Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints
Investigative Public Report

Maltreatment Report #: HL33914001M
Compliance #: HL33914002C

Date Concluded: March 2, 2020

Name, Address, and County of Licensee Investigated:
Optimum Care Services, LLC
7800 Metro Parkway Ste 300
Bloomington, MN 55425
Hennepin County

Name, Address, and County of Housing with Services location:
Optimum Care Services, LLC
484 Page Street East
Saint Paul, MN 55107
Ramsey County

Facility Type: Home Care Provider

Investigator's Name: Casey DeVries, RN
Special Investigator

Finding: Substantiated, facility and individual responsibility

Nature of Visit:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Allegation(s):
It is alleged: A client was neglected when an alleged perpetrator (AP) failed to administer the client's prescribed monthly injection, which lead to the client experiencing a psychotic episode. Additionally, it was alleged at the same time, the client suffered a heat stroke due to the facility's air conditioning not working and the client was hospitalized due to heat stroke and a psychotic episode.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility and the AP were responsible for the maltreatment. The AP (a nurse) failed to provide reasonable and necessary care when she failed to administer the client's antipsychotic medication on time and when she failed to monitor the client's behavioral symptoms, and conduct re-assessment or reporting to the client's mental health provider. Additionally, the facility failed to have systems to ensure the facility would administer the client's medications as prescribed. As a result, the facility administered the client's medication off schedule during six administration periods in a row. This contributed to the client

experiencing increased psychotic symptoms, which required hospitalization. The allegation that the client also experienced a heat stroke was not substantiated.

The investigator conducted interviews with facility administrative staff and the client's external care team, including the client's case manager and psychiatric care provider. Additionally, the investigator interviewed the client and the client's family member. The investigator reviewed client medical records, facility incident reports, personnel records, facility policies and procedures and made observations of day-to-day operations including medication administration procedures.

The client received services from the comprehensive home care provider for diagnoses that included bipolar schizophrenia. The client had a history of psychotic symptoms, which included auditory hallucinations, in addition to a history of substance abuse. The client had a physician's order for an extended release injectable antipsychotic medication, once every 24 days. Facility unlicensed personnel (ULP) administered the client's oral medications daily; however, the nurse was responsible for administering the injectable medication. The client's record indicated the facility would monitor the client's behavior for any sign of drug use or mood changes.

The client's record indicated the facility did not administer the injection on time during the six administration periods that preceded the client's hospitalization. During those six episodes, the client received the injection one day early twice, one day late once, three days late twice and sixteen days late in the last instance. The AP was responsible for the last four of those administrations.

Review of the client's record indicated on multiple occasions, in the five months preceding the hospitalization, the client exhibited signs of mood changes or of illicit drug use including:

- The client yelled and cursed at staff on multiple occasions.
- The client reported to staff that the voices he was hearing were getting strong, unable to control and were annoying and negative.
- The client punched multiple holes in his bedroom walls.
- The client would often talk to himself and scream.
- The client reported to staff that he wanted God to leave him alone.
- On at least two occasions, the client possessed illicit drugs and paraphernalia to include pipes, needles and syringes.

On the day the client was hospitalized, the client was yelling at himself and told staff that something in his brain was disturbing him. An unlicensed personnel progress note indicated the client's family member transported him to the hospital. The injection was fourteen days overdue at that point.

The client's hospital after-visit summary indicated that the hospital treated the client in the emergency department for auditory hallucinations and crisis evaluation. The client required

two doses of an antipsychotic medication while hospitalized. The client returned to the home care provider the following day.

Despite the client's change of condition and hospitalization, the AP did not administer the client's injection until one day after the client returned from the hospital, sixteen days after the medication was due.

The client's mental health clinic record, dated post hospitalization, indicated the client reported he had gone to the emergency department because, "my schizophrenia got really bad" and that the client had punched a car and yelled at a person.

The client's record lacked evidence that facility management or the AP investigated the management of the client's medication administration, or that the AP re-assessed the client after the client returned. Further, the record lacked evidence of any required routine assessments, or re-assessments following changes in the client's condition, over an approximate fourteen-month period.

Email correspondence indicated that after a family member of the client looked into the incident, she emailed the facility manager and the AP to point out the facility's pattern of failure to follow physician's orders regarding the injection administration schedule. The facility manager acknowledged that the client's hospitalization was an avoidable incident. The manager indicated the incident occurred because an emergency had prevented the AP from administering the medication on the most recent due date, and then afterward, the AP forgot to do it. The manager also indicated the other facility staff had not paid attention to the client's medication administration record (MAR), which contributed to the error. Neither the manager nor the AP acknowledged the pattern of inconsistent administration dates prior to the extended delay in administration that preceded the client's hospitalization.

The client's MAR, utilized by the facility's staff for the administration of the client's daily oral medications, contained a location for the nurse to document the client's injection. The MAR lacked a clear indicator of the date the injection was due, for all of the six injection administration periods not administered on time. Therefore, there was no measure in place to alert the direct care staff that the injection date was approaching or had passed.

During an interview, the client's psychiatric care provider stated the injection was intended to be administered once every 28 days, however, because the client had historically experienced an increase in psychotic symptoms leading up to the next dose, the provider moved up the dosing schedule to once every 24 days. The provider stated if the facility administered the medication late, the client's symptoms would increase because the medication would fall below therapeutic blood levels. Additionally, the provider stated the client's usage of illicit drugs could lessen the effect of the medication, and could worsen the client's symptoms. The provider stated the facility only notified the clinic on one occasion (approximately four months prior to

the hospitalization), one day after the injection was due, that the facility did not have a nurse available, and asked if the client could receive the injection in the clinic.

During an interview, a facility manager stated he was unaware of any reporting of the client's behaviors, psychotic symptoms or illicit drug usage to the client's psychiatric care provider. The manager stated it was not something they were keeping a close eye on and the only monitoring that he was aware of was the documentation completed in daily progress notes. The manager stated it was both the responsibility of the nurse and of himself, for not paying closer attention, that the client's injection was consistently not administered on time.

During an interview, the client's family member stated that the client's injectable medication targets symptoms and lessens the effect of schizophrenia such as hearing voices, mood, anxiety and depression. The family member stated historically, in the days leading up to the next injection due date, the client would talk to himself and to talk to people who are not there. The family member stated the day prior to the client's hospitalization, the client expressed that the voices in his head were terrifying him and the client complained of panic attacks and nightmares. The family member stated the client made calls to other family members to check on them because the voices in his head told him that he was torturing his family.

