Class A and F Home Care Surveys
Survey Exit Dates of May 2011 – May 2012

# of Licensing Orders Issued per Home Care Survey

- Weighted average = 7.1 licensing orders per survey – topped the Nursing Home average deficiencies for the first time (Nursing Homes are averaging around 6.0 – 6.6 deficiencies per survey)!
- Minnesota currently has 1236 home care agencies that are surveyed by this MDH team of survey staff (724 Class F providers and 512 Licensed-Only Class A providers).
- Time between surveys tends to run around 5-6 years, not counting OHFC investigations and resurveys.
- Fines are assessed only upon failure to “pass” resurveys; they then double at each resurvey.
- Survey length depends on number of clients, number of locations, and types of findings discovered.....but the average is around 3 days.

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<th>MDH ID Code</th>
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Home Care Surveys

144A.44 Subd. 1 (2) (MN Statute)
Bill of Rights
Acceptable Medical or Nursing Standards
Issued in 45% of surveys (Survey exit dates May 2011 – May 2012)

Acceptable Medical or Nursing Standards
There are 21 “rights” provided in the home care bill of rights. This deficiency relates to “right” #2:

HOME CARE BILL OF RIGHTS - Statement of rights. A person who receives home care services has these rights:
(2) the right to receive care and services according to a suitable and up-to-date plan, and subject to accepted medical or nursing standards, to take an active part in creating and changing the plan and evaluating care and services

What supports this finding?

- Falls Assessments
  - Home care provider did not address client falls and that no further assessment of client falls had been completed)
  - Licensee failed to assess and evaluate client falls, in order to develop interventions and minimize their occurrences.
  - Limited (or no) documentation of falls in client records
  - Vital signs not taken after documented falls
  - Client records did not include a fall prevention plan
  - Record indicated that the client’s physician had been notified after falls but the client’s record lacked evidence that a RN had assessed the client’s falls such as identifying any possible contributing factors

- Changes in Condition/Assessments
  - Increase in behaviors (wandering, outbreaks, altercations with other clients) with no evidence of further assessment of the escalating behaviors
  - Change in medical needs with no further evaluation by a RN in the client records indicating the changes had been assessed and acted on
  - Changes in range of motion, continence, skin/pressure ulcers

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- Pain not assessed or reassessed, with no interventions implemented
- Bruises not assessed to determine causes
- Change in transfer ability not assessed
- Lacked evidence that an RN had completed an assessment as to whether the client could be assisted to transfer with one or two staff
- RN not notified of client's death ("the RN doesn't want to be bothered like that")

**Pressure Ulcers/Skin Treatments**
- Record lacked evidence that wound care was provided as directed and that ongoing monitoring was completed by RN.
- Physician order was for daily monitoring of wound. No baseline assessment was documented, no description of the site being measured, policies not followed
- Client's record lacked evidence that wound dressings had been changed as prescribed

**Infection Control**
- Lancet not changed after use
- Staff did not wash hands between providing care to clients
- Staff did not change gloves
- Staff did not wash hands after removing gloves
- Same glucometer used on multiple clients with incorrect cleaning procedures performed
- Lancets disposed of in garbage can rather than sharps container
- Gloves not worn when administering insulin injections or blood sugar checks
- Eye drops not administered properly – no gloves worn

**Medications**
- Change in dose after readmission from hospital not noticed – could not locate physician's order
- Staff did not wait 5 minutes before repeat of inhaler, per manufacturer's directives
- Staff did not wait 5 minutes before giving a second type of eye drop

**Diabetes Management**
- Client record lacked evidence that staff had given client the required carbohydrates when low blood sugar was identified and failed to recheck blood sugar as directed
o Client’s record lacked documentation the physician was notified that the client was adjusting own insulin

o Client’s record lacked documentation that nurse was notified when client’s blood sugar was less than 70 or greater than 250, per “flow sheet directives”.

o Client’s record lacked evidence that the RN had been notified of the client’s low and elevated blood sugars, per policy

• Siderails

  o Records lacked an assessment for use of siderails

  o Use of side rails not on the client care plan

  o Side rails not used per manufacturer’s directions

  o Side rails were non compliant with FDA dimensional guidance

• Oxygen Use

  o Physician’s order to attempt to taper and discontinue client’s oxygen and monitor oxygen saturations every shift times seven days. Client records lacked evidence that either had been done. Some documentation in the “communication book”, which is not part of the client’s permanent record.

