

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Email: LPASSEL@CAREANDREHAB.ORG

January 31, 2018

Mr. Larry Passel, Administrator Roseview Court Care Agency 425 North Badger Street Caledonia, MN 55921

Re: Enclosed State Licensing Orders - Project Number SL20196012

Dear Mr. Passel:

On January 10, 2018, staff of the Minnesota Department of Health completed a follow-up survey of your agency to determine correction of orders found on the survey completed on May 4, 2017, with orders received by you on May 25, 2017; and follow-up survey completed on July 27, 2017, with orders including penalties received by you on August 26, 2017; and follow-up survey completed on October 20, 2017, with orders including penalties received by you on November 20, 2017. At this time these correction orders were found corrected and are listed on the attached State Form: Revisit Report.

If you have questions, contact Jeri Cummins at (218) 302-6193. It is your responsibility to share the information contained in this letter and the results of the visit with the President of your organization's Governing Body.

Sincerely,

PAULA M. BASTIAN

Senior Health Program Representative

Lawla MSastian

Health Regulation Division

Home Care & Assisted Living Program











Enclosure

Cheryl Hennen, Office of the Ombudsman for Long Term Care cc:

Houston County Social Services

	STAT	E FORM: REVIS	IT REPORT				
A. Building	NSTRUCTIO	N					VISIT Y3
H20196 NAME OF FACILITY ROSEVIEW COURT CARE AGENCY B. Wing STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921							
olished. Each def viously shown on t	ficiency sho the State Si	ould be fully identified urvey Report (prefix o	using either the codes shown to the	regulation on the left of ea	r LSC provision	number and to the survey	the report
Y5	Y4		Y5	Y4			-
Correction Completed	ID Prefix Reg. # LSC	00870 144A.4791, Subd. 9(f)	Correction Completed 01/10/2018	ID Prefix Reg. # LSC		i. 2	ection
	A. Building B. Wing AGENCY A State surveyor to plished. Each del viously shown on the control of the control	MULTIPLE CONSTRUCTIO A. Building B. Wing AGENCY A State surveyor to show those plished. Each deficiency show viously shown on the State	MULTIPLE CONSTRUCTION A. Building B. Wing AGENCY STI 425 CA State surveyor to show those deficiencies previously shown on the State Survey Report (prefix of the state Survey Report (prefix	A. Building B. Wing STREET ADDRESS, C 425 NORTH BADGER CALEDONIA, MN 559 State surveyor to show those deficiencies previously reported that plished. Each deficiency should be fully identified using either the viously shown on the State Survey Report (prefix codes shown to the state Survey Report (prefix	MULTIPLE CONSTRUCTION A. Building B. Wing STREET ADDRESS, CITY, STATE 425 NORTH BADGER STREET CALEDONIA, MN 55921 State surveyor to show those deficiencies previously reported that have been polished. Each deficiency should be fully identified using either the regulation of viously shown on the State Survey Report (prefix codes shown to the left of each polished. DATE Y5 Y4 Correction ID Prefix 00870 Completed Reg. # Completed Reg. # Completed Reg. # Completed Reg. # Completed Reg. #	MULTIPLE CONSTRUCTION A. Building B. Wing STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921 State surveyor to show those deficiencies previously reported that have been corrected and to plished. Each deficiency should be fully identified using either the regulation or LSC provision viously shown on the State Survey Report (prefix codes shown to the left of each requirement DATE	MULTIPLE CONSTRUCTION A. Building B. Wing STREET ADDRESS, CITY, STATE, ZIP CODE 425 NORTH BADGER STREET CALEDONIA, MN 55921 State surveyor to show those deficiencies previously reported that have been corrected and the date such plished. Each deficiency should be fully identified using either the regulation or LSC provision number and viously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey) DATE Y5 TEM Y4 Y5 TEM Y6 TOTIC TITEM Y6 TOTIC TOTIC TOTIC TITEM TOTIC



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Email: LPETERSON@CAREANDREHAB.ORG Certified Mail # 7015 3010 0001 4648 4329

November 16, 2017

Mrs. Lorri Peterson, Administrator Roseview Court Care Agency 425 North Badger Street Caledonia, MN 55921

Re: Enclosed State Licensing Orders - Project Number SL20196012

Dear Mrs. Peterson:

On October 20, 2017, staff of the Minnesota Department of Health completed a follow-up survey of your agency to determine correction of orders found on the survey completed on May 4, 2017, with orders received by you on May 30, 2017; and follow-up survey completed on July 27, 2017, with orders including penalties received by you on August 26, 2017,

State licensing orders issued pursuant to the survey completed on July 27, 2017, found corrected at the time of the October 20, 2017 follow-up survey, are listed on the attached State Form: *Revisit Report.*

State licensing orders are delineated on the attached Minnesota Department of Health order form. The Minnesota Department of Health is documenting 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 is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by."

IMPOSITION OF FINES

Level 1, no fines or enforcement.

Level 2, fines ranging from \$0 to \$500, in addition to any of the enforcement mechanisms authorized in section 144A.475 for widespread violations.

Level 3, fines ranging from \$500 to \$1,000, in addition to any of the enforcement

Roseview Court Care Agency November 16, 2017 Page 2

mechanisms authorized in section 144A.475. Level 4, fines ranging from \$1,000 to \$5,000, in addition to any of the enforcement mechanisms authorized in section 144A.475.

At the time of this survey it was determined, in accordance with Minn. Stat. 144A.474, subd. 11, the following fines were issued:

\$500.00	Level/2; Scope/Widespread Contents of Service Plan, Minn. Stat. 144A.4791, subd. 9 (f)
\$500.00	Level/2; Scope/Widespread Prov of Med Mgmt Svs, Minn. Stat. 144A.4792, subd. 2
\$500.00	Level/2; Scope/Widespread Indiv Med Mgmt Plan, Minn. Stat. 144A.4792, subd. 5
\$300.00	Level/2; Scope/Pattern Indiv Treatment/Therapy Mgmt Plan, Minn. Stat. 144A.4793, subd. 3

Total = \$1,800.00

The details of the violations noted at the time of this follow-up survey completed on October 20, 2017, (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stats. 144A.43 to 144A.484, the total amount that you are assessed is \$1,800.00. This amount is to be paid by check within 15 calendar days of the receipt of this notice and made payable to the Minnesota Department of Health and sent to:

Minnesota Department of Health Health Regulation Division P.O. Box 3879 85 East 7th Place, Suite 220 St. Paul, Minnesota 55101

In accordance with Minn. Stat. 144A.475, subd. 4, you may request a hearing on any fines resulting from noncompliance with these orders provided that a written request is made to the Department within 15 calendar days of receipt of this notice.

Also, at the time of this follow-up survey completed on October 20, 2017, additional violations were cited as follows:

Level/2; Scope/Widespread Correction Orders, Minn. Stat. 144A.474, subd. 8

They are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column

Roseview Court Care Agency November 16, 2017 Page 3

without brackets will identify these licensing orders.

If, upon follow-up, it is found that the correction order(s) cited herein are not corrected, a fine for each order not corrected shall be assessed in accordance with a schedule of fines described in Minn. Stat. 144A.474, subd. 11.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. 144A.474, subd. 8 (c), by the correction order date, the home care provider must document in the provider's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the home care provider's action to respond to the correction orders in future surveys, upon a complaint investigation, and as otherwise needed.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. 144A.474, subd. 12, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine(s) assessed. The written request for reconsideration must be received by the Commissioner within 15 calendar days of the correction order receipt date. In an effort to accurately review each citation challenged, please also submit all supporting documents within the same 15 calendar days of the correction order receipt date. The Commissioner shall then begin reviewing the request for reconsideration and supporting documents. The Commissioner shall respond in writing to the request within 60 days of the date the provider requests a reconsideration. Any documentation received after the Commissioner's response is completed will not be considered. You are required to send your written request and all supporting documents to renae.dressel@state.mn.us; or, if you prefer you can mail it to:

Renae Dressel, Senior Health Program Representative Home Care Correction Order Reconsideration Process Minnesota Department of Health/Health Regulation Division P.O. Box 3879 85 East 7th Place, Suite 220 St. Paul, Minnesota 55101

We urge you to review these orders carefully. If you have questions, contact Jeri Cummins at (218) 302-6193.

Roseview Court Care Agency November 16, 2017 Page 4

It is your responsibility to share the information contained in this letter and the results of the visit with the President of your organization's Governing Body.

Sincerely,

PAULA M. BASTIAN

Senior Health Program Representative **Health Regulation Division**

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Home Care & Assisted Living Program











Enclosure

cc: Cheryl Hennen, Office of the Ombudsman for Long Term Care

Houston County Social Services

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		H20196	B. WING		10/20/2017	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ROSEVII	EW COURT CARE AG	FNCY	'H BADGER IIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE	
{0 000}	Initial Comments		{0 000}			
	In accordance with 144A.43 to 144A.48 been issued pursual Determination of whom corrected requires or requirements provious indicated below. Whom contains several ite of the items will be compliance. INITIAL COMMENT SL20196012 On October 19, and Department's staff of above provider to for pursuant to a survey and July 27, 2017. Were 15 clients received.	VIDER LICENSING DER Minnesota Statutes, section 32, this correction order(s) has ant to a survey. The ther a violation has been compliance with all ded at the Statute number then Minnesota Statute ms, failure to comply with any considered lack of TS: 1 20, 2017, a surveyor of this conducted a revisit at the ollow-up on orders issued y completed on May 4, 2017, At the time of the survey, there eiving services under the nse. As a result of the revisit,		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota State Statutes for Hom Providers. The assigned tag numb appears in the far left column entit Prefix Tag." The state Statute num the corresponding text of the state out of compliance is listed in the "Summary Statement of Deficienc column. This column also includes findings which are in violation of the requirement after the statement, "Minnesota requirement is not met evidenced by." Following the surve findings is the Time Period for Cor PLEASE DISREGARD THE HEALTHE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION STATUTES. The letter in the left column is use tracking purposes and reflects the and level issued pursuant to 144A	oftware. to e Care eer led "ID lber and Statute lies" s the le state This as eyors' rection. DING OF THIS ON FOR TATE d for scope	
0 560 SS=F	144A.474, Subd. 8	Correction Orders	0 560	subd.11 (b) (1) (2).		
	This MN Requireme	ent is not met as evidenced				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		SURVEY PLETED	
		H20196	B. WING			R 20/2017
	PROVIDER OR SUPPLIER EW COURT CARE AG	FNCY 425 NOR	DRESS, CITY, S TH BADGER S NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
0 560	by: Based on interview licensee failed to ha with actions taken to orders from a survey and a revisit survey. This practice result violation that did not safety but had the policent's health or sacause serious injury was issued at a wide problems are pervertailure that has affer a large portion or a include: On October 19, 20 a.m., a request was (assisted living coof for a documented police for a documented p	and record review, the ave sufficient documentation o comply with the correction by completed on May 4, 2017, or completed on July 27, 2017. The din a level two violation (and tharm a client's health or cotential to have harmed a fety, but was not likely to by, impairment, or death), and despread scope (when asive or represent a systemic cted or has potential to affect and or the clients). The findings of the clients of the clients on May 4, 2017. The findings of the clients of t	0 560			

Minnesota Department of Health

STATE FORM 6899 H8ZH13 If continuation sheet 2 of 15

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		H20196	B. WING		F 10/2	R 0/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROSEVIEW COURT CARE AGENCY 425 NOR			H BADGER			
		CALEDON	IIA, MN 559			
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0 560	Continued From pa	ge 2	0 560			
	noted findings. The requirement.	employee was aware of the				
	No further informati	on was provided.				
{0 870} SS=F		O(f) Contents of Service Plan	{0 870}			
	(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					
		ding to the client's current ent and client preferences;				
	(2) the identification staff who will provide	of the staff or categories of the services;				
	(3) the schedule an reviews or assessm	d methods of monitoring nents of the client;				
		sessions of supervision of rsonnel who will supervise				
	provider and by the representative if the scheduled service (ii) information and client's representati provider; (iii) names and conclient wishes to havif there is a signification.	aken by the home care client or client's				

Minnesota Department of Health

STATE FORM 6899 H8ZH13 If continuation sheet 3 of 15

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(3) DATE SURVEY COMPLETED	
		H20196	B. WING		10/2	? 20/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROSEVI	EW COURT CARE AG	FNCY	TH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{0 870}	as to who has authorized civ) the circumstance medical services are consistent with chapters 145B and by the client under the sased on interview licensee failed to erall of the required consistent with respect to the sased on interview licensee failed to erall of the required consistent with respect to the sased on interview licensee failed to erall of the required consistent with the sased on interview licensee failed to erall of the required consistent with the sased on interview licensee failed to erall of the required consistent with the sased on interview licensee failed to erall of the required consistent with the sased on interview licensee failed to erall of the required consistent with the sased on one of the same sased on orders the sased on orders the sased on orders the sased on orders the same sased on orders the sased or orders the sased on orders the sased or	pority to sign for the client in an eas in which emergency is not to be summoned. 145C, and declarations made those chapters. ent is not met as evidenced and record review, the insure service plans included ontent for two of two clients cords reviewed. ed in a level two violation (a tharm a client's health or potential to have harmed a fety, but was not likely to y, impairment, or death), and lespread scope (when issive or represent a systemic cted or has potential to affect I of the clients). The findings 17, at approximately 10:45 a made to employee F reinator/unlicensed personnel) clan for compliance with the lat were issued on May 4, 2017, to include service plan	{0 870}			