In conclusion, neglect occurred. The AP is responsible for the neglect because the AP failed to ensure the client received the injectable antipsychotic medication as prescribed on four occasions, failed to contact a supervisor for direction when she was unable to administer the client's medication on time, failed to inform the client's mental health clinic of early or late doses and failed to monitor or report the client's behavior. Further, the AP failed to conduct routine or change of condition assessments for the client and failed to implement any interventions related to the client's exhibited self-abuse, despite evidence that she was aware illicit drug usage in the facility had occurred. Additionally, the AP failed to participate in the development of health care policies, procedures or systems to ensure the facility would administer the client's medications as prescribed.

The facility is also responsible for the neglect because the facility failed to ensure a registered nurse conducted re-assessments on the client when the client's needs changed; this included times before and after the facility employed the AP. The facility also failed to develop and maintain a current individualized medication management plan for the client, or a policy on injectable medications, to ensure the client received the client's injection on time.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"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.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No, the AP did not respond for an interview.

Action taken by facility:
The facility included all managers in the utilization of a shared calendar to track the client's medication due date. The AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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.

cc:
The Office of Ombudsman for Long-Term Care
Ramsey County Attorney
City of Saint Paul Attorney
City of Saint Paul Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H33914	A. BUILDING: _____ B. WING _____	C 02/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMUM CARE SERVICES LLC	7800 METRO PARKWAY STE 300 BLOOMINGTON, MN 55425

(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 ******ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to a survey. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On February 7, 2020, the Minnesota Department of Health initiated an investigation of complaint #HL33914002C/#HL33914001M. At the time of the survey, there were #6 clients receiving services under the comprehensive license. An immediate correction order was issued at that time, and a follow-up visit was conducted on February 11, 2020. The violation identified in the immediate correction order was corrected, and the following correction orders are issued, that were not issued at the time of immediate correction orders. The following correction orders are issued for #HL33914002C/#HL33914001M, tag identification 0810, 0815, 0860, 0865, 0870, 0920, and 1165.	0 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that 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. Per Minnesota Statute § 144A.474, Subd. 8(c), the home care provider must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider's Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144A.474, Subd. 11 (b).	
0 325	144A.44, Subd. 1(14) Free From Maltreatment	0 325		

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0 325	Continued From page 1 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 observations, interviews, and document review, the facility failed to ensure one of one clients reviewed (C1) was free from maltreatment. C1 was neglected. Findings include: On March 2, 2020, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility and an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325	No Plan of Correction (PoC) Required. Please refer to the public maltreatment report for details.	
0 810 SS=I	144A.479, Subd. 6(b) Individual Abuse Prevention Plan (b) Each home care provider must develop and implement an individual abuse prevention plan for each vulnerable minor or adult for whom home care services are provided by a home care provider. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by	0 810		

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0 810	Continued From page 2 another individual, including other vulnerable adults or minors; the person's risk of abusing other vulnerable adults or minors; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults or minors. For purposes of the abuse prevention plan, the term abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed and/or updated for four of four clients reviewed (C1, C2, C3, C4) to include an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults and self; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. This practice occurred at a level three violation (a violation 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients.) The findings include: Client #1 C1's record was reviewed. C1 began receiving services from the licensee on September 10,	0 810		

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0 810	Continued From page 3 2018. C1's service plan dated September 10, 2018 indicated C1 received services from the licensee that included comprehensive assessment, re-assessment, monitoring and medication management by the registered nurse (RN). The service plan indicated unlicensed personnel (ULP) would assist C1 with activities of daily living (ADLs) according to C1's care plan, conduct behavioral management, and twelve hours of supervision. C1's care plan dated September 10, 2018 lacked individualization of the services to identify how staff would assist C1. C1's document titled, "Coordinated Services and Supports Plan" (CSSP) for the months of 03/02/2018 - 02/28/2019 indicated C1 had a long history of mental illness and substance abuse disorder including amphetamine use, opioid use and heroin overdose. The CSSP indicated that structured daily activities were important for C1 to maintain his sobriety and to manage stressors. The IAPP indicated that the licensee must provide daily activity in/out of the home. C1's IAPP dated September 10, 2018 indicated C1 had vulnerability related to self-injurious behavior due to a history of substance abuse. The assessment indicated the licensee would monitor C1's behavior for any sign of drug use, mood changes, and of C1 neglecting other self-care such as showering or grooming. The assessment provided a location for documentation of referrals made when the person is susceptible to abuse outside the scope or control of the program. The assessment did not contain any referrals and lacked specific measures that the licensee would take to minimize C1's risk of abuse.	0 810		

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0 810	Continued From page 4 C1's record lacked evidence of an update to the IAPP after September 10, 2018 despite the following: C1's ULP progress note dated February 13, 2019 indicated C1 reported that the voices he was hearing were getting strong and unable to control and that the day prior was very bad and the voices were annoying and negative. C1's ULP progress note dated March 1, 2019 indicated that C1 had a black eye and that C1 had been punching his wall and there was a big hole in the wall. C1's ULP progress note dated March 8, 2019 indicated that C1 woke up during middle of the night and went out to smoke a couple of times and would start yelling. C1's ULP progress note dated May 4, 2019 indicated that C1 had two other clients in his room (one of which was C3) and when C1 saw staff, he threw something under his table. ULP checked to see what C1 threw and found an injection syringe and pipe. C1's ULP progress note dated, May 10, 2019 indicated a fire alarm in C1's room sounded. The ULP found C1 in his room with door locked. C1 opened the door and four people, including C1 and another client (C2) were in the room. The ULP documented that C1 was nervous and denied doing anything to trigger alarm. The ULP documented that s/he reported the incident to CEO-D and CEO-D came to the home to address it. C1's ULP progress note dated June 7, 2019	0 810		

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0 810	Continued From page 5 indicated that C1 was in his room shouting, yelling, cursing and that it took an hour for C1 to calm down. C1's ULP progress note dated June 12, 2019 indicated that C1 went outside to smoke and was yelling a lot and that C1 snuck a friend into his room, locked the door, and staff did not know what they were doing. C1's ULP progress note dated July 11, 2019 indicated C1 was yelling at staff. C1's ULP progress note dated July 12, 2019 indicated C1 woke up during the middle of the night and went outside. The note indicated while outside, C1 was talking to himself and screaming. C1's ULP progress note dated July 15, 2019 indicated C1 was awake all night and was screaming and slamming the wall. The note indicated C1 told staff that he wanted God to leave him alone. C1's ULP progress note dated July 16, 2019 indicated C1 told staff that he wanted to go to the hospital. C1's ULP progress note dated July 17, 2019 indicated C1 was screaming and yelling. C1's ULP progress note dated July 18, 2019 indicated C1 was talking to himself and was yelling and shouting. C1's ULP progress note dated July 26, 2019 indicated C1 was yelling at himself and saying that something in his brain was disturbing him and that he wanted to see the doctor. The note indicated staff notified the supervisor and	0 810		