• Bowel and Bladder Assessments

  o Change in bladder function with no follow up assessment in order to determine appropriate interventions and restore as much bladder function as possible

  o Use of catheter without medical need or justification

  o Incorrect catheter care – no staff competency on file

• Unexplained Injuries

  o Unexplained injuries were not assessed, investigated, and did not have interventions implemented (related to client altercations on a memory care unit)

  o Bruises not assessed to determine causes

• Restraints

  o Using siderails to keep residents from falling out of bed, lacked assessment of siderail

  o Lap buddy used to prevent rising from wheelchair, client unable to remove the restraint – lacked assessment for restraint use

• Transportation

  o Client’s handicapped van did not properly accommodate wheelchair, so staff “have to go slow”. Staff were not supposed to be transporting client in the first place
Home Care Surveys

626.557 Subd. 14(b) (MN Statute)
Individual Abuse Prevention Plans
Issued in 47% of surveys (Survey exit dates May 2011 – May 2012)

Individual Abuse Prevention Plans Summary
Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.

What supports this finding?

- Failed to ensure clients had an individual abuse prevention plan developed that identified risk factors for abuse and specific measures implemented to minimize the risks of abuse –
  - Vulnerable adult assessments and abuse prevention plans not done for any clients
  - Unable to locate abuse prevention plans
  - Record lacked individual abuse prevention plan for the client
  - Record lacked individual abuse prevention plan that includes an assessment of the individual’s susceptibility to abuse by others, with specific measures to minimize the risk of abuse
  - Abuse prevention plan was not current
  - Although the licensee identified client vulnerabilities, there were no specific measures or interventions identified designed to minimize the client’s risk of abuse
  - Memory impairment not identified as a vulnerability
  - Elopement risk not identified as a vulnerability
  - Client hallucinations, delusions, and anxiety not identified as a vulnerability
  - Yelling out and agitated behaviors not identified as a vulnerability
Plan was “secure unit with secure care transmitters”, yet client frequently eloped out patio doors and staff not aware when client leaves – “immediate correction order issued”.

Clients cutting of transmitters designed to provide elopement protection.

Doors that were supposed to be auto-locking were not functioning properly, only sounding alarm

Client-to-client altercations not addressed

Clients wandering into other clients rooms not addressed

Client was assessed to be vulnerable in the areas of anxiety/depression/mental illness. Client record lacked evidence that an abuse prevention plan had been developed to address identified areas of vulnerability

Vulnerable adult assessments were not signed or dated by the person completing the assessment

Unwelcome sexual comments, advances, and/or actions not addressed for clients (on either side of the interactions) – vulnerable adult assessments and current care plan did not address such behavior

Assessment did not address specific measures to be taken to minimize the risk of abuse related to visual or auditory difficulties

Smoking in bed not addressed in vulnerable adult assessment

Substance/Alcohol abuse not assessed with interventions

Multiple reports of theft involving one client. A review of client’s risk management plan failed to identify theft as a vulnerability, therefore, a plan to reduce the risk of abuse for that particular vulnerability was lacking

Risk of falls not assessed, ability to ambulate safely or mobility issues not identified as a vulnerability

Risk of starting cooking fires not assessed (previous incidents with burned pastries) not identified as a vulnerability

Risk of starting fires resulting from unsafe smoking not assessed (burn holes in carpets, clothes, bedding) not identified as a vulnerability

Spousal abuse not identified as a vulnerability

Lack of pain control not identified as a vulnerability
Home Care Surveys

4668.0040 Subp. 2 (MN Rule)
Complaint System Requirements
Issued in 26% of surveys (Survey exit dates May 2011 – May 2012)

Complaint System Requirements
The home care provider must establish a system for receiving, investigating, and resolving complaints from its clients. The system must provide written notice to each client that includes:

1. The client's right to complain to the licensee about the services received;
2. The name or title of the person or persons to contact with complaints;
3. The method of submitting a complaint to the licensee;
4. The right to complain to the Minnesota Department of Health, Office of Health Facility Complaints; and
5. A statement that the provider will in no way retaliate because of a complaint.

What supports this licensing order?

