MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
Specialty Care Group
2113 Girard Avenue South Suite 2
Minneapolis, Minnesota 55405
Hennepin County

Report #: HL27391001

Date: April 22, 2014

Date of Visit: November 12, 2013
Time of Visit: 8:30 a.m. – 12:30 p.m.

By: Lisa Jacobsen, R.N., Special Investigator

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

☐ Facility Self Report ☒ Complaint

Allegation(s): It is alleged that neglect occurred. The staff providing 24 hour care is unable to provide adequate care to the client. The staff is not able to manage tube feedings, the client was found positioned inappropriately and one staff member was found drunk and passed out in the client's bathroom.

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 Licensing Rules for Home Care (MN Rules Chapter 4668)

☐ 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:

The preponderance of evidence established that neglect of supervision occurred when the AP, who was assigned to provide twenty-four hour care and supervision to two clients, failed to provide the care and supervision necessary to maintain their physical health and safety, when the AP began drinking alcohol while on duty.

Client #1 and Client #2 resided in an apartment and received twenty-four hour live in home health aide care from the home care provider. Client #1 and Client #2 were not to be left alone.

Client #1 was identified as having dementia with some cognitive deficits, required assistance with dressing, toileting and continence care, could have nothing by mouth and required gastric tube feedings at 5:00 a.m., 10:30 a.m., 3:30 p.m. and 8:00 p.m., was diabetic and required blood sugar checks at 8:00 a.m., and insulin administration at 8:00 p.m. In addition, Client #1 required assistance with medication administration at 8:00 a.m. and 8:00 p.m. and received stand-by assistance with ambulation and transfers.

Client #2 was identified as having dementia with memory deficits, and required assistance with bathing, continence care and medication administration at 8:00 a.m., 10:00 a.m., 2:00 p.m., 5:00 p.m. and 8:00 p.m.

A family member arrived at Client #1 and Client #2's apartment and found the AP intoxicated, lying on the floor between the living room and the bathroom. There was no other staff present in the apartment and another staff person was not scheduled to report to work with Client #1 and Client #2 for several days. Client #1 was calling out for assistance to go to the bathroom. Client #1's gastric tube feeding tubing was still attached to the client. Client #1 had been calling for assistance and no one came to help the client. The police were called to assist with the AP.

The police report indicated a "Check Welfare" call was requested and the police arrived at the clients' apartment at 10:46 a.m. The report indicated the AP was found asleep on the couch. A PBT (preliminary breath test) sample to test for alcohol consumption was conducted and registered .222. (almost three times over the legal limit). The report indicated the AP drank a half a bottle (1.75 liters) of gin. The AP was transported to a detox center.

The AP was interviewed and gave the following account of what occurred: The AP started her/his shift at 10:00 a.m. At approximately 9:00 p.m., Client #1 and Client #2 were settled in bed and all personal cares were completed. The AP was in the kitchen cleaning, bumped a cupboard door and heard bottles clinking. The AP opened the cupboard door and saw numerous bottles of alcohol. The AP stated s/he remembered thinking that s/he would only have one or two drinks of alcohol. The next thing the AP remembered was at approximately 9:00 a.m. the following morning, the police were there and the AP was taken out of the apartment. The AP

stated s/he remembered thinking that s/he had not administered Client #1's gastric tube feeding at 5:00 a.m. The AP stated s/he believed that s/he did not pass out, but rather fell asleep. The AP could not recall how much alcohol s/he drank.

Concerns related to staff not being able to manage Client #1's tube feedings were reviewed during the investigation and a state licensing order was issued related to lack of training of the unlicensed personnel on how to administer the client's gastric tube feeding and also blood sugar checks and insulin administration.

Concerns related to Client #1 being found positioned inappropriately was reviewed during the investigation and no problems were identified. The client was able to reposition him/herself independently and required stand-by assistance with transfers and ambulation.

Additional state licensing orders were issued related to failure to have a registered nurse (RN) orient the unlicensed personnel to the care of the clients; failure to have the RN supervise the home health aides; failure to report an incident of suspected maltreatment to the common entry point and unlicensed staff drawing up the dose of insulin to be administered to the client.