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0 810	Continued From page 6 program manager and that C1's parents picked him up to take him to the hospital. C1's after visit summary dated July 26, 2019 indicated C1 received treatment in the emergency department due to auditory hallucinations and crisis evaluation. C1's incident report dated September 3, 2019 indicated staff found cocaine in C1's room along with a needle on the corner of C1's table. The report indicated when staff attempted to remove the items, C1 threated the staff and said if the staff moved, C1 would fight and kill the staff. The report indicated the staff attempted to calm C1 down, and asked C1 to call the supervisor. The report indicated C1 did call the supervisor who told C1 if C1 did not let the staff go, the supervisor would call the police and that C1 would go to jail. C1's incident report dated December 17, 2019 indicated that staff found C1 had a knife in his possession. C1 gave the knife to staff. Client #2 C2's record was reviewed. C2 began receiving services from the licensee on October 4, 2018. C2's service plan dated, October 9, 2018 indicated C2 received services from the licensee that included comprehensive assessment, re-assessment, monitoring and medication management by the registered nurse (RN). The service plan indicated ULP would assist C2 with activities of daily living (ADLs) according to C2's care plan, conduct behavioral management and twelve hours of supervision. C2's document titled, "Coordinated Services and	0 810		

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0 810	Continued From page 7 Supports Plan" (CSSP) for the months of 12/01/2018 - 11/30/2019 indicated that C2 had a long history of mental illness and substance abuse problems including regular use of "Meth" which contributes to episodes of mania, mood swings, anger and anxiety. C2's IAPP dated December 10, 2018 indicated C2 had vulnerability related to chronic conditions/pain/illness/disability due to a history of bipolar. The IAPP indicated C2 denied alcohol, chemical and/or other medication abuse and that interventions included client may not use alcohol/chemicals while a resident of the home care and staff were to report any use of alcohol or chemicals to the nurse promptly. Goals of the IAPP included that the client would remain free of illegal drugs and staff would monitor for risky behaviors with prescription medications. The assessment lacked specific measures that the licensee would take to minimize C2's risk of abuse. C2's record lacked evidence of an update to the IAPP after December 10, 2018 despite the following: C2's housemate (C1, a client with known illicit substance usage, including methamphetamine in the home) progress note dated May 10, 2019 indicated a fire alarm sounded. The ULP found C2 in C1's room with door locked. When C1 opened door, four people, including C2 were in the room. The ULP documented that C1 was nervous and denied doing anything to trigger alarm. The ULP documented that s/he reported the incident to CEO-D and CEO-D came to home to address. Incident report dated June 16, 2019 indicated	0 810		

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0 810	Continued From page 8 staff responded to a loud noise and found C2 and another client (C3) fighting. Staff separated the clients and noted bleeding scratches on C2's face. C2 told staff that when he tried to tell C3 that he was being too loud on the phone, C3 used the "F" word and insulted him. Incident report dated December 17, 2019 indicated staff found C2 had a knife in his possession and told the staff he had the knife for his protection. C2 told staff that another client (C1) also had a knife. C2 refused to give the knife to staff. The report indicated the staff notified the house manager. C2's ULP progress note dated January 28, 2020 indicated C2 told staff that he does "drugs" every day and without being caught. C2 made a reference to C1 and another client (C3) and how those clients get caught with drugs but C2 does not. The ULP documented that C2 appeared to be manic, talked about how he was a "king" and that the ULP discussed the matter with supervisors. C2's ULP progress note dated February 3, 2020 indicated C2 had been manic, had not stopped talking and feeding himself. C2 made statements of how he was the "the best and a king and rich and smart" and had multiple verbal arguments with another client. C2's ULP progress noted dated February 4, 2020 indicated C2 was still acting the same as the day prior, was verbally aggressive towards others and was getting into other people's faces. The ULP documented that C2 wanted a ride to see some people he owed money to "referring to drugs".	0 810		

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OPTIMUM CARE SERVICES LLC	7800 METRO PARKWAY STE 300 BLOOMINGTON, MN 55425

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0 810	Continued From page 9 Client #3 C3's record was reviewed. C3 began receiving services from the licensee on March 1, 2019. C3's service plan dated March 1, 2019 indicated C3 received services from the licensee that included comprehensive assessment, re-assessment, monitoring and medication management by the registered nurse (RN). The service plan indicated unlicensed personnel (ULP) would assist C3 with activities of daily living (ADLs) according to C3's care plan, conduct behavioral management and twelve hours of supervision. C3's IAPP dated March 4, 2019 indicated C3 had vulnerability related to chronic conditions/pain/illness/disability due to traumatic brain injury and mental health disorder. The IAPP indicated C3 had a history of alcohol and substance abuse and that interventions were that the client may not use alcohol/chemicals while a resident of the home care and staff were to report any use of alcohol or chemicals to the nurse promptly and that staff would monitor for risky behaviors with prescription medications. The IAPP indicated C3 was susceptible to abuse from other individuals, including other vulnerable adults due to memory impairment and that staff would monitor for signs or symptoms of abuse. The IAPP indicated C3 was at risk of abusing others due to a history of aggression and physical assault to others as well as at risk for self-abuse due to the client's history of substance abuse and self-neglect. Interventions for the known vulnerabilities were that staff would monitor the client behavior and intervene with any actions of abuse towards others and that staff would report concerns for self-abuse to the nurse. The assessment lacked specific measures that the licensee would take to minimize C3's risk of	0 810		

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0 810	Continued From page 10 abuse. C3's record lacked evidence of an update to the IAPP after March 4, 2019 despite the following: C3's housemate (C1, a client with known illicit substance usage, including methamphetamine in the home) progress note dated May 4, 2019 indicated the ULP found C3 in C1's room and that when C1 saw the ULP, he threw something under his table. The ULP checked to see what C1 threw and found an injection syringe and pipe. Incident report dated May 2, 2019 indicated C3 attempted to shoplift during an outing with staff at the store. Incident report dated May 4, 2019 indicated staff responded to a strong odor coming from C3's room. Staff requested that C3 open the door, but C3 refused. Staff used an extra key to enter C3's door and found C3's room filled with smoke. The incident report indicated that staff found "weed" on C3's table. Incident report dated June 16, 2019 indicated staff responded to a loud noise and found C3 and another client (C2) fighting. Staff separated the clients and noted scratches on C2's face. C3 told staff that he was on the phone and C2 attacked him. Incident report dated July 22, 2019 indicated C3 left the facility without telling staff at 9:45 p.m. and did not return until the following day at 2:00 p.m. Incident report dated August 9, 2019 indicated C3 left the facility in a car with a group of people and refused to tell staff where he was going.	0 810		