- Any ONE element of the five required elements missing from the complaint or grievance procedure or written notice of the agency’s complaint/grievance procedure.
- Failed to provide clients with a copy of the agency’s complaint procedure
- Provider thought this required information was covered in the Bill of Rights
Home Care Surveys

4668.0065 Subp. 1 (MN Rule)

Tuberculosis Screening

Issued in 38% of surveys (Survey exit dates May 2011 – May 2012)

Tuberculosis Screening

NOTE – This rule was essentially replaced with a blanket waiver released by MDH in January 2009 via Informational Bulletin 09-04 HC-26, effective March 9, 2009.

The bulletin and various resources are found here: http://www.health.state.mn.us/divs/fpc/profinfo/ib09_4.html

A summary of the waiver is found here: http://www.health.state.mn.us/divs/fpc/profinfo/TBguideHC0309.pdf

Home care providers found out of compliance with the waiver requirements are issued a licensing order under 4668.0065 Subp.1.

What supports this licensing order?

- Based on interview and record review, the agency failed to ensure that TB testing was completed prior to health care workers providing services to clients.
- Correct TB testing done, but after staff had already been providing services to clients
- No evidence of TB screening in agency or personnel records
- One-step TB screening completed
- Agency risk assessment for TB had not been completed
- Infection control plan with procedures for handling individuals with active TB had not been developed
- TB tests administered, but results not read or documented
Home Care

Minnesota Rule 4668.0065 Subp. 1 & 2 Employee Tuberculosis Program and Exposure to tuberculosis is waived.

**Conditions of Waiver**

- Follow the U. S. Centers for Disease Control and Prevention’s "Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings, 2005," Morbidity and Mortality Weekly Report (MMWR) 2005;54 (No. RR-17), and as subsequently amended, for infection control procedures and requirements ("CDC Guidelines"). Refer to this document for complete definitions of terms.

- Assign administrative responsibility for the TB infection control program to appropriate personnel. Administrative responsibilities include the establishment of an infection control team (one or more individuals), completion (and periodic update) of a written TB risk assessment, development (and periodic review) of a written TB infection control plan, and screening of health care workers (HCWs) for TB as discussed below.

- Conduct a problem evaluation if a case of suspected or confirmed TB disease is not promptly recognized and appropriate measures are not taken.

- Perform an investigation in collaboration with the local health department if health-care-associated transmission of *M. tuberculous* is suspected.

- All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive baseline TB screening. This screening must include a written assessment of any current symptoms of TB, and a two-step tuberculin skin test (TST) or single interferon gamma release assay (IGRA) for *M. tuberculosis* (e.g., QuantiFERON TB Gold or TB Gold-InTube, TSPOT TB).

- All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive serial TB screening based on the facility’s risk level: (1) low risk - not needed; (2) medium risk - yearly; (3) potential ongoing transmission – consult the Minnesota Department of Health’s TB Prevention and Control Program at 651-201-5414.

- HCWs with abnormal TB screening results must receive follow-up medical evaluation according to current CDC recommendations for the diagnosis of TB. See [www.cdc.gov/tb](http://www.cdc.gov/tb).

- All reports or copies of HCW TSTs, IGRAs for *M. tuberculosis*, medical evaluation, and chest radiograph results must be maintained in the HCW’s employee file.

- All HCWs exhibiting signs or symptoms consistent with TB must be evaluated by a physician within 72 hours. These HCWs must not return to work until determined to be non-infectious.
Home Care Surveys

4668.0815 Subp. 2 (MN Rule)
Reevaluation of Service Plan
Issued in 32% of surveys (Survey exit dates May 2011 – May 2012)

Reevaluation of Service Plan
A registered nurse must review and revise a client's evaluation and service plan at least annually or more frequently when there is a change in the client's condition that requires a change in services.

NOTE: It is important to distinguish between reevaluation and modification. MN Rule 4668.0815 Subp. 2 requires that the service plan be reevaluated at least annually. This means that a registered nurse must review and revise a client’s evaluation and service plan at least annually or more frequently when there is a change in the client’s condition that requires a change in services. (from the MDH FAQ document)

What supports this licensing order?