Minnesota Department of Health STATE FORM

H8ZH13 If continuation sheet 4 of 15

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	E CONSTRUCTION		E SURVEY PLETED	
		H20196	B. WING			R 20/2017
	PROVIDER OR SUPPLIER EW COURT CARE AG	FNCY 425 NOR	DDRESS, CITY, STATE BADGER S	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
{0 870}	Client #1's diagnose limited to, hypertent failure (CHF), depresinsomnia. The client January 18, 2017, is medication manage. Client #2's diagnose limited to, HTN, CH client's service plant 2017, indicated the medication and treat. Client #1 and client following content: - fees for services; - the schedule and reviews or assessmant frequency of sessing type of personnel was a contingency plant be taken by the hor client or client's represervice could not be method for a client contact the home of contact information to have notified in a significant adverse condition, including information as to we client in an emerge which emergency means a summoned consist 145C, and declarat those chapters. On October 20, 20° a.m., employee F vision and consist 145C, and declarat those chapters.	es included, but were not sion (HTN), congestive heart ession, weakness, and at's service plan form dated, andicated the client received ement services. es included, but were not IF, and depression. The aform dated, February 3, client received bathing, atment management services. #2's service plans lacked the methods of monitoring				

Minnesota Department of Health

STATE FORM 6899 H8ZH13 If continuation sheet 5 of 15

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		E SURVEY PLETED		
				A. BUILDING:			D
		H20196		B. WING			R 20/2017
NAME OF I	PROVIDER OR SUPPLIER	ST	REET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROSEVII	EW COURT CARE AG	FNCY		TH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
{0 870}	Continued From pa	age 5		{0 870}			
	noted content.						
	a.m., employee L (ı	17, at approximately 10: registered nurse) verified gs. The employee was a	d the				
		ntents of Service Plan" p d the service plan would isted content.					
	No further informat	ion was provided.					
{0 905 SS=F	} 144A.4792, Subd. : Services	2 Provision of Medicatio	n Mgt	0 905			
	services. (a) For eamedication manage comprehensive hor providing medication a registered nurse, or authorized presoconduct an assess medication manage provided and how to This assessment must the client. The identification and reclient is known to be identifications, side eallergic or adverse address these issue		orior to s, have ional, .37 ided. to-face de an the d				
	needed in manage diversion of medica	nt must identify intervent ment of medications to pation by the client or othe ess to the medications.	orevent				

Minnesota Department of Health

STATE FORM 6899 H8ZH13 If continuation sheet 6 of 15

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		H20196	B. WING		F 10/2	R 2 0/2017
ROSEVIEW COURT CARE AGENCY 425 NOR			DRESS, CITY, S TH BADGER NIA, MN 559		,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
{0 905		ge 6 s the misuse, theft, or illegal tion of medications.	0 905			
	by: Based on interview licensee failed to er (RN) conducted a n	and record review, the nsure the registered nurse nedication assessment to content for one of one client viewed.				
	violation that did no safety but had the p client's health or sa cause serious injury was issued at a wid problems are perva failure that has affe	ed in a level two violation (a t harm a client's health or potential to have harmed a fety, but was not likely to y, impairment, or death), and lespread scope (when sive or represent a systemic cted or has potential to affect I of the clients). The findings				
	a.m., a request was (assisted living coo for a documented p correction orders th	17, at approximately 10:45 s made to employee F rdinator/unlicensed personnel) lan for compliance with the lat were issued on May 4, 2017, which included the ment for client #1.				
	employee F provide Self-Administration December 29, 2014	17, at approximately 1:45 p.m., ed client #1's "Medication" assessment form, dated 4, that was provided during the 2017, and July 27, 2017. The				

Minnesota Department of Health

STATE FORM 6899 H8ZH13 If continuation sheet 7 of 15

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETED		
	D	
	017	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
ROSEVIEW COURT CARE AGENCY 425 NORTH BADGER STREET CALEDONIA, MN 55921		
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	(X5) OMPLETE DATE	
employee indicated the medication assessment form used for client #1 was the same medication assessment form used for all 15 of 15 clients who received medication management services. Client #1's diagnoses included, but were not limited to, hypertension (HTN), congestive heart failure (CHF), and pain. The client's service plan form dated, January 18, 2017, indicated the client received medication management services. Client #1's prescriber's orders dated, February 1, 2017, indicated the client received medication management services. Client #1's prescriber's orders dated, February 1, 2017, indicated the client's medications included, but were not limited to, the following: one diuretic; and one narcotic analgesic. Client #1's record lacked evidence the RN had conducted a face to face assessment with the client and/or the client's representative to include an identification and review of all the medications for the medications, side effects, contraindications, altergic or adverse reactions, and interventions needed in the management of medications to prevent diversion of medications. On October 20, 2017, at approximately 10:30 a.m., employee F verified client #1, and all other clients' medication assessment forms lacked the above noted content. On October 20, 2017, at approximately 10:30 a.m., employee L (RN) verified the above noted findings. The employee was aware of the requirement. The licensee's "Initial and On-Going Nursing Assessments of Clients" policy (undated), indicated, the medication assessment would be		

Minnesota Department of Health

STATE FORM 6899 H8ZH13 If continuation sheet 8 of 15

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		H20196		B. WING			२ 20/2017
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROSEVIE	EW COURT CARE AG	ENCY		TH BADGER NIA, MN 559			
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{0 905}	Continued From pa	ge 8		0 905			
	above noted conter	nt.					
	No further informati	on was provided.					
{0 920} SS=F	144A.4792, Subd. 5 Mgt Plan	5 Individualized M	edication	{0 920}			
	Subd. 5. Individualize plan. (a) For each of management service care provider must service plan a writte management service client. The provider must developed individualized medice each client based on the contain the following	elient receiving medees, the comprehences, the comprehence and includen statement of the ces that will be profession management of the cestion of the cesti	edication ensive home ide in the ene medication ovided to the a current ent record for				
	(1) a statement designangement service (2) a description of on the client's need diversion, and considerations; (3) documentation of relating to the admit (4) identification of promotioning medication refills are (5) identification of tasks that may be depersonnel; (6) procedures for some or appropriate when a problem arises with	ces that will be prostorage of medicals and preferences istent with the material of specific client in the material of specific client in the material of specific client in the medication of medical on supplies and one ordered on a time of the medication managed elegated to unlice the staff notifying a result of the medical of the med	ovided; ations based s, risk of anufacturer's enstructions cations; ble for ensuring that mely basis; gement ensed gistered professional				
	services; and	ui medicalion ma	mayemeni				

Minnesota Department of Health

STATE FORM 6899 H8ZH13 If continuation sheet 9 of 15

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED	
		H20196	B. WING			R 20/2017
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
ROSEVII	EW COURT CARE AG	FNCY	RTH BADGER DNIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
{0 920}	documenting mediciverifications that all medications prescribed, and mo prevent possible complications or ad (b) The medication current and updated changes. This MN Requiremed by: Based on interview licensee failed to de individualized medicione of one client (# This practice resultation that did not safety but had the publication that did not safety but had the publication that has affer a large portion or al include: On October 19, 201 a.m., a request was (assisted living coof or a documented publications or additional coof or	fic requirements relating to cation administration, are administered as nitoring of medication use to		DEFICIENCY		
	2017, and July 27, 2 medication manage However, no docum	2017, which included the ement plan for client #1; nentation was provided, and was found in the client's				

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		H20406	B. WING		F 40/2	
		H20196	D. W		10/2	0/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROSEVII	EW COURT CARE AG	FNCY	TH BADGER			
NOOLVII.	en ocon onne no	CALEDOI	NIA, MN 559	21		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
{0 920}	Continued From pa	ge 10	{0 920}			
	limited to, hypertens failure (CHF), and publication and publication of permanagement service. Client #1's prescribe 2017, indicated the management service. Client #1's prescribe 2017, indicated the but were not limited and one narcotic and continuous continuous continuous. Client #1's records individualized medication developed to individualized medication of permanitoring medication refills we identification of medication refills we identification of medication refills we identification of medication and problem are management service any client-specific in and problem are management service.	rice Plan," dated January 18, client received medication ces. er's orders dated, February 1, client's medications included, to, the following: one diuretic; halgesic. lacked evidence to indicate an cation management plan had include: rsons responsible for ion supplies and ensuring that ere ordered on a timely basis; edication management tasks ted to unlicensed personnel; if notifying a registered nurse licensed health professional ose with medication				
	medication use to p	escribed, and monitoring of prevent possible complications				
	employee F indicate clients who received services would lack On October 20, 201 a.m., employee L (F	s. 17, at approximately 1:45 p.m., ed client records for 15 of 15 d medication management the above noted content. 17, at approximately 10:30 RN) verified the above noted byee was aware of the				

Minnesota Department of Health

STATE FORM 6899 H8ZH13 If continuation sheet 11 of 15

Minnesota Department of Health

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H20196	B. WING		F 10/2	R 2 0/2017
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE		
		425 NORT	TH BADGER			
ROSEVII	EW COURT CARE AG	ENCY CALEDON	NIA, MN 559	21		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{0 920}	Continued From pa	ge 11	{0 920}			
	requirement.					
	Medication Manage Medication Record the RN would devel	velopment of the Individualized ement Plan and Individualized policy (undated), indicated op an individualized ement plan for each client to oted content.				
	No further informati	on was provided.				
{01035} SS=E	144A.4793, Subd. 3 Treatment/Therapy		{01035}			
	management plan. management of ord or therapy services, care provider must service plan a writte or therapy services client. The provider maintain a current i therapy manageme must contain at lease	red treatment or therapy For each client receiving lered or prescribed treatments, the comprehensive home prepare and include in the en statement of the treatment that will be provided to the must also develop and individualized treatment and int record for each client which set the following: The type of services that will be				
	,	of specific client instructions ments or therapy				
		treatment or therapy tasks that unlicensed personnel;				
	appropriate license	notifying a registered nurse or d health professional when a treatments or therapy				

Minnesota Department of Health STATE FORM

H8ZH13 If continuation sheet 12 of 15

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION IDENTIFICATION NOWBER. A. BUILDING:	
	R
H20196 B. WING	10/20/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
ROSEVIEW COURT CARE AGENCY 425 NORTH BADGER STREET CALEDONIA, MN 55921	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH COF	ER'S PLAN OF CORRECTION (X5) RRECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DATE DEFICIENCY)
(5) any client-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Bassed on interview and record review, the licensee failed to develop and maintain a current individualized treatment and therapy management record to include all required content for one of one client (#2) reviewed for treatments or therapies managed by the provider. 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 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: On October 19, 2017, at approximately 10:45 a.m., a request was made to employee F (assisted living coordinator/unlicensed personnel) for a documented plan for compliance with the correction orders that were issued on May 4, 2017, and July 27, 2017, which included the treatment management plan for client #2. However, no documentation was provided, and	

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		H20196	B. WING			२ 20/2017
	PROVIDER OR SUPPLIER EW COURT CARE AG	FNCY 425 NORT	DRESS, CITY, S FH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
{01035}	no documentation or record. Client #2's diagnose limited to, hypertentaliure. The client's October 17, 2016, it treatments included wraps to both lower morning, and removed. Client #2's service per 2017, indicated the leg wraps. The client therapy managementalized appropriate licental appropriate lic	es included, but were not sion, and congestive heart prescriber's orders dated, ndicated the client's d, but were not limited to, leg rextremities daily, in the ve in the evening. Colan form dated February 3, client received assistance for not lacked a treatment or ent plan to include: ifying a registered nurse (RN) sed health professional when the treatments or therapy requirements relating to reatment and therapy was escribed, and monitoring of y to prevent possible	{01035}			

Minnesota Department of Health STATE FORM

Minnesota Department of Health

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H2040¢	B. WING		F 40/2	
NAME OF		H20196	<u> </u>	0TATE 7ID 00DE	10/2	0/2017
	PROVIDER OR SUPPLIER	425 NORT	TH BADGER	STATE, ZIP CODE STREET		
ROSEVII	EW COURT CARE AG	FNC:Y	NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
{01035}	Continued From pa	ge 14	{01035}			
	indicated the RN we treatment plan for e above noted conter					
	No further informati	on was provided.				

6899

Minnesota Department of Health STATE FORM

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVIS	SIT
IDENTIFICATION NUMBER	A. Building			
H20196 _{Y1}	B. Wing	Y2	10/20/2017	Y3
NAME OF FACILITY STREET ADDRESS, CITY, STA				
ROSEVIEW COURT CARE AG	ENCY	425 NORTH BADGER STREET		
		CALEDONIA, MN 55921		

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).