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0 810	Continued From page 11 Incident report dated August 16, 2019 indicated C3 threatened staff with a knife when staff attempted to re-direct C3 from the facility's office area. The report indicated staff called the police and the police arrested C3. Incident report dated August 30, 2019 indicated on August 29, 2019 during a room check for C3, staff found marijuana and one-liter bottle with cough syrup and grape juice. The incident report indicated staff found C3 was mixing a 750ml (milliliter) bottle of hand sanitizer into a bottle of bleach. The report indicated C3 was threatening towards staff. C3's ULP progress note dated January 2, 2020 indicated staff found C3 in possession of marijuana. Client #4 C4's record was reviewed. C4 began receiving services from the licensee on December 1, 2019. C4's record lacked a service plan. C4's Coordinated Services and Supports Plan Addendum for the months of 11/30/2019 - 11/29/2020 indicated that C4 required staff's assistance with medication set-up, refills, and administration and may require occasional prompting and reminders to complete activities of daily living. The addendum indicated that had an alcohol abuse disorder, drank on a weekly basis, and that staff should encourage C4 to attend AA meetings/counseling and support his sobriety. The addendum indicated C4 was a risk for physical and verbal aggression due to a diagnosis of post-traumatic stress disorder (PTSD). The addendum indicated C4 was at high risk for self-neglect and external exploitation and may not	0 810		

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0 810	Continued From page 12 have the judgement and ability to cope with stressors, make appropriate decisions or take action in a potentially harmful situation. C4's IAPP dated December 6, 2019 indicated C4 was susceptible to sexual abuse due to being a vulnerable adult. The measures listed to minimize the risk of abuse were that if staff would observe C4 experiencing sexual assault/abuse, staff would redirect C4 away from the situation and would follow the chain of command to report any instance of abuse to C4's team and/or make a vulnerable adult report as needed. The IAPP indicated C4 was susceptible to physical abuse due to an inability to identify potentially dangerous situations, inappropriate interactions with others, verbally/physically abusive to others and vulnerable adult status. The measures listed to minimize the risk of abuse were that if staff would observe C4 experiencing verbal or physical aggression, staff would redirect C4 from the situation and would follow the chain of command to report any instance of abuse to C4's team and/or make a vulnerable adult report as needed. The IAPP indicated C4 was susceptible to self-abuse due to C4 neglecting or refusing to take medications and due to being a vulnerable adult. The measures listed to minimize the risk of abuse were that if staff would observe C4 engaging in self-abuse, staff would redirect C4 from the situation and would follow the chain of command to report any instance of self-abuse to C4's team and/or make a vulnerable adult report as needed. The IAPP indicated C4 was susceptible to financial exploitation due to being a vulnerable adult. The measures listed to minimize the risk of abuse were that if staff would observe C4 experiencing financial exploitation, staff would redirect C4 from the situation and would follow the chain of command to report any instance of	0 810		

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0 810	Continued From page 13 financial exploitation to C4's team and/or make a vulnerable adult report as needed. The assessment provided a location for documentation of referrals made when the person is susceptible to abuse outside the scope or control of the program. The IAPP failed to identify C4's known vulnerabilities of alcohol abuse disorder or risk for physical and verbal aggression due to a diagnosis of PTSD. The assessment did not contain any referrals and lacked specific measures that the licensee would take to minimize C4's risk of abuse. On February 21, 2020 at 3:30 p.m., the State Agency (SA) requested via email correspondence to program director (PD)-K, the facility's policy on individual abuse prevention plans/vulnerability assessments. On February 24, 2020 at 11:19 a.m., PD-K responded to the SA request and attached a blank IAPP template, which PD-K wrote constituted the licensee's policy on the completion of IAPPs. PD-K wrote that the licensee completed the IAPP annually for all clients. During email correspondence on February 27, 2020 at 4:17 p.m., PD-K indicated the facility did not possess any more current IAPPs for C1, C2, C3 or C4. PD-K acknowledged that the IAPPs provided to the SA were non-compliant and that she would be working to correct the problems as soon as she could arrange meetings with the client's teams. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		

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0 815 SS=E	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; (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	0 815		

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0 815	Continued From page 15 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 document review and interview, the licensee failed to ensure background studies were completed for four of eight employees (RN-C, ULP-H, ULP-I, ULP-J) reviewed. Additionally, the licensee failed to maintain orientation and training records for RN-C. This practice resulted in a level two 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, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly but is not found to be pervasive). The findings include: The licensee lacked a personnel file for RN-C. RN-C's date of hire was April 1, 2019. The licensee failed to maintain a record of a completed background study. Additionally, the licensee lacked evidence of orientation to home care, required annual training, infection control training, competency evaluations, job description including qualifications, responsibilities, and identification of staff providing supervision.	0 815		

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0 815	Continued From page 16 During email correspondence on February 12, 2020 at 1:41 p.m., chief executive officer (CEO)-D indicated he was not able to locate the record of a completed background study for RN-C and that he believed the study was run under a different account titled, "High Quality Services" because he thought the two accounts were linked. CEO-D indicated a job description was not completed for RN-C and that although he believed that he did provide RN-C with the orientation to home care training and review of the licensee's policies and procedures, he was unable to locate it. Review of background study web based system, NETStudy 2.0 on February 12, 2020 did not indicate the licensee had filed an application for a background study for RN-C under the licensee's name or under a different account titled, "High Quality Services." Licensee document titled, "Current and Former Employees" indicated that unlicensed personnel (ULP-H, ULP-I, ULP-J) were current employees of the licensee. Client (C)-1's medication administration record dated, February 2020 indicated ULP-H, ULP-I and ULP-J all provided medication administration assistance to C1 during the month of February 2020. Review of background study web based system, NETStudy 2.o on February 12, 2020 did not indicate the licensee had filed an application for a background study for ULP-H under the licensee's name or a different account titled, "High Quality Services".	0 815		