- Changes in client conditions did not trigger the reevaluation/revision of service plan
  - Increased falls
  - Initiation of Hospice
  - Initiation of Oxygen
  - Changes in ambulation
  - Changes in levels of pain
  - Initiation of alarms
  - Initiation of catheters
  - Change in transfer abilities or assistance needed
  - Changes in bladder continence
  - Changes in dialysis
  - Initiation of siderails
  - Readmission from hospital
- Increased episodes of **forgetfulness**
- New **open skin areas**, **new wound care** orders
- Ability to self-administer **medications**

- Service plan did not match current assessment of the client or services provided to client (functional assessment was not an actual depiction of the client’s current functional status)
- No annual reassessment of the service plan completed
- Assessment only included “what the family will go with”
Home Care Surveys

4668.0815 Subp. 4 (MN Rule)
Contents of Service Plan
Issued in 28% of surveys (Survey exit dates May 2011 – May 2012)

Contents of Service Plan
The service plan must include:

A. A description of the assisted living home care service or services to be provided and the
   frequency of each service, according to the individualized evaluation required under
   subpart 1;

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

C. The schedule or frequency of sessions of supervision or monitoring required by law, rule,
   or the client's condition for the services or the persons providing those services, if any;

D. The fees for each service; and

E. A plan for contingency action that includes:
   1. The action to be taken by the class F home care provider licensee, client, and
      responsible person if scheduled services cannot be provided;
   2. The method for a client or responsible person to contact a representative of the class
      F home care provider licensee whenever staff are providing services;
   3. The name and telephone number of the person to contact in case of an emergency or
      significant adverse change in the client's condition;
   4. The method for the class F home care provider licensee to contact a responsible
      person of the client, if any; and
   5. The circumstances in which emergency medical services are not to be summoned,
      consistent with Minnesota Statutes, chapters 145B and 145C, and declarations made
      by the client under those chapters.
What supports this licensing order?

- Client’s record lacked documentation of a service plan (schedule of services and rates was considered the service plan)
- Service plan did not include all services being provided to the client by the home care agency staff
- Service plans did not include:
  - Describe services to be provided
  - The person who is to provide the service
  - Frequency of services provided,
  - Frequency of supervision,
  - Contingency plan
  - Fees for services
- Service plan indicated EW GRH-XXX County Human Services, the county Social Worker as the person to provide services, and the frequency of service to be monthly
- Service plan indicated the client received “basic service package and level three services”, but did not describe the services or frequency of services
- Service plan indicated “see attached rate sheet”, but the rate sheet was completed by County Services and contained a list of potential services, not actual services provided
- Service plans lacked a client signature (or client’s representative)
- “Memory Care” noted as a service, with no description of what was included in that service
- “Well Check” noted as a service, with no description of what was included in that service
Delegated Nursing Services - Performance of Routine Procedures

A person who satisfies the requirements of part 4668.0835, subpart 2, may perform delegated nursing procedures if:

1. Before performing the procedures, the person is instructed by a registered nurse in the proper methods to perform the procedures with respect to each client;
2. A registered nurse specifies in writing specific instructions for performing the procedures for each client;
3. Before performing the procedures, the person demonstrates to a registered nurse the person's ability to competently follow the procedures;
4. The procedures for each client are documented in the client's record; and
5. The class F home care provider licensee retains documentation by the registered nurse regarding the person's demonstrated competency.

What supports this licensing order?

- Failed to ensure unlicensed personnel:
  - Were instructed by a RN in the proper methods to perform delegated nursing procedures for each client
  - Were provided specific written instructions for each client
  - Demonstrated to a RN the ability to competently follow procedures
    - Blood glucose checks in an unusual area (upper arms)
    - ADLs
    - Glucometer testing (usually staff observed to do something wrong regarding infection control)
    - No instructions on how to clean glucometers properly
    - TED stockings

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• Foley catheter care and cleaning
• Peak lung capacity flow (asthma protocol)
• Oxygen saturation levels (pulse oximeter)
• Nebulizers
• Oxygen equipment use
• Ace bandage application
• Thickened liquid preparation
• Proper use of alarms
• “Massage Machine” (inflatable leg sleeves)
• Leg braces
• Exercises ordered by PT
• Wound care procedures
• Blood pressure checks
• Dialysis issues: weight monitoring, fluid restrictions, renal diet guidelines
Home Care Surveys

4668.0855 Subp. 9 (MN Rule)

Medication Records

Issued in 36% of surveys (Survey exit dates May 2011 – May 2012)

**Medication Records**

The name, date, time, quantity of dosage, and the method of administration of all prescribed legend and over-the-counter medications, and the signature and title of the authorized person who provided assistance with self-administration of medication or medication administration must be recorded in the client's record following the assistance with self-administration of medication or medication administration. If assistance with self-administration of medication or medication administration was not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided.