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 AP was responsible for the neglect of supervision of Client #1 and Client #2. Although the home care provider was not in compliance with regulatory standards related to training, the AP had extensive nursing training as s/he completed the requirements to be a registered nurse. Although the home care provider had policies in their employee handbook related to employees presenting themselves in a professional and competent manner at all times and prohibiting drinking alcoholic beverages when providing direct services, the AP choose to not follow this policy. Staffing levels were consistent with other days; the ratio was one staff person to care for two clients. The AP did not follow professional standards in exercising professional judgment when s/he consumed alcohol when providing care and services to Client #1 and Client #2.

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 Licensing Rules for Home Care (MN Rules Chapter 4668) – Compliance Not Met
The requirements under State Licensing Rules for Home Care (MN Rules Chapter 4668) were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: _____

(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

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

State Statutes Chapters 144 & 144A – Compliance Met
The facility was found to be in compliance with State Statutes for Chapters 144 & 144A. No state licensing orders were issued.

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
☐ 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 pertinent medical records:

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

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: 0

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: _____

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: 0

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

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 5

Physician interviewed: ○ Yes ◉ No

Nurse Practitioner 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: Visited Client in his home

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

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

Were photographs taken: ○ Yes ◉ No Specify: _____

xc: Division of Compliance Monitoring - Licensing & Certification
Minnesota Board of Nursing
Oakdale City Police Department
Washington County Attorney
Oakdale City Attorney

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H27391	A. BUILDING: _____ B. WING _____	C 04/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPECIALTY CARE GROUP	2113 GIRARD AVENUE SOUTH STE 2 MINNEAPOLIS, MN 55405

(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
0 000	Initial comments ********Revised Correction Orders********** A complaint investigation was conducted to investigate case #HL27391001. 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 MN Department of Health, Division of Compliance Monitoring, Office of Health Facility Complaints; 85 East Seventh Place, Suite 220, P.O. Box 64970, St. Paul, Minnesota 55164-0970.	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.	
0 605	626.557 Subd.3 Timing of report Subd. 3. Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not	0 605		

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0 605	Continued From page 1 reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to	0 605		

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0 605	Continued From page 2 the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure that an incident of possible neglect was immediately reported to the common entry point for one of one client (C1) reviewed. The findings included: C1's record was reviewed. C1's "Vulnerability and Safety Assessment" dated October 3, 2013 indicated the client was dependent on a caregiver. C1's "Plan of Care" dated October 3, 2013 indicated the client required gastric tube feedings four times a day, required blood sugar checks and insulin daily and was not to be left alone. When interviewed April 4, 2014, family member F indicated he arrived at C1's residence to visit and found the unlicensed personnel (ULP) that was assigned to care for C1, intoxicated lying on the floor between the living room and the bathroom. Family Member F stated C1 was calling out for assistance to the bathroom. Family Member F	0 605		

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0 605	Continued From page 3 stated C1 indicated he had been calling for assistance and no one came to help him Family member F contacted the police to assist with the ULP. The police report dated October 15, 2013 indicated a "Check Welfare" call was requested and the police arrived at C1's apartment at 10:46 a.m. The report indicated ULP-D was found asleep on the couch. A PBT (preliminary breath test) sample to test for alcohol consumption was conducted and registered .222. (almost three times over the legal limit). ULP-D was transported to a detox center. The administrator confirmed on April 21, 2014 at 11:07 a.m., that the incident was not reported to the common entry point. The licensee's policy/procedure titled, "Vulnerable Adult Protection Act" indicated the following, "The law requires the following people to report suspected abuse of a vulnerable adult. Police Officers; social workers; social service, welfare, mental, or health agency workers; employees of long term care facilities (including nursing homes, adult family homes, boarding homes, adult residential care facilities, and others); doctors; nurses; nurse's aides and personal care aides; psychologists; and pharmacists. By law, these people must immediately report to APS (adult protection services) any time they have reasonable cause to believe that a vulnerable adult has suffered abuse, neglect, abandonment, or exploitation." TIME PERIOD FOR CORRECTION: Thirty (30) days	0 605		

