglect ☐ Financial Exploitation was:

◉ Substantiated ○ Not Substantiated ○ Inconclusive based on the following information:

Based on a preponderance of evidence, neglect of health occurred when staff didn't check the client's blood sugar and administer the client's insulin as prescribed over two days. The client required medical treatment at the hospital.

The client had a diagnosis of diabetes and dementia and required assistance with medication administration including insulin administration. The client received regularly scheduled insulin at bedtime. In addition, the client required blood sugar checks four times a day with administration of insulin based on the result of the blood sugar reading.

Two days after admission to the facility, the client received seven units of Novolog insulin at 4:30 p.m., when the client should have received six units based on the result of the client's blood sugar reading. In addition, the client did not receive her/his Lantus insulin at bedtime, nor was the client's blood sugar checked at bedtime and Novolog insulin administered based on the result of the blood sugar reading. The following evening, the client did not have her/his blood sugar checked at 4:30 p.m. and 8:00 p.m. Novolog insulin was not administered based on the result of the blood sugar check, nor did the client receive her/his regularly scheduled Lantus insulin at bedtime.

The following morning, the client was found on the floor confused, disoriented, sweating and had vomited clear fluid. The client's blood sugar reading registered "High" on the glucometer machine and the client's blood pressure was 80/50 with a heart rate of 120 beats per minute. Emergency personnel were contacted and the client was transferred to the hospital for evaluation.

Hospital records indicated the client was admitted with a diagnoses of diabetic ketoacidosis (a serious complication of diabetes that occurs when your body produces high levels of blood acids called ketones. The condition develops when your body can't produce enough insulin.) The client's blood sugar in the emergency room read, "High" which was over 600 (a normal blood sugar reading is 70-100). The client was initially started on an insulin drip and was treated in the intensive care unit. Later the client was switched to subcutaneous insulin injections. Hospital documentation indicated the client's ketoacidosis was caused by the

client not receiving her/his insulin, as there was no other source or focal infection found. The client was discharged back to the facility six days after being admitted to the hospital.

The AP, a medication aide, who worked for a supplemental staffing agency stated she had worked at the facility passing medications on a different floor only four shifts prior to the incident happening with the client. The AP stated she was assigned to pass medications to clients on the floor the client resided and an additional floor the two days she omitted checking the client's blood sugar and administering the client's insulin. The AP stated s/he tried to keep track of all the medications/blood sugars and insulin to give, but stated s/he was overwhelmed and somehow missed administering the client's blood sugar checks and insulin.

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ individual(s) and/or ☒ facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility is responsible for the neglect due to inadequacy of training of supplemental staff, inadequacy of staffing levels and inadequacy of caregiver supervision. The AP worked through a supplemental staffing agency and did not receive any orientation/training from the facility prior to the AP beginning her/his first shift at the facility. The AP was handed the medication cart keys and was expected to know what to do and where things were. The AP had worked at the facility passing medications only four shifts prior to the incident occurring with the client and passed medications on a different floor. The two days that the client did not receive her/his blood sugar checks and insulin was the first time the AP was assigned to pass medications on that floor and an additional floor. The adequacy of facility staffing levels were lacking. On the two days the client did not receive her/his blood sugar checks and insulin, the other staff person passing medications was a trained medication aide and also worked for a supplemental staffing agency. Of the five staff who worked the evening shift the two days the omissions occurred, three of the five staff were from a supplemental staffing agency. The adequacy of caregiver supervision was lacking. There was no nurse present in the facility and the AP was not given a phone number of a nurse to contact for questions/concerns the staff may have when administering medications.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met

The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557). No state licensing orders were issued.

State Statutes Chapters 144 & 144A – Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: _____
(State licensing orders will be available on the MDH website.)