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0 815	Continued From page 17 Review of background study web based system, NETStudy 2.o on February 12, 2020 did not indicate the licensee had filed an application for a background study for ULP-I under the licensee's name or a different account titled, "High Quality Services". Review of background study web based system, NETStudy 2.o on February 12, 2020 did not indicate the licensee had filed an application for a background study for ULP-J under the licensee's name or a different account titled, "High Quality Services". During email correspondence with program director (PD)-K on February 19, 2020 at 8:26 a.m., PD-K indicated that the licensee does not have a written policy for conducting background studies, but that the practice was to always complete a study prior to an individual having any direct client care or being allowed to work. TIME PERIOD FOR CORRECTION: Seven days	0 815		
0 860 SS=G	144A.4791, Subd. 8 Comprehensive Assessment and Monitoring Subd. 8. Comprehensive assessment, monitoring, and reassessment. (a) When the services being provided are comprehensive home care services, an individualized initial assessment must be conducted in person by a registered nurse. When the services are provided by other licensed health professionals, the assessment must be conducted by the appropriate health professional. This initial assessment must be completed within	0 860		

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0 860	Continued From page 18 five days after initiation of home care services. (b) Client monitoring and reassessment must be conducted in the client's home no more than 14 days after initiation of services. (c) Ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client and cannot exceed 90 days from the last date of the assessment. The monitoring and reassessment may be conducted at the client's residence or through the utilization of telecommunication methods based on practice standards that meet the individual client's needs. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed conduct required assessments and failed to ensure clients were re-assessed for significant changes in condition including increased psychotic symptoms, aggression, possession and usage of illicit drugs, and hospitalization for one of one client (C1) reviewed. C1's record lacked any nursing assessments for fourteen months. This practice resulted in a level three violation (a violation 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 was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	0 860		

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0 860	Continued From page 19 Findings include: C1's record was reviewed. C1 began receiving services from the licensee on September 10, 2018. C1's service plan dated September 10, 2018 indicated C1 received services from the licensee that included comprehensive assessment, re-assessment, monitoring and medication management by the registered nurse (RN). The service plan indicated unlicensed personnel (ULP) would assist C1 with activities of daily living (ADLs) according to C1's care plan, conduct behavioral management and twelve hours of supervision. C1's care plan dated September 10, 2018 lacked individualization of the services to identify how staff would assist C1. C1's individual abuse prevention plan dated September 10, 2018 indicated C1 had vulnerability related to self-injurious behavior due to a history of substance abuse. The assessment indicated the licensee would monitor C1's behavior for any sign of drug use, mood changes, and of C1 neglecting other self-care such as showering or grooming. C1's assessment dated September 10, 2018 indicated C1 had a diagnosis of schizoaffective disorder bipolar type. The neuro/behavioral/mental status category indicated C1 was alert, oriented, anxious, PERRLA (pupils are equal, round, reactive to light, and accommodate), and that C1 was forgetful. No other problems under the neuro/behavioral/mental status category were identified. C1's assessment dated September 24, 2018	0 860		

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0 860	Continued From page 20 indicated under the neuro/behavioral/mental status category that C1 was alert, oriented, depressed, agitated, anxious, PERRLA, had strong hand grasp, was forgetful and had hallucinations. The assessment did not indicate whether the hallucinations were visual or auditory and did not provide further information regarding this symptom. C1's ULP progress note dated February 13, 2019 indicated C1 reported to staff that the voices he was hearing were getting strong and unable to control and that the day prior was very bad and the voices were annoying and negative. C1's ULP progress note dated, March 1, 2019 indicated that C1 had a black eye and that C1 had been punching his wall and there was a big hole in the wall. C1's ULP progress note dated March 8, 2019 indicated that C1 woke up during middle of the night and went out to smoke a couple of times and would start yelling. C1's ULP progress note dated May 4, 2019 indicated that C1 had two other clients in his room and when C1 saw staff, he threw something under his table. ULP checked to see what C1 threw and found a drug injection syringe and pipe. C1's registered nurse (RN) progress noted dated May 7, 2019 indicated RN-C became aware of the incident when C1 admitted to a ULP that he had used methamphetamine on May 4, 2019. The note indicated the ULP collected a pipe, needles, syringes and partial drug from C1. RN-C documented that C1 had three injection sites to the left forearm and that C1 said one was from May 4, 2019. The note indicated RN-C would with	0 860		

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0 860	Continued From page 21 chief executive officer (CEO)-D and would follow policy and procedure protocol. C1's ULP progress note dated, May 10, 2019 indicated a fire alarm in C1's room sounded. The ULP found C1 in his room with door locked. C1 opened door and four people, including C1 were in the room. C1 was nervous and denied doing anything to trigger the alarm. The ULP documented that s/he reported the incident to CEO-D and CEO-D came to the home to address it. C1's ULP progress note dated June 7, 2019 indicated that C1 was in his room shouting, yelling, cursing and that it took an hour for C1 to calm down. C1's ULP progress note dated June 12, 2019 indicated that C1 went outside to smoke and was yelling a lot and that C1 snuck a friend into his room, locked the door, and staff did not know what they were doing. C1's ULP progress note dated July 11, 2019 indicated C1 was yelling at staff. C1's ULP progress note dated July 12, 2019 indicated C1 woke up during the middle of the night and went outside. The note indicated while outside, C1 was talking to himself and screaming. C1's ULP progress note dated July 15, 2019 indicated C1 was awake all night and was screaming and slamming the wall. The note indicated C1 told staff that he wanted God to leave him alone. C1's ULP progress note dated July 16, 2019 indicated C1 told staff that he wanted to go to the	0 860		

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0 860	Continued From page 22 hospital. C1's ULP progress note dated July 17, 2019 indicated C1 was screaming and yelling. C1's ULP progress note dated July 18, 2019 indicated C1 was talking to himself and was yelling and shouting. C1's ULP progress note dated July 26, 2019 indicated C1 was yelling at himself and saying that something in his brain was disturbing him and that he wanted to see the doctor. The note indicated staff notified the supervisor and program manager and that C1's parents picked him up to take him to the hospital. C1's after visit summary dated July 26, 2019 indicated C1 received treatment in the emergency department due to auditory hallucinations and crisis evaluation. C1's incident report dated September 3, 2019 indicated staff found cocaine in C1's room along with a needle on the corner of C1's table. The report indicated when staff attempted to remove the items, C1 threated the staff and said if the staff moved, C1 would fight and kill the staff. The report indicated the staff attempted to calm C1 down, and asked C1 to call the supervisor. The report indicated C1 did call the supervisor who told C1 if C1 did not let the staff go, the supervisor would call the police and that C1 would go to jail. C1's incident report dated December 17, 2019 indicated that staff found C1 had a knife in his possession. C1 agreed to give the knife to staff. C1's record lacked evidence of assessment	0 860		