ITEI Y4	M	DATE Y5	ITEM Y4			DATE Y5	ITEM Y4			DATE Y5
ID Prefix Reg. # LSC	144A.479, Subc	Correction 5. 7 Completed 10/20/2017	LSC	144A.4	791, Subd. 3	Correction Completed 10/20/2017	ID Prefix Reg. # LSC	144A.4792, Subd	. 8	Correction Completed 10/20/2017
ID Prefix Reg. # LSC	01045 144A.4793, Sub	Correction od. 5 Completed 10/20/2017	ID Prefix Reg. # LSC		.795, Subd. 7(b)	Correction Completed 10/20/2017	ID Prefix Reg. # LSC	01150 144A.4795, Subd	. 7(c)	Correction Completed 10/20/2017
ID Prefix Reg. # LSC	01165 144A.4796, Sub	Correction Completed 10/20/2017	ID Prefix Reg. # LSC		.796, Subd. 6	Correction Completed 10/20/2017	ID Prefix Reg. # LSC	01225 144A.4797, Subd	. 3	Correction Completed 10/20/2017
ID Prefix Reg. # LSC		Correction	ID Prefix Reg. # LSC			Correction Completed	ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC		Correction	ID Prefix Reg. # LSC			Correction Completed	ID Prefix Reg. # LSC			Correction Completed
REVIEWE AGENCY REVIEWE CMS RO		REVIEWED BY (INITIALS): PMB REVIEWED BY (INITIALS)	DATE: 11/	16/17	SIGNATURE OF	SURVEYOR: 3	1217		DATE: 1	0/20/17
FOLLOW 5/4/2017		COMPLETED ON			R ANY UNCORREC CTED DEFICIENCIE				☐ YES	s 🗆 NO

Page 1 of 1 EVENT ID: H8ZH13



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Email: MRAUK@CAREANDREHAB.ORG Certified Mail # 7015 1730 0001 7737 1974

May 25, 2017

Ms. Marian Rauk, Administrator Roseview Court Care Agency 425 North Badger Street Caledonia, MN 55921

Re: Enclosed State Licensing Orders - Project Number SL20196012

Dear Ms. Rauk:

A survey of the Home Care Provider named above was completed on May 4, 2017 for the purpose of assessing compliance with State licensing regulations. At the time of survey, staff from the Minnesota Department of Health noted one or more violations of these regulations that are issued in accordance with Minnesota Statutes, sections 144A.43 to 144A.484. If, upon follow-up, it is found that the correction order(s) cited herein are not corrected, a fine for each order not corrected may be assessed in accordance with a schedule of fines described in Minnesota Statutes, section 144A.474, subdivision 11.

State licensing orders are delineated on the attached Minnesota Department of Health order form. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota 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 is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by."

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minnesota Statutes, section 144A.474, subdivision 8 (c), by the correction order date, the home care provider must document in the provider's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the home care provider's action to respond to the correction orders in future surveys, upon a complaint investigation, and as otherwise needed.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minnesota Statutes, section 144A.474, subdivision 12, you have one opportunity to

Roseview Court Care Agency May 25, 2017 Page 2

challenge the correction order issued, including the level and scope, and any fine(s) assessed. The written request for reconsideration must be received by the Commissioner within 15 calendar days of the correction order receipt date. In an effort to accurately review each citation challenged, please also submit all supporting documents within the same 15 calendar days of the correction order receipt date. The Commissioner shall then begin reviewing the request for reconsideration and supporting documents. The Commissioner shall respond in writing to the request within 60 days of the date the provider requests a reconsideration. Any documentation received after the Commissioner's response is completed will not be considered. You are required to send your written request and all supporting documents to the following:

Home Care Correction Order Reconsideration Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 85 East 7th Place, Suite 220 St. Paul, Minnesota 55164-0900

We urge you to review these orders carefully. If you have questions, contact Jeri Cummins at (218) 302-6193.

It is your responsibility to share the information contained in this letter and the results of the visit with the President of your organization's Governing Body.

Sincerely,

PAULA M. BASTIAN

Senior Health Program Representative

Health Regulation Division

Lawla Mastran

Home Care & Assisted Living Program

MDH Minnesota Department of Health

🖸 f 💆

Enclosure(s)

cc: Home Care and Assisted Living Program File

Cheryl Hennen, Office of the Ombudsman for Long Term Care

Houston County Social Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COMP		
		H20196	B. WING		05/04/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE	,
ROSEVIE	EW COURT CARE AG	FNCY	H BADGER IIA, MN 559		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
0 000	Initial Comments		0 000		
	Determination of who corrected requires or requirements provious indicated below. Who contains several ite of the items will be compliance. INITIAL COMMENT On May 1, 2, 3, and Department's staff, the following correctime of the survey, the survey is survey.	VIDER LICENSING DER Minnesota Statutes, section 32, this correction order(s) has ant to a survey. The ther a violation has been compliance with all ded at the Statute number then Minnesota Statute ms, failure to comply with any considered lack of		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota State Statutes for Home Providers. The assigned tag numbers appears in the far left column entire Prefix Tag." The state Statute numbers to corresponding text of the state out of compliance is listed in the "Summary Statement of Deficient column. This column also includes findings which are in violation of the requirement after the statement, "Minnesota requirement is not met evidenced by." Following the surve findings is the Time Period for Column STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TEDERAL DEFICIENCIES ONLY WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION STATUTES. The letter in the left column is use tracking purposes and reflects the and level issued pursuant to 144A subd.11 (b) (1) (2).	oftware. I to e Care per tled "ID aber and e Statute sies" s the as state This as eyors' rrection. DING OF TO THIS O ON FOR FATE
0 815 SS=E	144A.479, Subd. 7	Employee Records	0 815		
		records. The home care tain current records of each			

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						SURVEY PLETED
		H20196	B. WING		05/0	04/2017
	PROVIDER OR SUPPLIER EW COURT CARE AG	FNCY 425 NORT	DRESS, CITY, S FH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
0 815	paid employee, regularly providing home car individual contractor services. The recor information: (1) evidence of curr registration, or certi registration, or certi registration is re rules; (2) records of orien and infection contro evaluations; (3) current job deso qualifications, responsibility reviews which ident needed and training needs; (4) documentation or reviews which ident needed and training needs; (5) for individuals p verification that req section 144A.4798 dates of those scree (6) documentation or required under section Each employee recolleast three years aff care	y scheduled volunteers re services, and of each or providing home care rds must include the following rent professional licensure, ification, if licensure, quired by this statute or other tation, required annual training of training, and competency cription, including consibilities, and identification of con; of annual performance tify areas of improvement roviding home care services, uired health screenings under have taken place and the enings; and of the background study as	0 815			

Minnesota Department of Health

STATE FORM 6899 H8ZH11 If continuation sheet 2 of 67

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H20196	B. WING		05/0	4/2017
	PROVIDER OR SUPPLIER EW COURT CARE AG	FNCY 425 NORT	DRESS, CITY, S FH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 815	by or under contract If a home care provider records must be ma	ge 2 It with the home care provider. It ceases operation, employee aintained for three years. It ceases operation three years.	0 815			
	by: Based on observati review, the licensee employee (B) recor records of orientatio failed to ensure an was completed for	on, interview, and record e failed to ensure one of one d contained all required on. In addition, the licensee annual performance review one of one employee (D) with nd who had been employed				
	violation that did no safety but had the p client's health or sa pattern scope (whe of clients are affect number of staff are	ed in a level two violation (a tharm a client's health or votential to have harmed a fety), and is issued at a n more than a limited number ed, when more than a limited involved, or the situation has y but is not found to be dings include:				
	RECORD OF ORIE Employee B (registory was hired on June 2	ered nurse/director of nursing)				
	indicate the employ orientation to home -an overview of sec -introduction and re policies and proced home care services	tions 144A.43 to 144A.4798; view of all the provider's lures related to the provision of				

Minnesota Department of Health

STATE FORM 6899 H8ZH11 If continuation sheet 3 of 67

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		H20196	B. WING		05/	04/2017
	PROVIDER OR SUPPLIER	FNCY 425 NOR	DRESS, CITY, S TH BADGER : NIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
0 815	-compliance with an maltreatment of vul 626.557; -home care bill of ri-handling of clients' complaints, and whincluding informatic Facility Complaints -consumer advocate Ombudsman for Mc Developmental Dis Ombudsman at the Services, county mother relevant advorreview of the types employee will be proceed in the services of licensure. On May 3, 2017, at her own orientation required content as unable to locate do had been provided. ANNUAL PERFOR Employee D (unlice provide direct home 12, 1996. Employee D was of services to client #2017. The employee's reannual performance.	and reporting of the inerable adults under sections of the inerable adults under sections. If the inerable adults under sections of the inerable adults under section 144A.44; complaints, reporting of inere to report complaints on on the Office of Health and the Common Entry Point; by services of the Office of ing-Term Care, Office of ing-Term C	0 815			

Minnesota Department of Health

STATE FORM 6899 H8ZH11 If continuation sheet 4 of 67

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMI	SURVEY PLETED
		H20196	B. WING		05/	04/2017
	PROVIDER OR SUPPLIER	FNCY 425 NORT	DRESS, CITY, S I H BADGER NIA, MN 559	*		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
0 815	On May 3, 2017, at verified employee E annual performance. The licensee's "Per (undated), indicated maintained for each of orientation, and operformance review improvement needs. No further information.	1:00 p.m., employee B D's record did not include an e review. Isonnel records" policy d, a personnel file would be n employee to include records documentation of annual ws which identify areas of ed and training needs.	0 815			
0 835 SS=A	Services Subd. 3. Statement to the initiation of somust provide to the representative a wridentifies if the provides a basic or community the services the provident services the provident services the the scope of the procare provider shall obtain from the clients that statement or must a could not obtain the	prehensive home care license, ovider is authorized to provide, provider cannot provide under ovider's license. The home in written acknowledgment to the provider has provided the document why the provider	0 835			

Minnesota Department of Health STATE FORM

H8ZH11 If continuation sheet 5 of 67

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		H20196	B. WING		05/0	04/2017
ROSEVIEW COURT CARE AGENCY 425 NORT		DRESS, CITY, S FH BADGER NIA, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
0 835	Based on interview licensee failed to er home care services and/or the client's reclients (#1, and #2) This practice resulte violation that has not a minimal impact on health or safety), ar (when more than a affected, more than involved, or the situ but is not found to be include: Client #1, and #2's client and/or the client and/or the client provided with a write the licensee as a Coprovider, and the selicense. On May 4, 2017, at employee B (registe verified the clients' statement that ident their comprehensive hor requested and not provided and provided an	and record review, the asure a written statement of a was provided to the client epresentative for two of two with records reviewed. The din a level one violation (a potential to cause more than a the client and does not affect and was issued at pattern scope limited number of clients are a limited number of staff are ation has occurred repeatedly be pervasive). The findings The findings	0 835			

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	H20196		B. WING		05/0	4/2017
	425 NORT			STATE, ZIP CODE STREET		
ROSEVII	EW COURT CARE AG	CALEDON	IIA, MN 559	21		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 860	Continued From pa	ge 6	0 860			
0 860 SS=D	144A.4791, Subd. 8 and Monitoring	3 Comprehensive Assessment	0 860			
	services being provided are compran individualized iniconducted in person by a regis services are provide professionals, the aconducted by the all This initial assessmitive days after initial (b) Client monitoring conducted in the clidays after initiation of sell (c) Ongoing client number be conducted in the needs of the clidays from the last of monitoring and reassessment client's residence of telecommunication standards that mee This MN Requirements by: Based on observation review, the licensed registered nurse (R	rehensive home care services, tial assessment must be stered nurse. When the ed by other licensed health assessment must be oppropriate health professional. Itent must be completed within tion of home care services. If and reassessment must be ent's home no more than 14 rvices. In an				

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		H20196	B. WING		05/0	04/2017
ROSEVIEW COURT CARE AGENCY 425 NORT		DDRESS, CITY, S TH BADGER S NIA, MN 5592				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
0 860	This practice result violation that did no safety but had the policity health or sa cause serious injury was issued at an is limited number of colimited number of situation has occur findings include: Client #2 was admi 2016, with diagnost not limited to, hyperheart failure (CHF), service plan, dated client received bath management service. Client #2's record in Assessment dated prior to initiation of lacked evidence an assessment had be within five days after the attempt of the prior to initiation of lacked evidence an assessment had be within five days after the attempt of the prior to may 3, 2017, at client #2 was obsert treatment administration of lacked evidence an individual completed within five days after the prior to initiation of lacked evidence an individual completed within five days after the prior to may 3, 2017, at employee B (registing) verified clievidence an individual completed within five services. The licensee's "Initiation of lacked evidence an individual completed within five services."	ed in a level two violation (a of harm a client's health or cotential to have harmed a fety, but was not likely to y, impairment, or death), and olated scope (when one or a lients are affected or one or a taff are involved or the red only occasionally). The ted for services on June 30, es which included, but were rension (HTN), congestive and depression. The client's June 30, 2016, indicated the hing, medication and treatment ces. Included an "Admission II, June 27, 2016, three days services. The client's record individualized initial een completed by the RN er the initiation of services. Approximately 8:00 a.m., reved for medication, and	0 860			