**What supports this licensing order?**

- Medication orders changed by prescriber, not acted on by home care provider
- Pain medication regimen was too complicated for the ULP to administer (as described by the RN)
- PRN did not indicate the dose given to client
- Insulin not given per sliding orders
- No reassessment after hospitalization, permitting medication records and administration to be inconsistent with client needs (dialysis)
- Client record lacked evidence who set up clients medications (seven day supply) (RN)
- Eye drops administered and not recorded in the record
- Eye drops administered to both eyes instead of just one eye
- Did not document the number of eye drops administered
- Nasal spray administered and not recorded in the record
- Inhalers not used according to manufacturer’s recommendations (time between puffs, mouth rinse)
• Time insulin injection given was not recorded in the record
• Medications initialed as given prior to administering the medications
• Medications that require to be given with food administered without food
• Incorrect dosage of medication given (two tablets Tylenol instead of one)
• Documented insulin as given prior to injecting it
• Medications given but not documented as given on the MAR
• Failed to document the self-administration of a client’s insulin (ULP brought the pre-filled insulin syringe to client) (“I document administration of all medications at the end of my shift”)
• No documentation of a pain score used for PRN pain medications (per directive)
• “Sometimes I wait and document all the clients’ medications at one time”
Home Care Surveys

4668.0855 Subp. 7 (MN Rule)

Medications - Performance of Routine Procedures – Medications
Issued in 25% of surveys (Survey exit dates May 2011 – May 2012)

Medications - Performance of Routine Procedures
Medication Administration and Assistance with Self-Administration of Medication –

An unlicensed person who satisfies training requirements may perform assistance with self-administration of medication or medication administration if:

1. Before performing the procedures, the person is instructed by a registered nurse in the proper methods to perform the procedures with respect to each client;
2. A registered nurse specifies in writing specific instructions for performing the procedures for each client;
3. Before performing the procedures, the person demonstrates to a registered nurse the person’s ability to competently follow the procedures;
4. The procedures for each client are documented in the client's records; and
5. The class F home care provider licensee retains documentation by the registered nurse regarding the person’s demonstrated competency.

What supports this licensing order?

- Failed to ensure unlicensed personnel had received instruction by a RN for the task of medication administration
- Failed to ensure unlicensed personnel had demonstrated competency prior to the administration of medications
- RN failed to provide in writing specific instructions for administering medications that were ordered on a PRN basis
- RN failed to provide in writing specific instructions for administering a medication in patch form
- Licensee stated all TMAs and other unlicensed staff receive training in medication administration from another source
- Training provided by a LPN instead of a RN
- Competency testing provided by a LPN instead of a RN
• Common triggers:
  o Inhalers
  o Nebulizers
  o Eye drops
  o Peak Flow meters
  o Insulin
  o PRN meds (pain, eye drops, nitro-stat, inhalers, etc.)
  o Dialysis catheter dressing changes (and instructions for showering)
Class F Licensed Only Home Care Agency
Frequently Asked Questions

Updated June 2010- Additions Bolded

Bill of Rights

1. **Question:** Where can a current copy of the Home Care Bill of Rights required by MN Rule 4668.0030 be found?

**Answer:** The most current Home Care Bill of Rights may be obtained at:
http://www.health.state.mn.us/divs/fpc/consumerinfo/otherlang2.html

Delegation by Professionals

1. **Question:** I am a registered nurse. May I delegate blood sugar monitoring and insulin administration to a trained unlicensed person?

**Answer:** A registered nurse may delegate to an unlicensed person the task of checking a client’s blood sugar and insulin administration if all the requirements of MN Rule 4668.0825 and MN Rule 4668.0855 are met.

   - The unlicensed person (ULP) cannot determine the dose, including dialing an insulin pen or any other device that requires manipulation in order to administer a dose.
   - The ULP cannot decide what dose to administer.
   - The ULP cannot draw up insulin into a syringe.
   - Injections given by a trained unlicensed person are limited to insulin administration.
   - The ULP must be trained and competency tested in the tasks that are delegated to them.
   - The ULP may visually verify that the client has dialed up the correct dose on an insulin pen prior to the client self administering their own insulin.
   - ULP’s MAY give an insulin injection from an insulin pen when the dose is dialed by a licensed nurse and then only if they have been trained and competency tested by a registered nurse.
   - May administer sliding scale insulin as long as they meet the training requirements and the syringe is clearly labeled.