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated
"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect
"Neglect" means:

(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:

(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and

(2) which is not the result of an accident or therapeutic conduct.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

☒ Medical Records
☒ Medication Administration Records
☒ Facility Incident Reports
☒ ADL (Activities of Daily Living) Flow Sheets
☒ Physician Orders
☒ Nurses Notes
☐ Activities Reports
☐ Therapy and/or Ancillary Services Records
☐ Skin Assessments
☒ Service Plan
☐ Care Guide
☒ Treatment Sheets
☒ Physician Progress Notes
☒ Laboratory and X-ray Reports
☐ Social Service Notes
☐ Meal Intake Records
☐ Weight Records
☒ Assessments
☒ Care Plan Records
☐ Other, specify: _____

Other pertinent medical records:

☒ Hospital Records ☐ Ambulance/Paramedics ☐ Medical Examiner Records ☐ Death Certificate

☐ Police Report ☐ Other, specify: _____

Additional facility records:

☐ Resident/Family Council Minutes
☒ Staff Time Sheets, Schedules, etc.
☒ Facility Internal Investigation Reports
☐ Call Light Audits
☒ Personnel Records/Background Check, etc.
☒ Facility In-service Records
☒ Facility Policies and Procedures
☐ Other, specify: _____

Number of additional resident(s) reviewed: 3

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

◉ Yes ○ No ○ N/A Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s): ○ Yes ○ No ◉ N/A Specify: Facility Self-Report

If unable to contact complainant, attempts were made on:
Date/time: _____ Date/time: _____ Date/time: _____

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation: ○ Yes ◉ No ○ N/A Specify: The client was visited, but unable to be interviewed due to cognitive deficits.

Did you interview additional residents: ◉ Yes ○ No

Total number of resident interviews: 2

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 6

Physician interviewed: ○ Yes ◉ No

Nurse Practitioner interviewed: ○ Yes ◉ No

Physician Assistant interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ◉ Yes ○ No ○ N/A Specify: _____

Attempts to contact: Date/time: _____ Date/time: _____ Date/time: _____

If unable to contact was subpoena issued: ○ Yes , date subpoena was issued _____ ○ No

Were contacts made with any of the following:

☐ Emergency personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☐ Wound Care	☒ Medication Pass	☐ Meals
☐ Personal Care	☐ Dignity/Privacy Issues	☐ Restorative Care
☐ Nursing Services	☐ Safety Issues	☐ Facility Tour
☐ Infection Control	☐ Cleanliness	☐ Injury
☐ Use of Equipment	☐ Transfers	☐ Incontinence
☐ Call Light	☒ Other: Observed staff conducting blood sugar checks	

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A Specify: _____

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A Specify: _____

Were photographs taken: ○ Yes ◉ No Specify: _____

xc: Health Regulation Division - Home Care & Assisted Living Program
Inver Grove Heights City Police Department
Dakota County Attorney
Inver Grove Heights City Attorney

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	H26132	A. BUILDING: _____ B. WING _____	C 01/22/2016

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0 000	Initial Comments *****ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, these correction order(s) are issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On November 3, 2015, a complaint investigation was initiated to investigate #HL26132011. At the time of the survey, there were 48 clients that were receiving services under the comprehensive license. The following correction orders are issued.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes/Rules for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute/Rule number and the corresponding text of the state Statute/Rule out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER ' S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
0 265	144A.44, Subd. 1(2) Up-To-Date Plan/Accepted Standards Practice Subdivision 1. Statement of rights. 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	0 265		

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0 265	Continued From page 1 accepted health care, medical or nursing standards, to take an active part in developing, modifying, and evaluating the plan and services; This MN Requirement is not met as evidenced by: Based on observation, interview and policy review, the licensee failed to ensure that services were provided according to nursing standards for two of two clients (C2 and C3) observed receiving blood glucose checks and insulin administration. This practice resulted in a level 3 violation (a violation that that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and is issued at an isolated scope (1 or a limited number of clients are affected). The findings included: According to the Centers for Disease Control and Prevention, the Best Practices for Assisted Blood Glucose Monitoring and Insulin Administration included the following: "Whenever possible, blood glucose meters should be assigned to an individual person and not be shared. If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions to prevent carry-over of blood and infectious agents. If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be shared." Observations of a medication administration pass on November 3, 2015 at 12:15 p.m. revealed the following: An unlicensed person (ULP)-B was observed to check C2's blood glucose and	0 265		