Minnesota Department of Health

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		H20196	B. WING		05/0	4/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ROSEVII	EW COURT CARE AG	FNCY	H BADGER			
	0.18.44.574.074		IIA, MN 559		011	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 860	Continued From pa	ge 8	0 860			
	for each client within five days of the initiation of services.					
	No further informat	ion provided.				
	TIME PERIOD FOR CORRECTION: Twenty one (21) days					
0 870 SS=E	0 870 SS-E 144A.4791, Subd. 9(f) Contents of Service Plan		0 870			
	(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;					
	(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					
	provider and by the representative if the scheduled service ((ii) information and client's representati provider; (iii) names and con	aken by the home care client or client's				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	H20196	B. WING		05/04/201	17
ROSEVIEW COURT CARE AGENCY 425 NORT		DRESS, CITY, ST TH BADGER S NIA, MN 5592	STREET		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COM	X5) IPLETE ATE
client's condition, in information as to who has authorized emergency; and (iv) the circumstan medical services a consistent with chapters 145B and by the client under. This MN Requiremed by: Based on interview licensee failed to eall of the required of (#1, and #2) with result of the client's health or sapattern scope (who of clients are affect number of staff are occurred repeated pervasive). The fince the client of	ant adverse change in the including identification of and anority to sign for the client in an idea in which emergency are not to be summoned if 145C, and declarations made those chapters. The including identification of an idea in a level two violation (and the including is seen to have harmed a identification in a level two violation (and the including is seen in a level two violation (and it is a level two violation (and	0 870			

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			MULTIPLE CONSTRUCTION (X3) DATE COM		SURVEY LETED	
	H20196		B. WING		05/04/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ROSEVIE	EW COURT CARE AG	FNCY	H BADGER			
0/0.15	CLIMMA DV CTA		NIA, MN 559		ON	()(5)
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
0 870	Continued From pa	ge 10	0 870			
	medication adminis management service	stration, and treatment ces.				
	following content: -fees for services; -the schedule and r or assessments of -frequency of sessic type of personnel w -contingency plan to taken by the home or client's represent cannot be provided a client or client's re home care provided information of person notified in an emerg adverse change in identification of and authority to sign for and the circumstan medical services ar consistent with cha	methods of monitoring reviews the client; ons of supervision of staff and tho will supervise staff; and that includes: the action to be care provider and by the client tative if the scheduled service; information and a method for expresentative to contact the crimames and contact ons the client wishes to have gency or if there is a significant the client's condition, including information as to who has the client in an emergency; ces in which emergency re not to be summoned opters 145B and 145C, and by the client under those				
	On May 4, 2017, at approximately 9:30 a.m., employee B (registered nurse/RN/director of nursing) verified client #1, and #2's service plans did not include the above listed content as required. The licensee's "Contents of Service Plan" policy (undated), indicated, the service plan would include the above listed content.					
	No further informati	ion was provided.				
	TIME PERIOD FOR CORRECTION: Twenty One					

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			D WING			
		H20196	B. WING		05/0	4/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ROSEVII	EW COURT CARE AG	ENCY	TH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
0 870	Continued From pa	age 11	0 870			
	(21) days					
0 880 SS=D	144A.4791, Subd. 1	11 Client Complaint and ess	0 880			
	process. (a) The howitten policy and sinvestigating, report complaints from its clients or of policy should clearly clients may file a complaint services and an experience an	implaint and investigative ome care provider must have a system for receiving, rting, and attempting to resolve dients' representatives. The dy identify the process by which at or concern about home care eplicit statement that the home scriminate or retaliate against a groncerns or complaints. At thave a process in place to ons of complaints made by the entative about the services in at are or are not being provided entative about the services in at are or are not being provided entative about the services in at are or are not being provided entative if the client's representative if				
	regarding complaints received, including the date the complaint was received, and the home care provider's investigation and resolution of the complaint. This complaint record must be kept for each					

Minnesota Department of Health STATE FORM

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			B. WING			
		H20196			05/0	4/2017
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S FH BADGER	STATE, ZIP CODE		
ROSEVII	EW COURT CARE AG	FNCY	NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 880	Continued From pa	ige 12	0 880			
	event for at least two years after the date of entry and must be available to the commissioner for review.					
		mplaint system must provide each client or client's includes:				
	provider about the sign (2) the name or title the home care provided (4) a statement that	e of the person or persons with vider to contact with ubmitting a complaint to the				
	(d) A home care provider must not take any action that negatively affects a client in retaliation for a complaint made or a concern expressed by the client or the client's representative.					
	by: Based on observation review, the licenses client (#2) record or complaints received. This practice result violation that did not safety but had the policent's health or sa cause serious injury was issued at an is limited number of collimited number of significant reviews.	ent is not met as evidenced ion, interview and record e failed to ensure one of one ontained documentation of d and resolution . ed in a level two violation (a ot harm a client's health or obtential to have harmed a fety, but was not likely to y, impairment, or death), and olated scope (when one or a lients are affected or one or a taff are involved or the red only occasionally). The				

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					DATE SURVEY COMPLETED	
		H20196	B. WING		05/0	04/2017
	PROVIDER OR SUPPLIER	FNCY 425 NORT	DRESS, CITY, S FH BADGER NIA, MN 559		-	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRE		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
0 880	Client #2's record la	acked documentation the client	0 880			
	nursing (DON). On May 3, 2017, at employee D (unlice observed to provide client #2. Prior to th the ULP attempted pressure (BP) with monitor. The BP me indicated the BP me working properly. T	approximately 8:15 a.m., nsed personnel/ULP) was emedication administration to emedication administration to check the client's blood an automatic digital BP onitor failed to work. The ULP onitor had a history of not he ULP stated she would find and left the clients apartment.				
	"because of these r blood pressure take indicated the ULP r consistently monito approximately one complaint had beer the client had not be been investigated of lacked documentation	r the client's BP for month. The client stated, a made to the DON, however een notified the complaint had or resolved. The client's recordion of the complaint.				
	(registered nurse/D notified her of the a documentation had clients record related.) The licensee's "Corpolicy (undated), inwould investigate a	12:33 p.m., employee B ON) confirmed the client had bove complaint, and that not been entered in the ed to the complaint. mplaint Policy and Procedure" dicated, the RN or designee Il submitted complaints, within an appropriate time				

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H20196	B. WING		05/0	04/2017
	PROVIDER OR SUPPLIER	FNCY 425 NOR	DRESS, CITY, S TH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
0 880	Continued From pa	ge 14	0 880			
	would be kept in the	e client's file.				
0 905 SS=D	144A.4792, Subd. 2 Services	2 Provision of Medication Mgt	0 905			
	services. (a) For ea medication manage comprehensive hor providing medication a registered nurse, or authorized presoconduct an assessimedication manage provided and how to the thing assessment mover the identification and reclient is known to be identification must in medications, side eallergic or adverse address these issue (b) The assessment	ne care provider shall, prior to an management services, have licensed health professional, riber under section 151.37 ment of determine what ement services will be he services will be provided. The services will be provided and eview of all medications the etaking. The review and include indications for ffects, contraindications, reactions, and actions to es.				
	diversion of medica who may have acce "Diversion of medications" mean	ment of medications to prevent tion by the client or others ess to the medications. s the misuse, theft, or illegal tion of medications.				
	by:	ent is not met as evidenced on, interview and record				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
	H20196		B. WING		05/0	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
ROSEVII	EW COURT CARE AG	FNCY	H BADGER			
		CALEDON	NIA, MN 559			
(X4) ID PREFIX TAG			ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CON		(X5) COMPLETE DATE
0 905	Continued From pa	ge 15	0 905			
	registered nurse (R assessment to incluone of two clients (a This practice result violation that did no safety but had the polient's health or sa cause serious injury was issued at an is limited number of colimited number of serious injury.	e failed to ensure the N) conducted a medication ude all required content for #1) with records reviewed. ed in a level two violation (and tharm a client's health or cotential to have harmed a fety, but was not likely to y, impairment, or death), and colated scope (when one or a lients are affected or one or a taff are involved or the				
	findings include:	red only occasionally). The				
	Client #1's record lacked evidence the RN had conducted a face to face assessment with the client and/or the client's representative to include an identification and review of all the medications the client was known to be taking, indications for the medications, side effects, contraindications, allergic or adverse reactions, and interventions needed in the management of medications to prevent diversion of medications.					
	observed receiving from employee D (to Client #1's diagnos limited to, hyperten failure (CHF), depreinsomnia. The clien Plan," dated Janua	8:50 a.m., client #1 was medication administration unlicensed personnel/ULP). es included, but were not sion (HTN), congestive heart ession, weakness, and at's "Individualized Service ry 18, 2017, indicated the lication management services.				
	2017, indicated the	er's orders dated, February 1, client's medications included, I to, the following: one				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		H20196	B. WING		05/0	4/2017
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
ROSEVII	EW COURT CARE AG	ENIC-A	TH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 905	hormone for contro anti-hypertensive; a Client #1's "Medica assessment form, on the administration to state left blank. The second included a form title Assessment" which medication administration which medication management assessment assessments of client administration of the task would include, iden medications for medications for medications for medications to addrinterventions needs	le narcotic analgesic; one I of sleep and wake cycle; one and one bronchodilator. tion Self-Administration" dated December 29, 2014, sident defer med aff," the assessment area was and page of the assessment area was one indicated the client received stration. The assessment indicate a medication asment had been completed. The proximately 9:30 a.m. are and assessment to include a ment assessment would be an and On-Going Nursing and and On-Going Nursing and and the complete and the client assessment would be an and the client and review of all and the complete and the complete and review of all and the complete and review of al	0 905			
	TIME PERIOD FOR	R CORRECTION: Seven (7)				

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H20196	B. WING		05/	04/2017
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ROSEVI	EW COURT CARE AG	FNCY	RTH BADGER S ONIA, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
0 920 SS=E	Subd. 5. Individuali plan. (a) For each of management service are provider must service plan a written management service client. The provider must deveindividualized medieach client based on the contain the followin (1) a statement design management service (2) a description of on the client's need diversion, and considirections; (3) documentation relating to the admit (4) identification of monitoring medication refills at medication refills at the service of the se	Individualized Medication zed medication management client receiving medication ces, the comprehensive home prepare and include in the en statement of the medication ces that will be provided to the clop and maintain a current cation management record for client's assessment that must g: scribing the medication ces that will be provided; storage of medications based as and preferences, risk of sistent with the manufacturer's constructions inistration of medications; persons responsible for ion supplies and ensuring that are ordered on a timely basis; medication management		DEFICIENCY		
	tasks that may be opersonnel; (6) procedures for s	delegated to unlicensed staff notifying a registered se licensed health professional				
	when a problem arises w services; and (7) any client-speci documenting media verifications that all medications	ith medication management fic requirements relating to cation administration, s are administered as contoring of medication use to				

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H20196	B. WING		05/0	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROSEVII	EW COURT CARE AG	FNCY	TH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
0 920	Continued From pa	ge 18	0 920			
	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 observation, interview and record review, the licensee failed to develop and maintain a current individualized medication management plan for two of two clients (#1, and #2) who received medication management.					
	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), and is issued at a pattern scope (when more than a limited number of clients are affected, when 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:					
	a.m., employee D (etween 8:00 a.m., and 9:00 unlicensed personnel/ULP) Iminister medication for client				
	indicate an individu	records lacked evidence to alized medication had been developed.				
	limited to, osteoarth congestive heart fa weakness, and inso "Individualized Serv	es included, but were not nritis, hypertension (HTN), ilure (CHF), depression, omnia. The client's vice Plan," dated January 18, client received medication				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					ATE SURVEY OMPLETED	
		H20196	B. WING		05/0	04/2017
	PROVIDER OR SUPPLIER	FNCY 425 NOR	DRESS, CITY, S FH BADGER NIA, MN 559	· · · · · · · · · · · · · · · · · · ·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
0 920	management service Client #1's prescrib 2017, indicated the but were not limited anti-depressant; on hormone for contro anti-hypertensive; at Client #1's record la individualized medication of permonitoring medicated medication refills weighted individualized medication of medication refills weighted individualized medication of medication of medication of medication of medication of medication appropriate when a problem are management services any client-specific documenting medication use to permodication use to permodicate the individuality 30, 2016, indicated management service. Client #2's prescrib 2016, indicated the but were not limited.	ces. er's orders dated, February 1, client's medications included, 1 to, the following: one e narcotic analgesic; one of of sleep and wake cycle; one and one bronchodilator. acked evidence to indicate an extraction management plan had domaintained to include: resons responsible for it is supplies and ensuring that the ere ordered on a timely basis; adication management tasks the to unlicensed personnel; if notifying a registered nurse of licensed health professional ones; and requirements relating to extract administration, medications were escribed, and monitoring of the extraction administration, medications were escribed, and monitoring of the extraction administration. The ed Service Plan," dated June the client received medication	0 920			