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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
0 860	Continued From page 23 between September 24, 2018 and November 15, 2019. During an interview on February 11, 2019 at 10:40 a.m., CEO-D stated he had terminated RN-C due to her failure to assess clients. CEO-D stated that no 90-day assessments had been conducted prior to the hire of a new registered nurse in November of 2019. Licensee policy titled, "Comprehensive Client Assessment" adapted from the Minnesota Comprehensive Home Care Policy Manual dated 2014 indicated a comprehensive assessment would be conducted by a registered nurse would be completed based on client needs, change in condition or client request, and not more than 90 days after the previous assessment. TIME PERIOD FOR CORRECTION: Seven (7) days	0 860		
0 865 SS=G	144A.4791, Subd. 9(a-e) Service Plan, Implementation & Revisions Subd. 9. Service plan, implementation, and revisions to service plan. (a) No later than 14 days after the initiation of services, a home care provider shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the home care provider and by the client or the client's representative documenting agreement on the services to be provided. The service plan must be revised, if	0 865		

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0 865	Continued From page 24 needed, based on client review or reassessment under subdivisions 7 and 8. The provider must provide information to the client about changes to the provider's fee for services and how to contact the Office of the Ombudsman for Long-Term Care. (c) The home care provider must implement and provide all services required by the current service plan. (d) The service plan and revised service plan must be entered into the client's record, including notice of a change in a client's fees when applicable. (e) Staff providing home care services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure the service agreement was followed for one of four clients reviewed for medication administration, when C1's monthly psychotropic medication was not consistently administered according to physician's orders. This contributed to an excerbation of C1's mental health symptoms. This practice resulted in a level three violation (a violation 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 was issued at an isolated scope (when one or a	0 865		

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0 865	Continued From page 25 limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: C1's record was reviewed. C1's service plan dated, September 10, 2018 indicated C1 received services from the licensee that included comprehensive assessment, re-assessment, monitoring and medication management by the registered nurse (RN). The service plan indicated unlicensed personnel (ULP) would assist C1 with activities of daily living (ADL's) according to C1's care plan. C1's care plan dated, September 10, 2018 indicated ULP and the RN would assist C1 medication administration for diagnoses including bipolar schizoaffective disorder. C1's medication management plan dated September 10, 2018 indicated the licensee was responsible for administration, monitoring and re-ordering C1's medications. The document indicated the RN was responsible for verification that all medications/treatments/therapy services were carried out as prescribed or ordered. C1's assessment dated September 24, 2018 indicated C1 needed assistance with medication administration due to memory impairments and forgetfulness. The assessment indicated C1 required assistance to administer injections. C1's physician order dated, November 20, 2018 indicated C1's psychiatric care provider (PCP)-G prescribed Abilify Maintena DSC (extended-release antipsychotic injectable medication) 400mg (milligrams) every 24 days.	0 865		

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0 865	Continued From page 26 C1's medication administration record (MAR) dated February 2019 indicated C1 received the Abilify Maintena injection on February 13, 2019. C1's MAR dated March 2019 indicated C1 received the Abilify Maintena injection on March 8, 2019, one day early. C1's MAR dated April 2019 indicated C1 received the Abilify Maintena injection on April 1, 2019. During an interview on February 14, 2020 at 11:47am, PCP-G confirmed C1 received the Abilify Maintena injection in clinic on April 2, 2019, one day late. C1's MAR dated April 2019 indicated C1 received the Abilify Maintena injection on April 25, 2019, one day early. C1's MAR dated May 2019 indicated C1 received the Abilify Maintena injection on May 22, 2019, three days late. C1's MAR dated June 2019 indicated C1 received the Abilify Maintena injection on June 18, 2019, three days late. C1's ULP progress note dated July 18, 2019 indicated C1 was talking to himself and was yelling and shouting. C1's ULP progress note dated July 26, 2019 indicated C1 was yelling at himself and saying that something in his brain was disturbing him and that he wanted to see the doctor. The note indicated staff notified the supervisor and program manager and that C1's parents picked him up to take him to the hospital.	0 865		

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0 865	Continued From page 27 C1's after visit summary dated July 26, 2019 indicated C1 received treatment in the emergency department due to auditory hallucinations and crisis evaluation. C1's MAR dated July 2019 indicated C1 received the Abilify Maintena injection on July 28, 2019, sixteen days late. During an interview on March 2, 2020 at 10:54 a.m., chief executive officer (CEO)-D stated the reasons that C'1 Abilify Maintena injection was consistently administered off schedule had to do with the facility nurse not following the protocol and because he had not stayed on top of it. CEO-D stated the due date for C1's medication should have been clearly marked on the MAR but that he later realized that was not done consistently. Licensee policy titled, "Service Plan Implementation and Revisions" from the Minnesota Comprehensive Home Care Policy Manual dated, 2014 indicated home care services would be provided according to a suitable and current written service plan. TIME PERIOD FOR CORRECTION: Seven (7) days	0 865		
0 870 SS=F	144A.4791, Subd. 9(f) Content of Service Plan (f) The service plan must include: (1) a description of the home care services to be provided, the fees for services, and the frequency of each service, according to the client's current review or assessment and client preferences;	0 870		

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0 870	Continued From page 28 (2) the identification of the staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring reviews or assessments of the client; (4) the frequency of sessions of supervision of staff and type of personnel who will supervise staff; and (5) a contingency plan that includes: (i) the action to be taken by the home care provider and by the client or client's representative if the scheduled service cannot be provided; (ii) information and a method for a client or client's representative to contact the home care provider; (iii) names and contact information of persons the client wishes to have notified in an emergency or if there is a significant adverse change in the client's condition, including identification of and information as to who has authority to sign for the client in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the client under those chapters. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure the service plans contained all the required content for four of four clients (C1, C2, C3, C4) reviewed when the service plans lacked multiple components.	0 870		

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0 870	Continued From page 29 This practice resulted in a level two 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, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients). The findings include: C1's record was reviewed. C1 began receiving services from the licensee on September 10, 2018. C1's service plan dated September 10, 2018 indicated C1 received services from the licensee that included comprehensive assessment, re-assessment, monitoring and medication management by the registered nurse (RN). The service plan indicated unlicensed personnel (ULP) would assist C1 with activities of daily living (ADL's) according to C1's care plan, conduct behavioral management and twelve hours of supervision. C1's service plan lacked evidence of the following required content: * A description of the home care services to be provided * Fees for services * Frequency of each service according to the client's current assessment and preferences * The identification of staff or categories of staff who will provide the services * A contingency plan that includes the actions to be taken by the home care provider and by the client or client's representative if the scheduled services cannot be provided, information and a method for a client or client's representative to	0 870		