2. **Question:** If a client uses an insulin pen for the administration of insulin, what services may an unlicensed staff member provide related to the use of the insulin pen?

**Answer:** Unlicensed personnel:

   - may not dial up the dose on an insulin pen (MN Rule 4668.0855 Subp. 6)
- may visually verify that the client has dialed up the correct dose
- may handle the insulin pen including changing the needle as long as they have been trained and competency tested by a registered nurse. (MN Rule 4668.0825 Subp. 4) It is expected that this training would include elements of infection control and safety.
- ULP’s MAY give an insulin injection from an insulin pen when the dose is dialed by a licensed nurse and then only if they have been trained and competency tested by a registered nurse

3 Question: I am a registered nurse. Can I delegate B12 injections to a medication trained unlicensed person?

Answer: No. MN Rule 4668.0855 Subpart 6 does not permit an unlicensed person to inject any medication except insulin.

4. Question: One of my clients who is normally independent has the flu and needs some extra help with bathing, foot soaks, dressing and meal preparation. I am not a registered nurse (RN); can I delegate these services for this client?

Answer: No. MN Rule 4668.0825 Subp. 3 specifically requires that an RN delegate foot soaks and bathing (G) and also requires that an RN delegate dressing and meal preparation during episodes of acute illness (H). Additional information regarding delegation of nursing services may be obtained from the Minnesota Board of Nursing web-site: www.nursingboard.state.mn.us

General Licensing

1. Question: Can a Class F home care provider provide services in more than one housing with services establishments?

Answer: Yes, MN Rule 4668.0800 Subp. 1 states that a Class F home care provider may provide home care services in one or more registered housing with services establishments.

2. Question: Our corporation holds multiple MDH licenses and we have staff that work across these multiple licensed entities. For example, our registered nurse may work for our nursing home, Class A (licensed only) home care provider and our Class F home care agency. How many background studies do we need to conduct to meet the requirements of 144A.46 Subd. 5?

Answer: Only one background study is required for each individual working on a campus or in a corporation as long as both of the following requirements are met:

1. Personnel records and the responsibility for background studies are centralized and

2. One individual (this can be a position) is clearly designated to be the contact person for background studies.

See MN Statute 245C.07.
3. **Question:** I have received correction orders. What do I need to do?

**Answer:** After all corrections are made and on or prior to the last date listed in orders for the time period for correction, the Class F home care provider is asked to sign and date the first page of the correction order(s) and return the first page to the Minnesota Department of Health address listed on the correction order. Note: In Minnesota, Class F home care providers are not required to submit a plan of correction when correction orders are issued.

4. **Question:** Posting of Home Care License – where are surveyors expecting these to be posted?

**Answer:** Licensees follow: *Minnesota Rule 4668.0012 Subp. 17. Display of license. The original license must be displayed in the provider's principal business office and copies must be displayed in all other offices. The licensee must provide a copy of the license to any person who requests it.*

**Survey Focus:**

The home care licensure requirements require the license/copies to be displayed as stated above. It would be consistent with the Home Care licensure requirements for a surveyor to inquire where the license is posted and if a licensee had multiple offices for the license to be displayed in these offices.

5. **Question:** How do I apply to become a Class F home care provider?

**Answer:** You can access the information you need from the Minnesota Department of Health, Compliance Monitoring Division - Licensing and Certification Program’s website listed below: [http://www.health.state.mn.us/divs/fpc/profinfo/licensure.html](http://www.health.state.mn.us/divs/fpc/profinfo/licensure.html)

- Scroll down to middle of page and click onto the underlined words “Class F Home Care Provider (Formerly ALHCP)” This will take you to the application, guidelines, statutes, rules and more information that you will need. After reviewing all of the information, if you have additional questions feel free to call 651-201-4101 and ask to speak with a Program Assurance representative.

6. **Question:** What home care services can a Class F home care provider provide?