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0 265	Continued From page 2 administer the client's insulin. ULP-B was observed to use a multi-client or "house" glucometer machine to check the client's blood glucose, because the client was out of his own test strips for his personal glucometer machine. ULP-B was observed to prick C2's finger with a lancet without cleaning the client's finger with an antiseptic swab prior to puncturing the client's skin. After receiving the result of the client's blood glucose, ULP-B was observed to dial the dose of insulin on C2's insulin pen and inject the insulin into the client's abdomen, again without cleaning the area on the client's abdomen with an antiseptic swab prior to the injection. After checking C2's blood glucose with the "house" glucometer, ULP-B was observed to check C3's blood glucose on November 3, 2015 at 12:30 p.m. ULP-B stated C3 was out of test strips also so she used the "house" glucometer machine to test C3's blood glucose. ULP-B did not clean/disinfect the glucometer machine before using it on C3, nor did she clean/disinfect the machine after she was done checking C3's blood glucose and put the machine back into the medication cart. ULP-B was observed to prick C3's finger to get a sample of blood to test the client's blood sugar and was observed to administer C3's insulin into her abdomen without using an antiseptic wipe to clean C3's finger or the area on the client's abdomen prior to the injection. The facility's policy/procedure dated August 22, 2014 titled, Blood Glucose Testing indicated staff were to clean the site to be punctured with an antiseptic swap and allow to dry completely. The facility's policy/procedure which was undated, indicated that after choosing the injection site,	0 265		

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0 265	Continued From page 3 staff were to clean the site with an alcohol wipe and allow to dry before pushing the needle into the skin. When interviewed December 21, 2015 at 9:05 a.m., registered nurse (RN)-A stated staff were trained to swab the area with an antiseptic wipe prior to puncturing the client's skin to test the client's blood sugar and prior to injecting a needle to administer a client's insulin. In addition, RN-A stated s/he was unsure whether the licensee had a policy regarding cleaning/disinfecting multi-person glucometer machines. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 265		
0 325	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights: (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on interview and documentation, the licensee failed to ensure that a client receiving home care services was free from neglect when one of three clients (C1) did not get her blood sugar checked and insulin administered as ordered, requiring hospitalization. This practice resulted in a level 3 violation (a violation that harmed a client's health or safety, not including serious injury, impairment , or death), and is issued at an isolated scope (1 or a limited	0 325		

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0 325	Continued From page 4 number of clients are affected). The findings included: C1's record was reviewed. C1 began receiving services from the licensee on October 15, 2015 and had diagnoses of Type 1 diabetes and dementia. C1's "Individual Service Plan Agreement" dated November 3, 2015 indicated the client received assistance with medication administration, blood glucose monitoring and insulin injections. C1 had prescriber's orders dated October 14, 2015 for blood sugars to be checked four times a day, prior to breakfast, lunch, dinner and at bedtime and a sliding scale of Novolog Insulin to be administered based on the blood sugar readings. In addition, C1 had prescriber's orders dated October 14, 2015 for Lantus insulin 15 units at bedtime. C1's medication administration record (MAR) for October 2015 revealed that on October 17, 2015, C1's blood sugar was 80 at 4:30 p.m. The unlicensed person (ULP)-G administered 7 units of Novolog insulin in error. The client's sliding scale of insulin at 4:30 p.m. indicated 6 units of Novolog insulin was to administered for a blood sugar reading of 80-150. In addition, C1's October 2015 MAR was blank in the staff initial area that indicated whether or not a medication was administered, for C1's Lantus insulin at bedtime on October 17 and 18, 2015 and was blank in the staff initial area for checking C1's blood sugar and administering Novolog insulin based on the client's sliding scale at bedtime on October 17, 2015 and 4:30 p.m. and bedtime on October 18, 2015. C1's progress notes dated October 19, 2015 indicated the client was found on the floor, confused, disoriented, sweating and had vomited	0 325		