PRINTED: 05/25/2017 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		H20196	B. WING		05/0	04/2017
	PROVIDER OR SUPPLIER	425 NOR	DDRESS, CITY, S	STATE, ZIP CODE		
ROSEVI	EW COURT CARE AG	HNCY	NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
0 920	Client #2's record la individualized medi been developed an -identification of pe monitoring medicat medication refills w-identification of methat may be delega -procedures for sta appropriate license problem arose with services; and -any client-specific documenting medic verifications that all administered as promedication use to por adverse reaction. On May 4, 2017, at employee B (registinursing) verified a rhad not been devel include the above of the RN would devermedication manage Medication Manage Medication manage include, the medication persons responsibl supplies and ensur ordered timely, ider delegated to ULP, puthe RN or LPN when	acked evidence to indicate an cation management plan had d maintained to include: rsons responsible for ion supplies and ensuring that ere ordered on a timely basis; edication management tasks ted to unlicensed personnel; ff notifying an RN or d health professional when a medication management requirements relating to cation administration, medications were escribed, and monitoring of prevent possible complications is. approximately 9:30 a.m., tered nurse/RN/director of medication management plan oped for clients' #1, and #2 to	0 920			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			X3) DATE SURVEY COMPLETED	
		H20196	B. WING		05/0	4/2017
	PROVIDER OR SUPPLIER	FNCY 425 NORT	DRESS, CITY, S TH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 920	client-specific requi documenting medic verifications that all as prescribed, and to prevent possible reactions.	rements relating to cation administration, medications are administered monitoring of medication use complications or adverse	0 920			
0 935 SS=E	Subd. 8. Document medications. Each comprehensive hor documented in the documentation must include the sig who administered the documentation must include the mand time administration. The reason why medication was prescribed and documented as prescribed and documented and in compliance was not and in compliance was not an agement plan.	ation of administration of medication administered by ne care provider staff must be client's record. The gnature and title of the personne medication. The edication name, dosage, date red, and method and route of staff must document the tion administration was not ument any follow-up re provided to meet the	0 935			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		H20196	B. WING		05/	04/2017
	PROVIDER OR SUPPLIER EW COURT CARE AG	FNCY 425 NORT	DRESS, CITY, S TH BADGER IIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
0 935	by: Based on observation review, the licensess medication was do record, for two of two received medication. This practice result violation that did not safety but had the publication that did not safety but had the publication safety but had the publication safety but had the publication of clients are affect number of staff are occurred repeatedly pervasive). The find On May 3, 2017, bearm., employee D (was observed to accommedications. Multiput medication administered. On May 3, 2017, at (registered nurse/R client records included the commentation medication. The employee the electronic records included the electronic records	on, interview and record e failed to ensure administered cumented in the client's vo clients (#1, and #2) who in management services. ed in a level two violation (a st harm a client's health or cotential to have harmed a fety), and is issued at a in more than a limited number ed, when more than a limited involved, or the situation has y but is not found to be dings include: etween 8:00 a.m., and 9:00 unlicensed personnel/ULP) diminister client #1 and #2's ale areas on the clients' stration records (MAR) lacked dication had been 1:00 p.m., employee B N/director of nursing) stated, ded paper and electronic byte indicated if staff were to medication administration in d, the paper record would be es included, but were not comia, depression, congestive hypertension (HTN), gastric and hypothyriodism. The client's vice Plan," dated January 18, client received medication	0 935			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H20196	B. WING		05/0	4/2017
	PROVIDER OR SUPPLIER EW COURT CARE AG	FNCY 425 NOR	DDRESS, CITY, ST TH BADGER S NIA, MN 5592	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
0 935	2017, indicated the but were not limited -Lortab (narcotic pa (mg) -325 mg table -Melatonin (hormor cycles) 3 mg daily a -mirtazapine (antide -Lasix (diuretic) 20 -carvedilol (for hear 6.25 mg BID; -Lisinopril (antihype -omeprazole (gastr -Levothyroxine Sod micrograms (mcg) -Vitamin D supplem Client #1's Februar electronic MAR lact medication adminis February 2017 -Lortab lacked documentazapine lacked document	er's orders dated, February 1, client's medications included, I to, the following: ain analgesic) 10 milligram t every four hours; he to regulate sleep wake at hour of sleep (HS); he pressant) 7.5 mg daily; mg twice daily (BID); ht failure and antihypertensive) hertensive) 5 mg daily; fic ulcer) 40 mg daily; hium (for hypothyroid) 125 hertensive;				
	one of four times as March 2017 -Lortab lacked doct -Melatonin lacked of	nent lacked documentation dministered. umentation 30 of 31 days. documentation 17 of 31 days. I documentation 17 of 31 days.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	H20196	B. WING		05/	04/2017	
NAME OF PROVIDER OR SUPPLIER ROSEVIEW COURT CARE AGE	NCY 425 NOR	DDRESS, CITY, ST TH BADGER S NIA, MN 5592	STREET			
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
-carvedilol lacked doc -Lisinopril lacked doc -omeprazole lacked of daysLevothyroxine lacked daysVitamin D suppleme one of four times adn April 2017 -Lortab lacked docum -Melatonin lacked doc -mirtazapine lacked of -Lasix lacked docume -carvedilol lacked doc -carvedilol lacked doc -omeprazole lacked of daysLevothyroxine lacked -Vitamin D suppleme three of four times ad The client's paper MA On May 3, 2017, at a client #1 stated, all m administered as sche Client #2's diagnoses limited to HTN, CHF, gastroesophageal ref client's "Individualized 30, 2016, indicated th administration service Client #2's prescriber	entation 14 of 31 days. cumentation 31 of 31 days. cumentation 13 of 31 days. documentation 14 of 31 ddocumentation 14 of 31 ddocumentation 12 of 31 ent lacked documentation ministered. Internation 29 of 30 days. cumentation 26 of 30 days. documentation 26 of 30 days. cumentation 21 of 30 days. ent lacked documentation ddocumentation 21 of 30 days. ent lacked documentation ddocumentation ddocumentatio					

Minnesota Department of Health

STATE FORM 6899 H8ZH11 If continuation sheet 25 of 67

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		H20196	B. WING		05/0	04/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
ROSEVI	EW COURT CARE AG	FNCY	TH BADGER NIA, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
0 935	-Simvastatin (for ch-Aspirin 81 mg daily-Lasix (diuretic) 20 -Omeprazole (for Good of the composition of the	nolesterol) 40 mg daily; y; mg daily; and GERD) 20 mg daily. 2's prescriber's order dated, 6, included, but was not limited g, twice daily. y, and April, 2017, electronic and March 2017, electronic cumentation of medication	0 935				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		H20196	B. WING		05/0	4/2047	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	05/0	4/2017	
		425 NORT	H BADGER	•			
ROSEVIE	EW COURT CARE AG	CALEDON	IIA, MN 559	21			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
0 935	Continued From pa	ge 26	0 935				
	-Carvedilol lacked	documentation 27 of 30 days.					
		8:25 a.m., client #2 stated, all en administered as scheduled.					
	employee B verified personnel had adm #1, and #2, and fur	approximately 10:40 a.m., d the licensees' unlicensed inistered medication to client ther verified documentation for of client's medication had not					
	Management Service indicated, staff wou medication administ medication record is completed to include date and time of administration.	cumentation of Medication ces" policy (undated), Id document each instance of stration on the client's mmediately after the task is Ie medication name, dosage, ministration, method and cion, signature and title of the ng the medication.					
	No further informati	ion was provided.					
	TIME PERIOD FOR days	R CORRECTION: Seven (7)					
0 940 SS=F	144A.4792, Subd. 9 Medication Setup	9 Documentation of	0 940				
	Documentation of coname of medication, quar administered, route of person	ration of medication setup. dates of medication setup, ntity of dose, times to be of administration, and name tion setup must be done at the					

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		H20196	B. WING		05/	04/2017
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
ROSEVII	EW COURT CARE AG	FNCY	TH BADGER NIA, MN 559			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	COMPLETE DATE
0 940	Continued From pa	ge 27	0 940			
	by: Based on observati review, the licenses documentation was medication setup for #2) who had medic practical nurse (LPI This practice result violation that did no safety but had the p client's health or sa cause serious injury was issued at a wid problems are perva failure that has affe	s completed at the time of or two of two clients (#1, and ations pre setup by a licensed				
	a.m., employee D (was observed to ad	etween 8:00 a.m., and 9:00 unlicensed personnel/ULP) distributed medication for client been setup by the LPN.				
	indicate documenta time of setup to incl medications, quanti administered, route	records lacked evidence to ation was completed at the lude the name of the ity of dose, times to be of administration, and the who setup the medications.				
	(register nurse/RN, there was no docur client #1, #2, and al medication set up b unaware of the requ	10:40 a.m., employee B director of nursing) verified mentation for the setup of II other clients that had their by the LPN. The employee was uirement.	6			

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		H20196	B. WING		05/0	04/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROSEVII	EW COURT CARE AG	FNCY	TH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
0 940	indicated, the RN o date, name, quantit be administered, ro direction for the me name of person con each medication as No further informat	ces" policy (undated), r LPN would document the cy of dose, dates and times to pute of administration, specific edication for the client, and empleting medication setup for so it is set up.	0 940			
0 945 SS=F	Subd. 10.Medication will be away from he provider who is promanagement service the client's access develop and impler for giving accurate medications to clientimes away from he individualized medi policy and procedur (1) for planned times be obtained from the registered nurse acceptant and federal laws are practice; (2) for unplanned times is not able to proviourse or unlicensed	on management for clients who ome. (a) A home care viding medication ces to the client and controls to the medications must ment policies and procedures and current this for planned or unplanned ome according to the client's cation management plan. The	0 945			