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01570	Continued From page 4	01570		
01570	4668.0100 Subp.3 Limitations on administering medications Subp. 3. Limitations on administering medications. A person who administers medications under subpart 2 may not inject medications into veins, muscle, or skin. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure that unlicensed personnel (ULP) did not draw up the dose of insulin to be administered for one of one client (C1) reviewed. The findings included: C1's record was reviewed. C1's plan of care dated October 3, 2013 indicated the client required insulin injections daily. When interviewed April 8, 2014 at 1:40 p.m., ULP-B stated she has assisted C1 with his insulin injections. ULP-B stated she drew up the dose of insulin into a syringe from a vial and administered C1's insulin by injection. ULP-B stated she knew how to do this, because a family member of hers was diabetic. When interviewed April 17, 2014 at 4:10 p.m., registered nurse (RN)-G stated he was not aware that the ULPs were drawing up C1's dose of insulin into a syringe. TIME PERIOD FOR CORRECTION: Thirty (30) days	01570		

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01575	Continued From page 5	01575		
01575	4668.0100 Subp.4 Performance of routine procedures Subp. 4. Performance of routine procedures. A person who satisfies the requirements of subpart 5 may perform delegated medical or nursing and assigned therapy procedures, if: A. prior to performing the procedures, the person is instructed by a registered nurse or therapist, respectively, in the proper methods to perform the procedures with respect to each client; B. a registered nurse or therapist, respectively, specifies, in writing, specific instructions for performing the procedures for each client; C. prior to performing the procedures, the person demonstrates to a registered nurse or therapist, respectively, the person's ability to competently follow the procedures; and D. the procedures for each client are documented in the clients' records. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure that when the registered nurse (RN) delegated nursing tasks of gastric tube feedings, blood sugar checks and insulin administration to unlicensed personnel (ULP), that the RN instructed the staff on how to perform the procedure, that there were written instructions on how to perform the procedure and prior to performing the procedure the ULP demonstrated to a RN their ability to competently follow the	01575		

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01575	Continued From page 6 procedure for two of two ULP's (ULP-B & ULP-C) who performed delegated nursing tasks. The findings included: C1's record was reviewed. C1's plan of care dated October 3, 2013 indicated the client required gastric tube feedings four times a day, blood sugar checks daily and insulin injections daily. When interviewed April 8, 2014 at 1:40 p.m., ULP-B stated she took care of C1 for approximately two-twenty four hour shifts. ULP-B stated she administered C1's gastric tube feeding, checked his blood sugar and administered the client's insulin. ULP-B stated she did not receive any training from a RN on how to perform the delegated nursing tasks of gastric tube feedings, blood sugar checks and administration of insulin, nor did she (ULP-B), demonstrate to a RN her ability to competently perform the procedure. ULP-B stated she had administered a tube feeding at a prior job with a different home care provider so was familiar with the procedure. In addition, ULP-B stated she was not instructed by a RN on how to perform a blood sugar check or administer insulin to C1 nor did she (ULP-B) demonstrate to a RN her ability to competently perform the procedures. ULP-B stated the administrator (who was not a registered nurse) showed her where the supplies were kept to check C1's blood sugar and administer C1's insulin. When interviewed April 7, 2014 at 12:00 noon, ULP-C stated she had administered C1's tube feeding. ULP-C stated she had never administered a tube feeding before and was trained by another ULP of the home care provider, not a RN.	01575		

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01575	Continued From page 7 When ULP training documents were requested, the administrator responded on April 4, 2014 at 9:51 a.m., that several training sessions were conducted for staff onsite at C1's residence and that the documentation was in a notebook at the residence that was not given back to the licensee when care was no longer provided. When interviewed April 4, 2014 at 2:45 p.m. and 3:30 p.m. respectively, family members E and F stated there were no training documents that they were aware of that were kept in C1's apartment. When interviewed April 17, 2014 at 4:10 p.m., RN-G stated his responsibility with C1 was to set-up C1's medications. RN-G stated he did show one ULP, who happened to be working at the time he was at C1's apartment as to how C1's gastric tube feeding works and observed the ULP do a return demonstration on how to conduct the tube feeding. RN-G stated he does not recall the name of the ULP. RN-G stated he may have shown a couple of staff how to do C1's blood sugar, but did not recall who the staff were or when he would have done this. RN-G stated he did not write specific instructions for the ULP on how to conduct C1's gastric tube feeding, blood sugar check or insulin injection. RN-G stated he did not document any training he may have done. RN-G stated his understanding of his responsibility was not training of the ULP but rather C1's medication set-ups. TIME PERIOD FOR CORRECTION: Thirty (30) days	01575		
01595	4668.0100 Subp.8 Initiation of home health aide tasks	01595		