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0 325	Continued From page 5 some clear fluid. In addition C1's blood sugar reading registered "High,"on the glucometer and the client's blood pressure was 80/50 and her heart rate was 120. Documentation indicated emergency personnel were contacted and the client was transferred to the hospital for evaluation. Hospital records indicated C1 was admitted to the hospital on October 19, 2015 with a diagnoses of diabetic ketoacidosis (a serious complication of diabetes that occurs when your body produces high levels of blood acids called ketones. The condition develops when your body can't produce enough insulin). C1's blood sugar in the emergency room read "High" which was over 600 (normal blood sugar is 70-100). C1's discharge summary dated October 24, 2015 indicated the C1 was initially started on an insulin drip and was treated in the intensive care unit. Later the client was switched to subcutaneous insulin injections. The record indicated the likely cause for C1's ketoacidosis was the client not receiving her insulin at the facility as no other source or focal infection found. The client was discharged back to the facility on October 24, 2015. When interviewed December 21, 2015 at 10:00 a.m., ULP-G stated she was trying to keep track of all the medications/blood sugars and insulin to give, but stated she was overwhelmed and somehow missed C1's blood sugar checks and insulin. When interviewed December 21, 2015 at 9:05 a.m., registered nurse (RN)-A acknowledged that ULP-G had given an inaccurate dose of Novolog insulin to C1 per the client's sliding scale on October 17, 2015 at 4:30 p.m., and did not check C1's blood sugar and administer insulin per the	0 325		

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0 325	Continued From page 6 client's sliding scale on October 17, 2015 at bedtime and October 18, 2015 at 4:30 p.m. and bedtime. In addition, RN-A stated ULP-G did not administer C1's regularly scheduled Lantus insulin at bedtime on October 17 and 18, 2015. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 325		
0 815	144A.479, Subd. 7 Employee Records Subd. 7. Employee records. The home care provider must maintain current records of each paid employee, regularly scheduled volunteers providing home care services, and of each individual contractor providing home care services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification, if licensure, registration, or certification is required by this statute or other rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff providing supervision; (4) documentation of annual performance reviews which identify areas of improvement needed and training needs;	0 815		

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0 815	Continued From page 7 (5) for individuals providing home care services, verification that required health screenings under section 144A.4798 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. Each employee record must be retained for at least three years after a paid employee, home care volunteer, or contractor ceases to be employed by or under contract with the home care provider. If a home care provider ceases operation, employee records must be maintained for three years. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to maintain a record of each individual contractor providing home care services, that included the required information for four of four unlicensed persons, (ULP-B, ULP-D, ULP-G and ULP-I) reviewed. This practice resulted in a level 2 violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety), and is issued at a pattern scope (more than a limited number of staff are involved, or the situation has occurred repeatedly but is not found to be pervasive.). The findings included: On November 3, 2015 at 10:00 a.m., the investigator requested personnel records for ULP-B, ULP-D, ULP-G and ULP-I, who were employed by a supplemental staffing agency and were contracted to work for the licensee and administer medications/insulin and check client's	0 815		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 815	Continued From page 8 blood sugar. The licensee did not maintain any personnel records for the four contracted employees. The licensee requested the information from the supplemental staffing agency after the investigator requested the documents. A review of the documents received for the four ULP's, revealed there were no current job descriptions or competency evaluations for administering insulin, and checking client's blood sugars. When interviewed November 3, 2015, registered nurse (RN)-A was unaware the licensee needed to maintain information for contracted employees. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 815		
0 930	144A.4792, Subd. 7 Delegation of Medication Administration Subd. 7. Delegation of medication administration. When administration of medications is delegated to unlicensed personnel, the comprehensive home care provider must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each client and documented those instructions in the client's records; and	0 930		

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	H26132	A. BUILDING: _____ B. WING _____	C 01/22/2016