**Answer:** According to MN Statute 144A.4605 the services a Class F home care provider can provide include “nursing services, delegated nursing services, other services performed by unlicensed personnel, or central storage of medications solely for residents of one or more housing with services establishments registered under chapter 144D.”

7. **Question:** Are there limitations on where a Class F home care provider can provide care?

**Answer:** Yes, according to MN Rule 4668.0800 Subp. 1 the class F home care licensee may provide home care services solely to residents living in a building that is registered with the Minnesota Department of Health as a housing with services establishment.
**Individual Needs**

1. **Question:** What should a Class F home care provider do if a client needs skilled therapy such as physical, occupational or speech therapy?

**Answer:** Therapy is beyond the scope of a Class F home care provider license. If a Class F home care client needs therapy, the client should be provided a list of agencies that provide the needed therapy or the client may independently contract with another home care provider for the therapy. (MN Rule 4668.0800 Subp. 4)

**Medications and Treatment**

1. **Question:** Is oxygen considered a medication or a treatment? Do I need physician’s orders for oxygen?

**Answer:** Oxygen is considered a treatment. Prescriber’s orders are required for oxygen per MN Rule 4668.0860 Subp. 2 if staff from the Class F (licensed only) home care provider assists the client with oxygen.

2. **Question:** My agency staff does tests such as blood glucose monitoring. Is there anything special that I need to do related to these tests?

**Answer:** The Center for Disease Control (CDC) has guidance for glucose monitoring. See: [www.cdc.gov](http://www.cdc.gov) search enter ‘glucose monitoring’.

   The Federal Government requires a CLIA Certificate of Waiver when providers conduct laboratory tests including blood glucose monitoring, utilizing devices approved by the Food and Drug Administration (FDA). The tests that qualify for a CLIA Certificate of Waiver can be found in the categorization of tests area of: [http://www.cms.hhs.gov/clia](http://www.cms.hhs.gov/clia)


   The completed application form should be mailed to:

   CLIA Program  
   MN Department of Health  
   85 East 7th Place, Suite 220  
   P. O. Box 64900  
   St. Paul, MN 55164-0900  
   MDH’s CLIA phone number is: 651-201-4120
3. **Question:** If the nurse documents each medication that is set up, then is it permissible for the unlicensed staff to simply document “noon meds” and not document each medication individually?

**Answer:** Yes. Medication administration needs to be provided consistent with the assessment and service plan.

The licensee is responsible for assuring that medications administered or self-administered are provided to the client as ordered, at the prescribed date & time, prescribed dosage/quantity and that the administration can be verified by an authorized person through their signature and title.

If a licensee has authorized persons such as unlicensed staff to “document ‘noon meds’ and not document each medication individually”; and if the licensee has authorized persons such as a RN/pharmacist/physician to “set up” medications; and if the licensee can verify that either of these authorized person(s) has recorded in the client’s record administration of each medication, this system would be consistent with current rule.

The licensee through their system of medication administration/self-administration verifies in the client record as stated in the regulation:

> The name, date, time, quantity of dosage, and the method of administration of all prescribed legend and over-the-counter medications, and the signature and title of the authorized person who provided assistance with self-administration of medication or medication administration must be recorded in the client’s record following the assistance with self-administration of medication or medication administration. If assistance with self-administration of medication or medication administration was not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided.

**Survey Focus:**

Surveyors investigate to determine if medication administration has been/is being provided consistent with the assessment and service plan.

Surveyors evaluate if the licensee has assured that medications administered or self-administered are provided to the client as ordered, at the prescribed date & time, prescribed dosage/quantity and that the administration can be verified by an authorized person through their signature and title.

In this scenario, the surveyors would evaluate if the licensee has authorized persons such as unlicensed staff to “document ‘noon meds’ and not document each medication individually”. The surveyors would investigate further to determine if the licensee has authorized persons such as a RN/pharmacist/physician to “set up” medications. The surveyors would also investigate to determine if the licensee can verify that the appropriate authorized person(s) records the administration of each medication in the client’s record. The surveyors would observe the actual administration/self-administration of medications for appropriate medication service provision. MDH may also survey provisions under Minnesota Rule 4668.0865 regarding central storage of medication.
4. Question: If a licensee utilizes a medication set-up system, must a nurse, pharmacist or physician set the Over-the-Counter (OTC) medication up for Class A and Class F?