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0 870	Continued From page 30 contact the home care provider C1's care plan dated September 10, 2018 lacked individualization to identify what services staff would provide to C1. C1's medication administration record (MAR) dated February 2020 indicated unlicensed personnel (ULP) administer C1's medications twice daily. The MAR indicated an intramuscular injection, Ability Maintena, scheduled every twenty-four days, was administered by the registered nurse. C2's record was reviewed. C2 began receiving services from the licensee on October 4, 2018. C2's service plan dated October 9, 2018 indicated C2 received services from the licensee that included comprehensive assessment, re-assessment, monitoring and medication management by the registered nurse (RN). The service plan indicated unlicensed personnel (ULP) would assist C2 with activities of daily living (ADL's) according to C2's care plan, conduct behavioral management and twelve hours of supervision. C2's service plan lacked evidence of the following required content: * A description of the home care services to be provided * Fees for services * Frequency of each service according to the client's current assessment and preferences * The identification of staff or categories of staff who will provide the services * A contingency plan that includes the actions to be taken by the home care provider and by the client or client's representative if the scheduled	0 870		

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0 870	Continued From page 31 services cannot be provided, information and a method for a client or client's representative to contact the home care provider (staff member identified is not a current employee). C2's medication administration record (MAR) dated February 2020 indicated unlicensed personnel (ULP) administer C2's medications daily. C3's record was reviewed. C3 began receiving services from the licensee on March 1, 2019. C3's service plan dated March 1, 2019 indicated C3 received services from the licensee that included comprehensive assessment, re-assessment, monitoring and medication management by the registered nurse (RN). The service plan indicated unlicensed personnel (ULP) would assist C3 with behavioral management, twelve hours of supervision, and according to C3's care plan. C3's service plan lacked evidence of the following required content: * A description of the home care services to be provided * Fees for services * Frequency of each service according to the client's current assessment and preferences * The identification of staff or categories of staff who will provide the services * A contingency plan that includes the actions to be taken by the home care provider and by the client or client's representative if the scheduled services cannot be provided, information and a method for a client or client's representative to contact the home care provider. C3's medication administration record (MAR)	0 870		

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0 870	Continued From page 32 dated February 2020 indicated unlicensed personnel (ULP) administer C3's medications four times daily. C4's record was reviewed. C4 began receiving services from the licensee on December 1, 2019. C4's record did not contain a service plan. On February 21, 2020 at 3:30 p.m., the State Agency (SA) requested via email correspondence to program director (PD)-K, C4's service plan. On February 24, 2020 at 11:19 a.m., PD-K responded to the SA request and attached a document titled, "Coordinated Service and Support Plan (CSSP) Addendum" dated December 6, 2019. C4's CSSP addendum dated December 6, 2019 failed to clearly identify what services the comprehensive home care provider would provide to C4 due to the following contradicting statements. * The heading, "Health Information" contained the following statement: "High Quality Services does not provide medical services to [C4] and is not responsible for his medications." * The heading, "Health Needs" contained the following statement: Optimum Care Services will provide nurse visits, administer prescription medications, obtain prescription refills, and assist with scheduling and transportation for other routine and as-needed heath appointments." * The heading, "Psychotropic Medication Monitoring and Use" contained the following statement: "Medication administration will be recorded in house medicine log whenever it is administered. Any medication given as needed will include documentation of client's behaviors	0 870		

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0 870	Continued From page 33 and symptoms before and after administration." * The heading, "Services and Supports" contained the following statements: [C4] does need assistance with medication set-up, refills, and administration. He also requires assistance with setting up his health appointments and screenings." "[C4 may require occasional prompting/reminders to complete his ADL'/IADLs, but he is independent with most." C4's service plan lacked evidence of the following required content: * A description of the home care services to be provided * Fees for services * Frequency of each service according to the client's current assessment and preferences * The identification of staff or categories of staff who will provide the services * The schedule and methods of monitoring reviews or assessments of the client * The frequency of sessions of supervision of staff and type of personnel who will supervise staff * A contingency plan that includes the actions to be taken by the home care provider and by the client or client's representative if the scheduled services cannot be provided, information and a method for a client or client's representative to contact the home care provider, names and contact information of persons the client wishes to have notified in an emergency or if there is a significant adverse change in the client's condition, including identification of and information as to who has authority to sign for the client in an emergency and the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the client under those chapters.	0 870		

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0 870	Continued From page 34 During an interview on March 2, 2020 at 10:54 a.m., chief executive officer (CEO)-D stated he understood the comprehensive home care requirement for service plans was that whatever is documented on the client's service plan is what the facility must deliver. Licensee policy titled, "Service Plan Implementation and Revisions" from the Minnesota Comprehensive Home Care Policy Manual dated, 2014 indicated the service plan would include j) a contingency plan for circumstances when services cannot be provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 870		
0 920 SS=G	144A.4792, Subd. 5 Individualized Medication Mgt Plan Subd. 5. Individualized medication management plan. (a) For each client receiving medication management services, the comprehensive home care provider must prepare and include in the service plan a written statement of the medication management services that will be provided to the client. The provider must develop and maintain a current individualized medication management record for each client based on the client's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the client's needs and preferences, risk of	0 920		

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0 920	Continued From page 35 diversion, and consistent with the manufacturer's directions; (3) documentation of specific client instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any client-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure that the provider developed and maintained a current individualized medication management record, to include all required elements for one of one client (C1) reviewed. This contributed to failing to administer the medications as prescribed, which contributed to an excerbation of C1's mental health symptoms.	0 920		

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0 920	Continued From page 36 This practice resulted in a level three violation (a violation 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 was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: C1's record was reviewed. C1's service plan dated, September 10, 2018 indicated C1 received services from the licensee that included comprehensive assessment, re-assessment, monitoring and medication management by the registered nurse (RN). The service plan indicated unlicensed personnel (ULP) would assist C1 with activities of daily living (ADL's) according to C1's care plan. C1's care plan, dated September 10, 2018 indicated ULP and the RN would assist C1 medication administration for diagnoses including bipolar schizoaffective disorder. C1's physician order, dated November 20, 2018 indicated C1's psychiatric care provider (PCP)-G prescribed Abilify Maintena DSC (extended-release antipsychotic injectable medication) 400mg (milligrams) every 24 days. During observation on February 11, 2020 at 12:15 p.m., the investigator observed C1's medication administration record (MAR) dated February 2020. The MAR failed to identify the persons, or differentiate between the RN or ULP, who was responsible for administering C1's Abilify Maintena injection. Additionally, the MAR failed to	0 920		