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SPECIALTY CARE GROUP	2113 GIRARD AVENUE SOUTH STE 2 MINNEAPOLIS, MN 55405

(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
01595	Continued From page 8 Subp. 8. Initiation of home health aide tasks. Prior to the initiation of home health aide tasks, a registered nurse or therapist shall orient each person who is to perform home health aide tasks to each client and to the tasks to be performed. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure that a registered nurse (RN) oriented the unlicensed personnel (ULP) to the tasks that were to be performed for one of one client (C1)reviewed. The findings included: C1's record was reviewed. C1's Home Health Aide/PCA Care Plan dated October 4, 2013 indicated unlicensed personnel (ULP) were to assisted the client with bathing, oral hygiene, shaving, medications, gastric tube feedings, insulin injections and range of motion exercises. The care plan indicated the following: "Aide oriented to client and care plan by:" The administrator's signature was noted on this form as having oriented the aides to the client and care plan on October 3, 2013. The administrator was not a RN. When interviewed, ULP-B and ULP-C on April 8, 2014 at 1:40 p.m. and April 7, 2014 at 12:00 p.m. respectively, stated a RN had not oriented them to the client's care, but rather the administrator showed them where things were in C1's apartment. TIME PERIOD FOR CORRECTION: Thirty (30) days	01595		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H27391	A. BUILDING: _____ B. WING _____	C 04/21/2014

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SPECIALTY CARE GROUP	2113 GIRARD AVENUE SOUTH STE 2 MINNEAPOLIS, MN 55405

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01600	4668.0100 Subp.9 Supervision of Home Health Aide tasks Subp. 9. Periodic supervision of home health aide tasks. 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.	01600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H27391	A. BUILDING: _____ B. WING _____	C 04/21/2014

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01600	Continued From page 10 This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure that within fourteen days after initiation of home health aide services, a registered nurse (RN) supervised the unlicensed personnel (ULP) to verify the work was being performed adequately, to identify problems, and to assess the appropriateness of the care to the client's needs for one of one client (C1) who received home health aide services. The findings included: C1's record was reviewed. C1 began receiving home health aide services as of October 3, 2013. C1's Home Health Aide/PCA Care Plan dated October 4, 2013 indicated unlicensed personnel (ULP) were to assist the client with bathing, oral hygiene, shaving, medications, gastric tube feedings, insulin injections and range of motion exercises. C1's Service Agreement dated October 9, 2013 indicated the following, "Supervision of caregiver staff will be completed at no charge, a minimum of every 60 days." C1's services were discontinued October 22, 2013. C1's record did not contain a RN supervisory visit of the home health aides by the registered nurse within fourteen days after initiation of home health aide services. When interviewed April 17, 2014 at 4:10 p.m., RN-G stated that he did not provide any supervision of the ULP. RN-G stated his responsibility was to set-up C1's medication. TIME PERIOD FOR CORRECTION: Thirty (30) days	01600		

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
H27391	A. Building B. Wing	9/11/2014

Name of Facility	Street Address, City, State, Zip Code
SPECIALTY CARE GROUP	2113 GIRARD AVENUE SOUTH STE 2 MINNEAPOLIS, MN 55405

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix 00605 Reg. # 626.557 Subd.3 LSC	Correction Completed 09/11/2014	ID Prefix 01570 Reg. # 4668.0100 Subp.3 LSC	Correction Completed 09/11/2014	ID Prefix 01575 Reg. # 4668.0100 Subp.4 LSC	Correction Completed 09/11/2014
ID Prefix 01595 Reg. # 4668.0100 Subp.8 LSC	Correction Completed 09/11/2014	ID Prefix 01600 Reg. # 4668.0100 Subp.9 LSC	Correction Completed 09/11/2014	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By _____ CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:			
4/21/2014	_____	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES NO