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H20196	B. WING		05/0	4/2017
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/0	-1/2011
	EW COURT CARE AG	425 NORT	H BADGER	,		
KOSEVII	EW COURT CARE AG	CALEDON	NIA, MN 559	21		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 945	Continued From pa	ge 29	0 945			
	dosages needed for the length of the anticipated absence, not to exceed 120 hours;					
	provided written infi including any speci	ndling the medications,				
	medication containenthe provider's medication	must be placed in a er or containers appropriate to on system and must be ent's name and the dates and heduled; and				
	(5) the client or client's representative must be provided in writing the home care provider's name and information on how to contact the home care provider.					
	by: Based on interview licensee failed to en were developed, for medication manage accurate and currer planned times away licensee failed to en for giving accurate	and record review, the nsure policies and procedures r clients who received ement services, for giving nt medications to clients for y from home. In addition, the nsure the policy and procedure and current medications to ed times away from home was				
	violation that did no	ed in a level two violation (a tharm a client's health or potential to have harmed a				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H20196	B. WING		05/0	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROSEVIEW COURT CARE AGENCY			TH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
0 945	client's health or sa cause serious injury was issued at a wide problems are pervertailure that has affer a large portion or a include: During the entrance at approximately 1: (registered nurse/Rall clients received services, and did not medication. Employ would occasionally unplanned time awanurses or the unlice place the client's malabeled with the cliented with the cliented in the medications, and the clients record. The sent medication with be notified. The "Core Provider Current Clemployee B, indicated received medication with clients received medication." On May 3, 2017, at stated clients often planned and unplaremployee verified the medication with cliented in the cliented in the clients of the planned and unplaremployee verified the medication with cliented in the clients of the planned and been pure medication with cliented in the cliented	fety, but was not likely to y, impairment, or death), and lespread scope (when sive or represent a systemic cted or has potential to affect I of the clients). The findings a conference on May 1, 2017, 35 p.m., employee B N, director of nursing) stated medication management of have access to their the B verified some clients go out on a planned or any and either the licensed ensed personnel/ULP would edications in an envelope ent's name, the name of the stes and times to take the sen would document in the employee stated if the ULP he the client, the nurse would comprehensive Home Care ient Roster" provided by ted 12 of the current 12 clients in management services. 9:15 a.m., employee D (ULP) left the establishment for aned times away. The JLP would set up and send ents. The employee stated no	0 945			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 7	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING	A. BUILDING:		FLETED	
		H20196	B. WING		05/0	04/2017	
NAME OF	PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY,	STATE, ZIP CODE			
ROSEVII	EW COURT CARE AG	: - N(· V	ORTH BADGER				
	I	CALE	DONIA, MN 559	1			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
0 945	Continued From pa	nge 31	0 945				
	provided to the clienterpresentative on methe specific type of would be used to suppropriate to the period to the period to the container and the written information be given to the clienter on May 3, 2017, at confirmed the above unaware the ULP comedications to clientime away.	nt and/or the client's nedications; f container or containers that end the medications provider's medication system or containers must be labeled ation about the medications on the or client's representative. It 2:30 p.m. employee Bure findings, and stated she would not setup and provide that who go out on a planned	n; ed; to vas				
0 950 SS=F	•	10(b) Medication Mgt for d	0 950				
	nurse is not availab	time away when the licensed ble, the registered nurse may o unlicensed personnel if:					
	unlicensed staff and staff is	urse has trained the d determined the unlicensed the procedures for giving nts; and	i				
	procedures for the including any special instruct	urse has developed written unlicensed personnel, tions or procedures regardinces that are prescribed for the					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H20196	B. WING		05/0	4/2017
	PROVIDER OR SUPPLIER	FNCY 425 NOR	DDRESS, CITY, S TH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
0 950	Continued From pa	ge 32	0 950			
	client.					
	The procedures mu	ust address:				
		iner or containers to be used appropriate to the provider's				
	(ii) how the containe labeled;	er or containers must be				
	. ,	mation about the medications lient or client's representative;				
	the client's record to given to the client or the client o	sed staff must document in hat medications have been client's representative, ting the date the medications ent's representative and who ations, the person who gave				
		client, the number of ere given to the client, and				
	medications have b client's representati nurse needs to be of medications are	ed nurse shall be notified that been given to the client or ve and whether the registered contacted before the or the client's representative;				
	completion of this to	registered nurse of the ask to verify that this task was bly by the unlicensed				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		H20196	B. WING		05/	04/2017
	PROVIDER OR SUPPLIER EW COURT CARE AG	FNCY 425 NOF	DDRESS, CITY, S'RTH BADGER S	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
0 950	personnel. This MN Requirements: Based on interview licensee failed to expersonnel/ULP (D, registered nurse (R) competency to setuclients for unplanned addition, the RN fail written procedure for unplanned times as This practice result violation that did not safety but had the polient's health or sacause serious injury was issued at a wide problems are pervatallure that has affer a large portion or a include:	ent is not met as evidenced and record review, the nsure two of two unlicensed and E) were trained by the N) and had demonstrated up and give medications to ed times away from home. In led to develop a complete or the ULP to follow for client way. ed in a level two violation (aut harm a client's health or cotential to have harmed a fety, but was not likely to y, impairment, or death), and despread scope (when asive or represent a systemic cted or has potential to affect II of the clients). The findings	0 950			
	at approximately 1: (registered nurse/R all clients received services, and did not medication. Employ would occasionally unplanned time awanurses or the unlice	e conference on May 1, 2017, 35 p.m. employee B N, director of nursing) stated medication management of have access to their yee B verified some clients go out on a planned or ay and either the licensed ensed personnel/ULP would edications in an envelope				
	labeled with the clie medications, the da medications, and th clients record. The	ent's name, the name of the ates and times to take the nen would document in the employee stated if the ULP h the client, the nurse would				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		H20196	B. WING		05/	04/2017
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ROSEVII	EW COURT CARE AG	FNCY	RTH BADGER S			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETE DATE
0 950	Continued From pa	ge 34	0 950			
	Provider Current Cl employee B, indicate	omprehensive Home Care ient Roster" provided by ted 12 of the current 12 clients n management services.	3			
	clients often left the and unplanned time verified ULP would	9:15 a.m., employee D stated e establishment for planned es away. The employee set up and send medication aployee stated no training had				
	home care services	E, were hired to provide directs to clients, which included stration, on September 12, 2016, respectively.	et			
	employees had bee	cords lacked evidence the en trained, and had betency to setup and give nts for unplanned times away				
	been developed for address: -the specific written provided to the client representative on mathematical transfer of the specific type of would be used to see appropriate to the properties of t	lete written procedure had not the ULP by the RN to information that would be not and/or the client's nedications; container or containers that end the medications provider's medication system; or containers must be labeled tion about the medications to not or client's representative.				
	confirmed employe	2:30 p.m. employee B e D, E, and all other ULP, had ained to setup and give	I			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ED	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H20196	E	B. WING		05/0	4/2017
NAME OF I	PROVIDER OR SUPPLIER				TATE, ZIP CODE		
ROSEVII	EW COURT CARE AG	FNCY		I BADGER : A, MN 5592			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUI SC IDENTIFYING INFORMATIO	LL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
0 950	medications to clied Employee B verified complete written production and curred unplanned times as was unaware of the No further informated TIME PERIOD FOR	nts for unplanned times dithe licensee did not have cocedure for the ULP for the medications to clients way from home. The emerge requirement.	away. ave a r giving s for nployee	0 950			
SS=D	current medications comprehensive hor given to the client of when the client's seemanagement service plan. Medicin the client's private is deceased or that that have expired in the client's represe (b) The comprehendispose of any medicomprehensive hor discontinued or expite service contract according to state a disposition of mediculations. (c) Upon disposition care provider must record the dispositions when the disposition of the dispositions are provided to the comprehensive hor disposition of mediculations.	on of medications. (a) As being managed by the me care provider must be the client's representative plan ends or medices are no longer part of cations that have been see living space for a client have been discontinuenay be given to the client and be given to the client and the care provider that are bired or upon the terminative for disposal. The comprehensive has document in the client's document in the client's on of the medication income, strength, prescriptions and controlled and, the comprehensive has document in the client's on of the medication income, strength, prescriptions and controlled and the care provides and the comprehensive has document in the client's on of the medication income, strength, prescriptions.	e be				

6899

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H20196	B. WING		05/0	4/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ROSEVII	EW COURT CARE AG	FNCY	'H BADGER NA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
01010	Continued From parameters applicated medications were grames of staff and the disposition. This MN Requirements by: Based on interview licensee failed to endisposition of medication of two discharged or received medication. This practice result violation that did not safety but had the policent's health or saccause serious injury was issued at an isolimited number of colimited number of situation has occurrifindings include: Client #4 was admitted included medication 2013, and was discontrolled to Cottober 3, 2016. The documentation which name, strength, predate of disposition, individuals involved.	ge 36 ble, quantity, to whom the given, date of disposition, and other individuals involved in the same and record review, the same documentation of the cations was complete for one clients (#4) reviewed who in management services. Ited in a level two violation (and the harm a client's health or cotential to have harmed and fety, but was not likely to by, impairment, or death), and colated scope (when one or a lients are affected or one or a lients are involved or the red only occasionally). The litted for services, which is management, on March 1, harged from the agency on the client's record lacked on identified the medication escription number, quantity, and names of staff and other in the disposition.	01010	DEFICIENCY)		
	fibrillation, allergies client's service plan	n, osteoarthritis, atrial , and hypothyroidism. The , dated March 1, 2016, received medication ces.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		7 7	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		H20196	B. WING		05/0	4/2017
	PROVIDER OR SUPPLIER	FNCY 425 NORT	DRESS, CITY, S FH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01010	Client #4's prescribe 2016, included, but narcotic pain reliever reliever, one antihyl and one hormone. Client #4's discharg 2016, indicated the medications were glacked documentation medications to include the medications to include the medications for client medications for client the client's record ladisposition of the medication for client the client's record ladisposition of the medication for the medication for the medication for medication for medication of the medication of medication for the licensee's "Record using form to the licensee's "Record using form to the medication of the medica	er's orders dated March 4, were not limited to, one er, one non-narcotic pain pertensive, one antihistamine, de note dated, October 3, client had moved and the iven to the client. The record on of the disposition of the disposition of the de the above noted content. approximately 1:15 p.m., ered nurse/RN/director of the licensee managed on #4. The employee verified acked documentation of the edications as identified above. position or Disposal of undated), indicated, the cation upon termination of documented in the client is-605 [as noted below]. cord of the Inventory and rolled and Uncontrolled and Uncontrolled rescription number, the strength, quantity, date of in the medications were given, and other individuals involved	01010			
	TIME PERIOD FOF Twenty-One (21) da					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED	
		H20196	B. WING		05/	04/2017
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
ROSEVI	EW COURT CARE AG	ENCY	TH BADGER NIA, MN 559:			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
01035	Continued From pa	ge 38	01035			
01035 SS=D	144A.4793, Subd. 3 Treatment/Therapy		01035			
	management plan. management of orc or therapy services care provider must service plan a writte or therapy services client. The provider maintain a current i therapy management must contain at lease (1) a statement of the provided; (2) documentation of relating to the treate administration; (3) identification of will be delegated to (4) procedures for rappropriate license problem arises with services; and (5) any client-specification documentation of treceived, verification therapy was adminification of treater possible complication treatment or therap	he type of services that will be				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		H20196	B. WING		05/0	4/2017
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
ROSEVII	EW COURT CARE AG	FNCY	'H BADGER IIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
01035	Continued From pa	ge 39	01035			
	by: Based on observation review, the licenses in the service plan attreatment or therap required content for reviewed for treatment the provider.	on, interview and record e failed to prepare and include a written statement of the y services to include all rone of one client (#2) ents or therapies managed by				
	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). The findings include: Client #2's records lacked evidence to indicate an individualized treatment management plan had been developed as required.					
		es included, but were not sion, and congestive heart				
	2016, indicated the but were not limited	er's orders dated, October 17, client's treatments included, I to, leg wraps to both lower the morning, and remove in				
	employee D (unlice	approximately 8:30 a.m., nsed personnel) was application of client #2's leg				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMP	SURVEY LETED
		H20196	B. WING		05/0	4/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ROSEVIE	EW COURT CARE AG	FNCY	H BADGER IIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU! CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01035	Continued From page 40		01035			
	June 30, 2016, indicassistance for leg water treatment or therapinclude: -procedures for not licensed health profarose with treatmer-any client-specific documentation of treatment or therap complications or ad On May 4, 2017, at employee B (register nursing) verified at the treatment or the specific documentation of the specific at the specific documentation of th	approximately 9:30 a.m., ered nurse/RN/ director of reatment management plan oped for client #2 to include				
		e to review the licensees atment and therapy but not provided.				
	No further informati	ion was provided.				
	TIME PERIOD FOR days	R CORRECTION: Seven (7)				
01040 SS=D	144A.4793, Subd. 4 Treatments/Therap		01040			
	therapy. Ordered of therapies must be a physician, or other	ation of treatments and r prescribed treatments or administered by a nurse, licensed health professional rm the treatment or therapy, or				

Minnesota Department of Health

O1040 Continued From page 41 may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the home care provider must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each client and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each client and documented those instructions in the client's record; and (3) communicated with the unlicensed personnel about the individual needs of the client. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of one unlicensed personnel/ULP (D) was instructed in the proper methods and demonstrated the ability to competently follow the procedures for one of one client (#½) reviewed for treatments or therapies managed by the provider. 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		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
ROSEVIEW COURT CARE AGENCY (X4) ID PREERIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DIAGRATIC TO THE APPROPRIATE O1040 Continued From page 41 may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed health professional has: (1) instructed the unlicensed personnel, the home care provider must ensure that the registered nurse or authorized licensed health professional has: (2) specified, in writing, specific instructions for each client and documented those instructions in the client's record; and (3) communicated with the unlicensed personnel about the individual needs of the client. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of one unlicensed personnel/LIP (D) was instructed in the proper methods and demonstrated the ability to competently follow the procedures for one of one client (#2) reviewed for treatments or therapies managed by the provider. 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			H20196	B. WING		05/0	4/2017
CALEDONIA, MN 55921	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CALEDNIA, MN 59321 SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG PREFIX T	ROSEVII	FW COURT CARE AG	FNCY				
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG O1040 Continued From page 41 may be delegated or assigned to unlicensed personnel y the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the home care provider must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each client and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each client and documented those instructions in the client's record; and (3) communicated with the unlicensed personnel about the individual needs of the client. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of one unlicensed personnel/ULP (D) was instructed in the proper methods and demonstrated the ability to competently follow the procedures for one client (#2) reviewed for treatments or therapies managed by the provider. 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			CALEDON	NIA, MN 559			
may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the home care provider must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each client and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each client and documented those instructions in the client's record; and (3) communicated with the unlicensed personnel about the individual needs of the client. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of one unlicensed personnel/ULP (D) was instructed in the proper methods and demonstrated the ability to competently follow the procedures for one of one client (#2) reviewed for treatments or therapies managed by the provider. 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	PREFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
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	01040	may be delegated of personnel by the licaccording to the apfor delegation or as administration of a delegated or assign the home care provergistered nurse or professional has: (1) instructed the unproper methods with the unlicensed persability to competent (2) specified, in write each client and door the client's record; (3) communicated about the individual. This MN Requirements: (3) communicated about the individual. This MN Requirements: (3) communicated about the individual. This practice resont the proper methods to competently folloone client (#2) reviet therapies managed. This practice result violation that did not safety but had the proper methods to competently folloone client's health or sa cause serious injury was issued at an is	or assigned to unlicensed censed health professional propriate practice standards esignment. When treatment or therapy is ned to unlicensed personnel, vider must ensure that the authorized licensed health enlicensed personnel in the character to each client and sonnel has demonstrated the cly follow the procedures; ting, specific instructions for cumented those instructions in and with the unlicensed personnel and the end of the client. The entities not met as evidenced in a level two violation (and the procedures for one of eyed for treatments or and the provider. The entities and the procedures for one of eyed for treatments or and the provider. The entities are two violation (and the provider) and the provider. The entities are two violation (and the provider) and the provider of	01040			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		H20196	B. WING		05/0	4/2017
	PROVIDER OR SUPPLIER	FNCY 425 NORT	DRESS, CITY, S FH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01040	situation has occurr findings include: On May 3, 2017, at employee D (unlice observed to provide wraps. During the othe process twice a the specific steps for The employee indice provided for the specific steps for the employee indice provided for the specific steps for the application of the specific steps for	red only occasionally). The approximately 8:30 a.m., nsed personnel) was application of client #2's leg abservation, client #2 stopped and prompted the employee for application of the wraps. ated training had not been acific task, and stated "I just girl that trained me and [client apployee verified the N) had not provided training af the client's leg wraps. approximately 9:30 a.m., approxima	01040			
01045 SS=D	Treatment/Therapy Subd. 5. Document treatments and there therapy administere care provider must	ation of administration of rapies. Eachtreatment or ed by a comprehensive home be documented in the client's entation must include the	01045			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
l		H20196	B. WING		05/0	4/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	,	
ROSEVIE	EW COURT CARE AG	i-NCY	TH BADGER NA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
01045	administered the trainclude the date an treatment or therapordered or prescrib document the reason and any follow-up produced to meet the client's This MN Requirem by: Based on observative review, the licensed administration of tradocumented for on with treatments or the provider. This practice result violation that did not safety but had the provider. This practice result violation that did not safety but had the provider is health or sa cause serious injur was issued at an is limited number of situation has occur findings include: Client #2's record laindicate the unlicent consistently manage prescribed. Client #2's diagnos limited to, hypertentallure. Client #2's prescrib 2016, indicated the	eatment or therapy and must d time of administration. When ies are not administered as ed, the provider must on why it was not administered procedures that were provided needs. ent is not met as evidenced ion, interview and record	01045			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED	
		H20196	B. WING		05/	04/2017
	PROVIDER OR SUPPLIER	FNCY 425 NOR	DRESS, CITY, STANDERNIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
01045	extremities daily, in the evening. On May 3, 2017, at employee D (ULP) application of client Client #2's February and paper MAR's, a MAR's, lacked document and remove applied and remove february 2017 application of leg with the enditory of 28 days. February 2017 application of leg with ree of 28 days. March 2017 application of leg with ree of 31 days. April 2017 application of leg with removal of l	the morning, and remove in approximately 8:30 a.m., was observed to provide #2's leg wraps. y, and April, 2017, electronic and March 2017, electronic umentation the leg wraps were ed as followed: vraps lacked documentation ps lacked nurse/RN/ director of cumentation for the ent's leg wraps had not been e to review the licensees atment and therapy	01045			