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0 920	Continued From page 37 identify the dates the injection was due. The MAR contained a hand-written date of February 9, 2020 near the margin in the row where the Abilify Maintena was listed with RN-L's initials. RN-L's initials were also in the column dated February 5, 2020 where the medication was listed. RN-L documented in the notes section on the reverse side of the MAR that she administered the Abilify Maintena injection to the client on February 5, 2020. C1's next injection was due on February 29, 2020; however, the MAR lacked an indicator that the medication was due on that date. C1's document titled, "Medication/Treatment/Therapy Management Plan" dated, September 10, 2018 indicated services provided would include medication reminders, medication set-ups, assistance with self-administration of medications and administration of medications. The plan indicated documentation of specific client instructions and requirements relating to the administration of medications was located on the client medication administration record (MAR), service checkoff list, and in the client record in the lower office locked cabinets. The plan also indicated verification that all medications are administered/carried out as prescribed or ordered is located on the client medication administration record (MAR), service checkoff list, by the licensed nurse doing medication checks and in the client record in the lower office locked cabinets. C1's MAR dated February 2019 indicated C1 received the Abilify Maintena injection on February 13, 2019. C1's MAR dated March 2019 indicated C1 received the Abilify Maintena injection on March 8, 2019, one day early.	0 920		

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0 920	Continued From page 38 C1's MAR dated April 2019 indicated C1 received the Abilify Maintena injection on April 1, 2019. During an interview on February 14, 2020 at 11:47am, PCP-G confirmed C1 received the Abilify Maintena injection in clinic on April 2, 2019, one day late. C1's MAR dated April 2019 indicated C1 received the Abilify Maintena injection on April 25, 2019, one day early. C1's MAR dated May 2019 indicated C1 received the Abilify Maintena injection on May 22, 2019, three days late. C1's MAR dated June 2019 indicated C1 received the Abilify Maintena injection on June 18, 2019, three days late. C1's ULP progress note dated July 18, 2019, six days after the medication was due, indicated C1 was talking to himself and was yelling and shouting. C1's ULP progress note dated July 26, 2019, fourteen days after the medication was due, indicated C1 was yelling at himself and saying that something in his brain was disturbing him and that he wanted to see the doctor. The note indicated staff notified the supervisor and program manager and that C1's parents picked him up to take him to the hospital. C1's after visit summary dated July 26, 2019 indicated C1 received treatment in the emergency department due to auditory hallucinations and crisis evaluation. C1's MAR dated July 2019 indicated C1 received	0 920		

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0 920	Continued From page 39 the Abilify Maintena injection on July 28, 2019, sixteen days late. During email correspondence between chief executive officer (CEO)-D and family member (FM)-A on July 31, 2019 at 12:55 p.m., CEO-D assurred FM-A that in order to ensure C1 always received the Abilify Maintena injection on time moving forward, the faciltiy planned to 1) re-train all staff, including RN-C on medication administration, 2) manager and nursing would utilize a shared calendar to track upcoming injection dates, 3) the next due date would marked with a square and highlighted so that all staff would be aware of when the injection was due. During an interview on February 11, 2020 at 12:15 p.m., CEO-D and program manager (PM)-E stated the facility monitored the due dates for C1's injection solely via an electronic calendar shared between the facility nurse, CEO, program manager, program administrator and the facility's chief operations officer. Licensee's undated policy titled, "Medication Management Services" indicated the RN would develop an individualized medication management plan for each client receiving any type of medication management services, consistent with current practice standards and guidelines, and will develop specific procedures for medication management services that staff will provide. TIME PERIOD FOR CORRECTION: Seven (7) days	0 920		

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01165	Continued From page 40	01165		
01165 SS=D	144A.4796, Subd. 1 Orientation of Staff and Supervisors Subdivision 1. Orientation of staff and supervisors to home care. All staff providing and supervising direct home care services must complete an orientation to home care licensing requirements and regulations before providing home care services to clients. The orientation may be incorporated into the training required under subdivision 6. The orientation need only be completed once for each staff person and is not transferable to another home care provider. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the licensee failed to ensure one of one staff records, registered nurse (RN)-C, reviewed for orientation included orientation to home care licensing requirements and regulations before providing home care services to clients. This practice resulted in a level two 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, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: The licensee lacked a personnel file for RN-C.	01165		

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01165	Continued From page 41 RN-C's date of hire was April 1, 2019. The licensee lacked evidence of orientation to home care, required annual training, infection control training, competency evaluations, job description including qualifications, responsibilities, and identification of staff providing supervision. During email correspondence on February 12, 2020 at 1:41 p.m., chief executive officer (CEO)-D indicated although he believed that he did provide RN-C with the orientation to home care training and review of the licensee's policies and procedures, he was unable to locate it. Licensee's undated policy titled, "Orientation and Annual Training Requirements" indicated training and orientation to include the following would be retained in the personnel file: * Overview of sections 144A.43 to 144A.4798 which includes definitions, Bill of Rights, license, regulations and services. * Introduction and review of all provider policies and procedures related to the provision of home care services. The policies will be specific to the agency scope of services. * Handling of emergencies and use of emergency services-general agency policies and those specific to clients that will be included in client care plans. * Compliance with reporting of maltreatment of minors or vulnerable adults under sections 626.556 and 626.557. Clients will be assessed for risk and prevention plans identified. * Home Care Bill of Rights under section 144A.44 to include review of the rights and the advocacy services available as a resource for clients. * Handling of client's complaints, reporting of complaints and where to report complaints including information on the Office of Health	01165		

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01165	Continued From page 42 Facility Complaints and the Common Entry Points. * Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental disabilities, Managed Care Ombudsman at the Department of Human Services, county managed care advocates or other relevant advocacy services. Information will be provided to clients in their admission packets, and reviewed with staff in orientation as well as copies being present in client homes. * Review of the types of home care services the employee will be providing and the provider's scope of licensure. The policy indicated annual training to be retained would include: * Training on reporting of maltreatment of minors under section 626.556 and maltreatment of vulnerable adults under section 626.557, whichever is applicable to the services provided. * Review of the Home Care Bill of Rights in section 144A.44. * Review of infection control techniques used in the home and implementation of infection control standards including a review of hand-washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces and reporting of communicable diseases; and * Review of the providers policies and procedures relating to the provision of home care services, and how to implement those policies and procedures. During an interview on March 2, 2020 at 10:54 a.m., CEO-D stated that upon hiring RN-C, he	01165		

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01165	Continued From page 43 informed her of what her duties were, which included ordering client medications, transcribing to the client's medication administration records, makeing sure there were no medication errors and conducting intake, 14-day and 90-day assessments. CEO-D stated he did not maintain a training file for RN-C, rather, he had a file which contained policies and procedures RN-C was to follow, although he could not locate it. CEO-D was unable to provide explanation as to where the remainder of RN-C's personnel file was. TIME PERIOD FOR CORRECTION: Twenty one (21) days	01165		