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0 930	Continued From page 9 (3) communicated with the unlicensed personnel about the individual needs of the client. This MN Requirement is not met as evidenced by: Based on interview an document review, the licensee failed to ensure that when administration of insulin was delegated to unlicensed person (ULP), the registered nurse (RN) instructed the ULP in the proper methods to administer the medications, and the ULP has demonstrated the ability to competently follow the procedure, for four of four ULPs (ULP-B, ULP-D, ULP-G and ULP-I) contracted staff reviewed. This practice resulted in a level 2 violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) and is issued at a pattern scope (more than a limited number of staff are involved). The findings included: According to staffing records and medication administration records, contracted employees ULP-B, ULP-D, ULP-G and ULP-I administered insulin to clients while working for the licensee in October of 2015. There was no evidence that ULP-B, ULP-, ULP-G and ULP-I were instructed in the proper methods to administer insulin nor was there evidence that they had demonstrated their ability to competently follow the procedure for insulin administration. When interviewed December 22, 2015 at 9:30 a.m. RN-A stated she was not aware that the supplemental staffing agency did not conduct competency testing for their employees on insulin administration. RN-A stated she believed that the	0 930		

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0 930	Continued From page 10 supplemental staff were trained when they came to work for the licensee. The contract between the supplemental agency and the licensee dated July 24, 2015 was reviewed and did not specify which entity was responsible for the unlicensed staff training and competency. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 930		
0 935	144A.4792, Subd. 8 Documentation of Administration of Medication Subd. 8. Documentation of administration of medications. Each medication administered by comprehensive home care provider staff must be documented in the client's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the client's needs when medication was not administered as prescribed and in compliance with the client's medication management plan. This MN Requirement is not met as evidenced	0 935		

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0 935	Continued From page 11 by: Based on interview and document review the licensee failed to ensure that medications were administered as prescribed for three of four clients (C1, C2 and C4) reviewed. This practice resulted in a level 3 violation for one of four clients (C1) reviewed (a violation that harmed a client's health or safety, not including serious injury, impairment, or death) and this practice resulted in a level 2 violation for two of four clients (C2 and C4) reviewed (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety). This is issued at a pattern scope (more than a limited number of clients are affected). The findings included: C1's record was reviewed. C1 had prescriber's orders dated October 14, 2015 for blood sugars to be checked four times a day, prior to breakfast, lunch, dinner and at bedtime and a sliding scale of Novolog Insulin to be administered based on the blood sugar readings. In addition, C1 had prescriber's orders dated October 14, 2015 for Lantus insulin 15 units at bedtime. C1's medication administration record (MAR) for October 2015 revealed that on October 17, 2015, C1's blood sugar was 80 at 4:30 p.m. The unlicensed person (ULP)-G administered 7 units of Novolog insulin in error. The client's sliding scale of insulin at 4:30 p.m. indicated 6 units of Novolog insulin was to administered for a blood sugar reading of 80-150. In addition, C1's October 2015 MAR was blank in the staff initial area that indicated whether or not a medication was administered, for C1's Lantus insulin at bedtime on October 17 and 18, 2015 and was blank in the staff initial area for checking C1's blood sugar and administering Novolog insulin	0 935		

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0 935	Continued From page 12 based on the client's sliding scale at bedtime on October 17, 2015 and 4:30 p.m. and bedtime on October 18, 2015. When interviewed December 21, 2015 at 10:00 a.m., ULP-G stated she was trying to keep track of all the medications/blood sugars and insulin to give, but stated she was overwhelmed and somehow missed C1's blood sugar checks and insulin. C2's record was reviewed. C2 had prescriber's orders dated August 31, 2015 that indicated he was to have his blood sugar checked four times a day, before meals and at bedtime and administer Novolog insulin per a sliding scale based on the client's blood sugar reading. The client's sliding scale for his bedtime insulin was as follows: For a blood sugar of 90 or below, staff were to call the nurse; For a blood sugar of 91-180 = 0 units of insulin; For a blood sugar of 181-220 = 2 units of insulin; For a blood sugar of 221-260 = 3 units of insulin; For a blood sugar of 261-300 = 4 units of insulin; For a blood sugar of 301-340 = 5 units of insulin; Greater than 341 = 6 units of insulin. C2's October MAR was reviewed. C2's blood sugar on October 12, 2015 at bedtime was 300. Staff documented that they administered 5 units of Novolog, insulin which was an error. C2 should have received 4 units of Novolog insulin per the sliding scale. On October 28, 2015 at bedtime, C2's blood sugar was 259. Staff documented that they administered 4 units of Novolog insulin. which was an error. C2 should have received 3 units of Novolog insulin per the sliding scale. C4's record was reviewed. C4 had a prescriber's order for Pravastatin (a medication used to lower	0 935		