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STATE FORM 6899 H8ZH11 If continuation sheet 45 of 67

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		H20196	B. WING		05/0	4/2017
	PROVIDER OR SUPPLIER	FNCY 425 NOR	DDRESS, CITY, S TH BADGER NIA, MN 559		•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01045	Continued From page 45		01045			
	No further informati	on was provided.				
	TIME PERIOD FOR days	R CORRECTION: Seven (7)				
01080 SS=E	144A.4794, Subd. 3	3 Contents of Client Record	01080			
		of client record. Contents of a e the following for each client:				
	name, date of birth, number; (2) the name, address an emergency contrepresentative, if ar (3) names, address the client's health a and other home care pr (4) health informaticallergies, and when medications, treatmedocumentation, and records; (5) client's advance (6) the home care passessments and second (7) all records of coclient's home care (8) documentation (8) documentation (8) documentation (9) docu	on, including medical history, the provider is managing nents or therapies that require d other relevant health directives, if any; provider's current and previous ervice plans; mmunications pertinent to the services; of significant changes in the actions taken in response to including reporting to the				

Minnesota Department of Health

H20196 B. WING 05/04/2017	
<u> </u>	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	E OF PROVIDER OR SUPPL
ROSEVIEW COURT CARE AGENCY 425 NORTH BADGER STREET CALEDONIA, MN 55921	SEVIEW COURT CARE
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5 PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) (X5 PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY) (X6 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	EFIX (EACH DEFICIE
O1080 Continued From page 46 supervisor or health care professional; (10) documentation that services have been provided as identified in the service plan; (11) documentation that the client has received and reviewed the home care bill of rights; (12) documentation that the client has been provided the statement of disclosure on limitations of services under section 144A.4791, subdivision 3; (13) documentation of complaints received and resolution; (14) discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the client's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of one client (#2) record contained documentation of complaints received and resolution, and failed to ensure the client record contained a discharge summary for two of two discharged clients (#4, and #5) with records reviewed. 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, and is issued at a pattern scope (when 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:	supervisor or he (10) documental provided as idea (11) documental and reviewed the (12) documental provided the stallimitations of services under (13) documental resolution; (14) discharge stermination notified when applicable; and (15) other documental resolution. This MN Requiribles by: Based on obserview, the licerclient (#2) recording the client (#2) recording the client (#2) recording the client (#3) with recording the client (#4) with recording the client (#5) with recording the client (#6) with recording the clien

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		H20196	B. WING	B. WING		4/2017
	PROVIDER OR SUPPLIER	FNCY 425 NOR	DRESS, CITY, S TH BADGER NIA, MN 559	*		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01080	Continued From pa	ge 47	01080			
	indicate a discharge completed.	records lacked evidence to e summary had been				
l		tted for services on March 1, harged from the agency on				
	indicated the client management, and the	plan, dated March 1, 2016, received medication pathing services. In addition meal preparation, and				
	"Discharge To: Disc 3, 2016, the note in closer to family. The discharge summery relevant information	ncluded a note titled charged Date:" dated, October dicated the client had moved e record lacked evidence a was completed to include a related to the client's at the time of discharge.				
	Client #5 was admit September 19, 201 the agency on Janu	6, and was discharged from				
	2016, indicated the management, heari	plan, dated September 19, client received medication ing aid assist, and bathing in the client received meal				
	Client #5's record la summery was comp	acked evidence a discharge pleted.				
	verified client #4's r	2:30 p.m., employee B ecord lacked a completed , and verified client #5's				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION :		(X3) DATE SURVEY COMPLETED	
			B. WING			
		H20196	B. WING		05/	04/2017
NAME OF F	PROVIDER OR SUPPLIER		FADDRESS, CITY,			
ROSEVIE	W COURT CARE AG	FNCY	ORTH BADGER DONIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
01080	Continued From pa	ge 48	01080			
	record lacked a discharge summary.					
		e to review the licensees ent discharge but not provide	ed.			
	No further informati	ion was provided.				
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty O	ne			
01145 SS=E	144A.4795, Subd. 7 Evals All Staff	7(b) Training/Competency	01145			
		mpetency evaluations for all nel must include the following				
	(1) documentation requirements for all services provided;(2) reports of changes in the client's condition to the supervisor designated by the home care					
	provider; (3) basic infection c pathogens; (4) maintenance of	control, including blood-born a clean and safe	е			
	environment;	safe techniques in persona ing, including:	I			
		ims, and oral prosthetic				
	(iv) dressing and as(6) training on the p	riealing aids, and assisting with toileting; arevention of falls for provide derly or individuals at risk of	ers			
	perform them;	nce techniques and how to				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		H20196	B. WING		05/0	4/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ROSEVIE	W COURT CARE AG	FNCY	'H BADGER NA, MN 559			
(X4) ID PREFIX TAG	RÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01145	and assistance with (10) preparation of licensed health production the dignity of the clithe client and the client and considerable and	meal preparation, food safety, neating; modified diets as ordered by a fessional; next skills that include preserving ent and showing respect for lient's preferences, cultural amily; confidentiality and privacy; appropriate boundaries clients and the client's family; utilize in handling various ns; and commonly used health ent and assistive devices. The street is not met as evidenced fon, interview and record, the neure two of two unlicensed and E) received complete tency evaluations to include all	01145			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H20196	B. WING		05/0	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ROSEVII	EW COURT CARE AG	FNCY	H BADGER			
	T	CALEDON	IIA, MN 559			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01145	Continued From pa	ge 50	01145			
	services to clients, including medication administration and application of client #2's leg wraps on May 3, 2017.					
	the employee had of competency, in the edocumentation recognized provided; -reports of changes supervisor designation-maintenance of a compropriate and scanding, care and underessing and assisting-standby assistance perform them; -medication, exercitive preparation of modicine in the competence of t	in the client's condition to the ted by the home care provider; clean and safe environment; afe techniques in personal ing, including: hair care and se of hearing aids, and ing with toileting; techniques and how to se, and treatment reminders; diffied diets as ordered by a fessional; and monly used health technology				
	Employee E's record lacked evidence to indicate the employee had completed training and/or competency, in the following areas: -documentation requirements for all services provided; -reports of changes in the client's condition to the supervisor designated by the home care provider; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming, including: hair care and bathing, care of teeth, gums, and oral prosthetic devices, care and use of hearing aids, and dressing and assisting with toileting; -standby assistance techniques and how to perform them; and -medication, exercise, and treatment reminders.					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		H20196	B. WING		05/0	4/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROSEVIE	EW COURT CARE AG	FNCY	'H BADGER NA, MN 559			
(X4) ID PREFIX TAG	ÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01145	5 Continued From page 51		01145			
	employee B (regist nursing) confirmed provided medicatio to clients. The emp and E had not rece	approximately 10:00 a.m., ered nurse/RN/director of the above employees n administration and treatment loyee verified employee D, ived training, and had not competency, in the above				
	The licensee's "Training and Competency Evaluation of Unlicensed Staff" policy (undated), indicated, unlicensed staff would be trained, and competency evaluations completed to include the above noted content.					
	No further informat	ion was provided.				
	TIME PERIOD FOI (21) days	R CORRECTION: Twenty One				
01150 SS=E	144A.4795, Subd. Evals Comp Staff	7(c) Training/Competency	01150			
	competency evalua	aragraph (b), training and ation for unlicensed personnel ensive home care services				
	 (1) observation, reporting, and documenting of client status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the client; (4) recognizing physical, emotional, cognitive, and developmental needs of the client; 					

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H20196	B. WING		05/0	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	, , , , , ,	
ROSEVII	EW COURT CARE AG	FNCY	H BADGER			
		CALEDON	IIA, MN 559		011	
(X4) ID PREFIX TAG			ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE COM		(X5) COMPLETE DATE
01150	Continued From pa	ge 52	01150			
	(5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required.					
	This MN Requirement is not met as evidenced by: Based on observation, interview and record, the licensee failed to ensure two of two unlicensed personnel/ULP (D and E) received complete training and competency evaluations to include all of the required areas.					
	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:					
	12, 1996, and May Employee D was ol services to clients, administration, and	E, were hired on September 19, 2016, respectively. Deserved to provide direct care including medication application of client #2's leg 217.				
	wraps on May 3, 2017. Employees D, and E's records lacked evidence to indicate the employees had completed training and/or competency, in the following areas: -observation, reporting, and documenting of client status; -basic knowledge of body functioning and changes in body functioning, injuries, or other					

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		H20196	B. WING	B. WING		4/2017
	PROVIDER OR SUPPLIER	FNCY 425 NORT	DRESS, CITY, S FH BADGER NIA, MN 559	*		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
01150	observed changes appropriate personal recognizing physic developmental need-administering treat. In addition, employed to indicate the employed and/or competency reading and record respirations of the desafe transfer technological respirations administ clients. The employ had not received transfer technological respiration administ clients. The employ had not received transfer evaluated for compareas. The licensee's "Med Services" policy (unstaff would be trained evaluations complemedication manage indicated the training evaluations would desafe the training evaluations of Unlice indicated, unlicensed indicated, unlicensed indicated, unlicensed indicated, unlicensed indicated, unlicensed indicated indicated, unlicensed indicated indicated, unlicensed indicated, unlicensed indicated indicated, unlicensed indicated indicated, unlicensed indicated indicate	that must be reported to nel; al, emotional, cognitive, and ds of the client; and ments. Be E's record lacked evidence loyee had completed training, in the following areas: ding temperature, pulse, and slient; liques and ambulation; and and positioning. Approximately 10:00 a.m., ered nurse/director of nursing) e employees provided tration and treatment to ree verified employee D and Eaining, and had not been etency, in the above listed dication Management addated), indicated, unlicensed ed, and competency ted to perform all delegated ement tasks. The policy further g and competency documented in the personnel dining and Competency documented in the personnel staff would be trained, and tions completed to include the lit.	01150			