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0 935	Continued From page 13 cholesterol) 40 milligrams every bedtime. The client's October 2015 MAR had a blank where the initials would be of the staff person who administered the C4's Pravastatin. The Pravastatin was the only medication C4 received at bedtime. When interviewed November 3, 2015 at 1:55 p.m., C4 stated a few days ago she did not get her pill she gets at bedtime. C4 stated she only gets one pill at bedtime, and when she questioned staff about it, they stated she had gotten it with her other pills. C4 stated she knew she had not received her bedtime pill. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 935		
01040	144A.4793, Subd. 4 Administration of Treatments/Therapy Subd. 4. Administration of treatments and therapy. Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the home care provider must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each client and the unlicensed personnel has demonstrated the	01040		

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01040	Continued From page 14 ability to competently follow the procedures; (2) specified, in writing, specific instructions for each client and documented those instructions in the client's record; and (3) communicated with the unlicensed personnel about the individual needs of the client. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure when the treatment of blood sugar checks was delegated to unlicensed personnel (ULP), that the registered nurse (RN) instructed the ULP in the proper method with respect to each client and the ULP demonstrated the ability to competently follow the procedure for four of four contracted ULP (ULP-B, ULP-D, ULP-G and ULP-I) reviewed. This practice resulted in a level 2 violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety), and is issued at a pattern scope (more than a limited number of staff are involved). The findings included: According to staffing records and medication administration records, contracted employees ULP-B, ULP-D, ULP-G and ULP-I) checked clients' blood sugar while working for the licensee in October of 2015. There was no evidence that ULP-B, ULP-D, ULP-G and ULP-I were instructed in the proper methods to conduct a blood sugar check, nor was there evidence that they had demonstrated their ability to competently follow the procedure for blood glucose checks.	01040		

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01040	Continued From page 15 When interviewed December 22, 2015 at 9:30 a.m. RN-A stated she was not aware that the supplemental staffing agency did not conduct competency testing for their employees on blood sugar checks.. RN-A stated she thought the supplemental staff were trained when they came to work for the licensee. The contract between the supplemental agency and the licensee dated July 24, 2015 was reviewed and did not specify which entity was responsible for the unlicensed staff training and competency. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01040		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
H26132 Y1	A. Building B. Wing Y2	3/10/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
INVER GROVE HEIGHTS WHITE PINE	9056 BUCHANAN TRAIL INVER GROVE HEIGHTS, MN 55077

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 00265	Correction	ID Prefix 00325	Correction	ID Prefix 00815	Correction
Reg. # 144A.44, Subd. 1(2)	Completed	Reg. # 144A.44, Subd. 1(14)	Completed	Reg. # 144A.479, Subd. 7	Completed
LSC	03/10/2016	LSC	03/10/2016	LSC	03/10/2016
ID Prefix 00930	Correction	ID Prefix 00935	Correction	ID Prefix 01040	Correction
Reg. # 144A.4792, Subd. 7	Completed	Reg. # 144A.4792, Subd. 8	Completed	Reg. # 144A.4793, Subd. 4	Completed
LSC	03/10/2016	LSC	03/10/2016	LSC	03/10/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
1/22/2016	

EVENT ID: JFP612