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H20196	B. WING		05/0	4/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
ROSEVIE	EW COURT CARE AG	FNCY	H BADGER			
		CALEDON	IIA, MN 559	21		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
01150	Continued From pa	ge 54	01150			
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty One				
01170 SS=E	144A.4796, Subd. 2	2 Content of Orientation	01170			
	Subd. 2. Content. T the following topics	The orientation must contain :				
	(1) an overview of sections 144A.43 to 144A.4798; (2) introduction and review of all the provider's policies and procedures related to the provision of home care services; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of minors or vulnerable adults under sections626.556 and 626.557; (5) home care bill of rights under section 144A.44;					
	complaints, and whincluding informatic Facility Complaints (7) consumer advocombudsman for Lo Ombudsman for Modevelopmental Discombudsman at the Department of Humcare advocates, or services; and (8) review of the type employee will be prescope of licensure.	habilities, Managed Care han Services, county managed other relevant advocacy hes of home care services the oviding and the provider's				
	This MN Requireme	ent is not met as evidenced				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H20196	B. WING		05/0	4/2017
	PROVIDER OR SUPPLIER EW COURT CARE AG	FNCY 425 NORT	DRESS, CITY, S TH BADGER NIA, MN 559	···		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01170	by: Based on observation review, the licensessed employees (D, and content for orientation requirements and rehome care services. This practice results violation that did not safety but had the policient's health or sa pattern scope (where of clients are affects number of staff are occurred repeatedly pervasive). The find Employee D, (unlied hired on September On May 3, 2017, emprovide home care #2. Employees D's recomplete had rece upon conversion to October 15, 2014, to content: -introduction and repolicies and proced home care services home care bill of rishandling of clients' complaints, and whincluding information facility Complaints consumer advocation.	on, interview and record a failed to ensure two of two E) received all required on to home care licensing egulations before providing a to clients. ed in a level two violation (a tharm a client's health or obtential to have harmed a fety), and is issued at a n more than a limited number ed, when more than a limited involved, or the situation has y but is not found to be dings include: ensed personnel/ULP) was a 12, 1996. Inployee D was observed to services to client #1 and client ord lacked evidence the fived orientation to home care comprehensive license on o include the following view of all the provider's ures related to the provision of	01170			

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		H20196	B. WING		05/	04/2017
	PROVIDER OR SUPPLIER EW COURT CARE AG	FNCY 425 NOR	DDRESS, CITY, S TH BADGER NIA, MN 559	~		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
01170	Ombudsman for Modevelopmental Disonbudsman at the Services, county mother relevant advorated in the Services, county mother relevant advorated in the service will be proscope of licensure. Employee E, (ULP) Employees E's recomployee had recesto include the followan overview of seconding information of clients complaints, and whincluding information facility Complaints and whincluding information facility Complaints on the services, county mother relevant advorated in the services, county mother relevant advorated in the services of licensure. On May 4, 2017, at employee B (registropic the above of the training related noted above. The licensee's "Hor (undated), indicated care employees with the services of the training related noted above.	ental Health and abilities, Managed Care Department of Human anaged care advocates, or cacy services; and of home care services the oviding and the provider's was hired on May 19, 2016. Ord lacked evidence the ived orientation to home care ving content: ctions 144A.43 to 144A.4798; complaints, reporting of the ere to report complaints on on the Office of Health and the Common Entry Point; cy services of the Office of the office of the ental Health and abilities, Managed Care Department of Human anaged care advocates, or	01170			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H20196	B. WING		05/0	4/2017
	PROVIDER OR SUPPLIER	425 NOR	DRESS, CITY, S	STATE, ZIP CODE STREET		
ROSEVII	EW COURT CARE AG	CALEDOI	NIA, MN 559	21		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
01170	Continued From pa	ge 57	01170			
	to clients to include	the above noted content.				
	No further informati	on was provided.				
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty-one				
01187 SS=F	144D.065 Training	In Dementia Care Required	01187			
55=F	REQUIRED. (a) If a housing with registered under this program or special Alzheimer's disease advertises, markets establishment as provided in the establishment as provided in the establishment's arranged employees of the employee in the employee at least two hore least eight hours of the employee at least eight hours specified under par hours of the employinitial training is comprovide direct care employee on site weight hours of training dementia care and	a services establishment is chapter has a special care unit for residents with error other dementias or so, or otherwise promotes the roviding services for persons sease or other dementias, gated or general unit, stablishment and of the langed home care provider wing training requirements: irect-care staff must have at initial training on topics agraph (b) within 120 working ment start date, and must burs of training on topics care for each 12 months of fter; loyees must have completed of initial training on topics agraph (b) within 160 working ment start date. Until this inplete, an employee must not unless there is another ho has completed the initial ing on topics related to who can act as a resource arise. A trainer of the				

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	H20196	B. WING		05/0	4/2017
NAME OF PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
DOOFWEN COURT CARE ACENC	425 NORT	H BADGER	STREET		
ROSEVIEW COURT CARE AGENC	CALEDON	IIA, MN 559	21		
PREFIX (EACH DEFICIENCY MUS	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
01187 Continued From page 5	58	01187			
requirements under par supervisor meeting the (1), must be available for new employee until the complete. Direct-care eleast two hours of training dementia for each 12 methereafter; (3) staff who do not pro- maintenance, houseked staff, must have at least training on topics specification within 160 working hour date, and must have at on topics related to demended and the months of employment (4) new employees may requirements by product previously completed re- past 18 months. (b) Areas of required tra (1) an explanation of Al- related disorders; (2) assistance with active (3) problem solving with and (4) communication skill (c) The establishment se in written or electronic for training program, the cate trained, the frequency of topics covered. This infindisclosure requirements subdivision 2, clause (4) (d) Housing with service included in paragraph (1)	ragraph (b), or a requirements in clause or consultation with the training requirement is employees must have at ing on topics related to nonths of employment ovide direct care, including eping, and food service at four hours of initial fied under paragraph (b) are of the employment start aleast two hours of training mentia care for each 12 at thereafter; and ay satisfy the initial training cing written proof of equired training within the laining include: Izheimer's disease and vities of daily living; he challenging behaviors; as shall provide to consumers form a description of the ategories of employees of training, and the basic formation satisfies the sof section 325F.72, a). es establishments not (a) that provide assisted that provide assisted that are the section 144G must meet the	01187			

	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BUILDING:			
		H20196	B. WING		05/0	4/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ROSEVI	EW COURT CARE AG	FNCY	TH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETE DATE
01187	least four hours of specified under par hours of the employ have at least two herelated to demential employment thereat (2) direct-care employment thereat (2) direct-care employment it least four hours of specified under par hours of the employinitial training is corprovide direct care employee on site wfour hours of training dementia care and and assist if issues requirements under meeting the require clause (1), must be the new employee complete. Direct-caleast two hours of the dementia for each thereafter; (3) staff who do not maintenance, hous staff, must have at training on topics swithin 160 working date, and must have on topics related to months of employments by previously complete past 18 months.	initial training on topics ragraph (b) within 120 working yment start date, and must ours of training on topics a care for each 12 months of	01187			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		H20196	B. WING		05/	04/2017
	PROVIDER OR SUPPLIER EW COURT CARE AG	FNCY 425 NOR	DDRESS, CITY, S TH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
01187	hours of training in related to dementia 144D.065.	nsure three of three nd D) received the required the required time frame a care in accordance with	01187			
	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 potential to affect a large portion or all of the clients). The findings include: Employee B (registered nurse/director of nursing) was hired to provide direct home care services, and supervision of direct care staff, on June 2, 2016.					
	employee had com training as required	rd lacked evidence the pleted at least four hours of related to persons with working hours of the ate.				
		ensed personnel/ULP) was ect home care services to 2016.				
	the employee had of training as require	rd lacked evidence to indicate completed at least four hours red related to persons with 0 working hours of the ate.				
		was hired to provide direct to clients on September 12,				

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	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H20196	B. WING		05/0	4/2017
ROSEVIEW COURT CARE AGENCY 425 NORT		DRESS, CITY, S TH BADGER NIA, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01187	the employee had of training as required dementia within the employment. On May 4, 2017, at employee B verified other employees had hours of training rel. The licensee's "Der Disclosure" policy (training education was care staff and supe a. Current explanation related disorders; b. Effective approace when working with a c. How to communically allowed by the dother topics as described by the dother topics as described by the described by the policy did not a training would be provided annually and the formation of the dother topics and the policy did not a training would be provided annually and the formation of the formation of the dother topics as described by the policy did not a training would be provided annually and the formation of the forest of the formation of the formation of the formation of the for	and lacked evidence to indicate completed at least two hours of related to persons with last 12 months of approximately 10:30 a.m., at the above employees, and all ad not completed the required atted to dementia care. Training and undated), indicated Dementia vould be provided to all direct rvisors in the following: ion of Alzheimer's disease and ches to use to problem solve a client's challenging behavior; cate with clients who have redementia's; and letermined necessary or defense how many hours of rovided upon hire and within hours of the employment start by hours of training would be sequired.	01187			
01190 SS=E	144A.4796, Subd. 6	Required Annual Training	01190			

A. BUILDING:	ATE SURVEY OMPLETED	
H20196 B. WING	5/04/2017	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
ROSEVIEW COURT CARE AGENCY 425 NORTH BADGER STREET CALEDONIA, MN 55921		
(X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
01190 Continued From page 62 01190		
Subd. 6. Required annual training. All staff that perform direct home care services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the home care provider or another source and must include topics relevant to the provision of home care services. The annual training must include: (1) 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; (2) review of the home care bill of rights in section 144A.44; (3) 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 nevironmental surfaces; and reporting of communicable diseases; and (4) review of the provider's policies and procedures relating to the provision of home care services and how to implement those policies and procedures.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		H20196	B. WING		05/	04/2017
	PROVIDER OR SUPPLIER	FNCY 425 NOF	DDRESS, CITY, S' RTH BADGER S DNIA, MN 5592	STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
01190	This MN Requirements: Based on observation review, the licensed unlicensed personorminimum of eight heach 12 months of areas. This practice result violation that did not safety but had the policent's health or saccause serious injury was issued at a partimited number of a limited number of a limited number of situation has occur found to be pervasioned annual training in a 2016. On May 3, 2017, be a.m., employee D (medication administration administration and ministration in the followoreview of the provious and how to implement procedures;	ent is not met as evidenced ion, interview and record e failed to ensure one of one nel/ULP (D), received a ours of annual training for employment in all required ed in a level two violation (a ot harm a client's health or cotential to have harmed a fety, but was not likely to by, impairment, or death), and attern scope (when more than a staff are involved, or the red repeatedly; but is not ve). The findings include: Inited on September 12, 1996. Cord lacked evidence the more than eight hours of a literation to clients. The findings include: The findings include:				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		H20196	B. WING		05/0	4/2017
ROSEVIEW COURT CARE AGENCY 425 NORT		DRESS, CITY, S TH BADGER IIA, MN 559				
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01190	Continued From page 64		01190			
		approximately 10:00 a.m., ered nurse/director of nursing) e findings.				
	(undated), indicated least eight hours of employment to inclu- policies and proced of home care service	nual In-Service Training" policy d, all staff must complete at training for each 12 months of ude a review of the provider's ures relating to the provision ces, reporting of maltreatment ; and review of the home care				
	No further information was provided.					
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty One				
01225 SS=D	Subd. 3. Supervision nursing or therapy has who perform delegated care tasks must be licensed health profiperiodically where the provided to verify the performed competer and solutions related to perform the tasks performing medicated administration shall nurse or appropriate and must include observing medical must include observing must include observing must include observing medical must include observing must include must	be provided by a registered e licensed health professional	01225			

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STATEMENT OF DEFICIENCIES (X1)

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(3) DATE SURVEY COMPLETED	
			A. BOILDING.				
		H20196	B. WING		05/	04/2017	
NAME OF PRO	OVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, S	STATE, ZIP CODE			
ROSEVIEW	V COURT CARE AG	FNCY	TH BADGER NIA, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE	
01225 C	Continued From pa	ge 65	01225				
d a th p p T n lo B lii	delegated tasks mulafter the individual begin provider and therea performance. This requirement al not performed dele- penger. This MN Requirement by: Based on interview censee failed to en provided supervision delegated tasks wit	rvision of staff performing ust be provided within 30 days is working for the home care after as needed based on also applies to staff who have gated tasks for one year or ent is not met as evidenced and record review, the asure a registered nurse (RN) on of staff performing hin 30 days of hire for one of dipersonnel/ULP (E).					
v s c c c w lii s fi E e s d	riolation that did no afety but had the parent's health or sa cause serious injury was issued at an is mited number of comited number of suituation has occurrindings include: Employee E was his employee's record supervision by the lays of performing on May 4, 2017, at employee B (registerursing), verified er	ed in a level two violation (a of harm a client's health or cotential to have harmed a fety, but was not likely to by, impairment, or death), and colated scope (when one or a lients are affected or one or a taff are involved or the red only occasionally). The red on May 19, 2016. The lacked evidence of direct RN of the employee within 30 a delegated task. approximately 9:30 a.m., ered nurse/RN/director of mployee E had not been ting a delegated task within 30					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		H20196	B. WING		05/0	4/2017
ROSEVIEW COURT CARE AGENCY 425 NORT			DRESS, CITY, S FH BADGER NIA, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
01225	The licensee's "Sup Unlicensed Person RN would supervise nursing tasks, withi work.	pervision of Licensed and nel" (undated), indicated the ethe ULP providing delegated n 30 days after beginning	01225			