Answer: Yes, a medication may be set up by a nurse, pharmacist or physician. When a medication is taken out of the prescribed, original container and placed into another medication set-up container, this setting up of the medication must be done by a nurse, pharmacist or physician.

Applicable Regulations: Minnesota 4668.0003, Subp. 2a

5. Question: Are herbal over the counter OTC medications considered medications and do providers need an order for them?

Answer: Yes. Herbal medications are over-the-counter drugs and are medications. Minnesota Rule 4668.0860 requires prescriber order for over the counter drugs.

6. Question: Do Class A and F licensees need an order for oxygen saturation monitoring?

Answer: Yes. If the oxygen saturation monitoring is part of treatment plan then a prescriber’s order is required. An example would be oxygen saturation monitoring in conjunction with oxygen therapy or as a treatment plan to monitor oxygen levels periodically.

Applicability: Minnesota Rule 4668.0150 4668.0860

7. Question: Can you please tell me what is meant by central storage of medications in MN Rule 4668.0865?

Answer: The term central storage of medication generally refers to the storing of medications in one central location such as a medication cupboard or medication cart.

- If a provider chooses to centrally locate and secure all of an individual client’s medications in a secure location in the client’s room or apartment and states that this is the provider’s method of central storage, all of the requirements for central storage will apply.
- Therefore, central storage of medications for the purpose of MN Rule 4668.0865 refers to both of the following:
  - medications that are kept in a common facility medication area and also to
  - medications stored within a central area of the client’s personal living area as long as this area in the client’s living space is represented by the facility as central storage of medications.
**Service Plan**

1. **Question:** MN Rule 4668.0815 lists the required components of a service plan. Do all of these components need to be included in the service plan?

   **Answer:** Yes, MN Rule 4668.0815 Subp. 4 lists the required components of a service plan and all must be present. It is acceptable to reference other documents such as a DHS services document for specific components of the service plan.

2. **Question:** How often do I have to modify the service plan?

   **Answer:** It is important to distinguish between reevaluation and modification.
   - MN Rule 4668.0815 Subp. 2 requires that the service plan be reevaluated at least annually. This means that a registered nurse must review and revise a client’s evaluation and service plan at least annually or more frequently when there is a change in the client’s condition that requires a change in services.
   - MN Rule 4668.0815 Subp. 3 addresses modifications of the service plan. Modifications are generally considered to be changes made in the service plan to reflect changes in services or any of the components of the service plan listed in 4668.0815 Subp. 4. Modifications must be in writing and agreed to by the client or the client’s responsible person before the modification is initiated.

**Supervising and Monitoring**

1. **Question:** Is direct or indirect supervision the norm and must “all cares” be directly supervised?

   **Answer:** There is no language in the current home care regulations about “direct or indirect supervision, however some language does require supervision at the residence.

   Licensees are responsible for assuring that services including supervision are provided consistent with current nursing and medical standards and are consistent with the needs of the clients and applicable home care licensure requirements such as the Minnesota Home Care Bill of Rights, acceptance of clients, individual service agreement/service plan, supervision requirements and other applicable requirements.

   Class F licensure requirements state: *After the orientation…, a registered nurse must supervise, or a licensed practical nurse under the direction of a registered nurse must monitor, unlicensed persons who perform assisted living home care services that require supervision by a registered nurse at the housing with services establishment, to verify that the work is being performed adequately, identify problems, and assess the appropriateness of the care to the client's needs.*

   *If the unlicensed person is monitored by a licensed practical nurse, the client must be supervised by a registered nurse at the housing with services establishment at least every other visit and the licensed practical nurse must be under the direction of a registered nurse….*
Survey Focus

The surveyors will investigate to determine that the supervisory visit occurred at the client’s residence. The surveyors will investigate further and seek information from the licensee that through supervision the licensee has verified that the work is being performed adequately, identified problems, and assessed the appropriateness of the care to the client’s needs. The surveyors will observe, interview and corroborate in record review for verification. Licensees implement supervision requirements differently. As part of an MDH survey or investigation to determine compliance, MDH staff may ask questions related to supervision and this investigation may include inquiry about how this supervision is implemented. The provision of supervision is also reviewed in relation to the identified service needs of the client. This information helps the surveyor to understand how the licensee implements service provision for client/resident health and safety.


Training

1. Question: Where do I get information for the orientation to home care required by MN Rule 4668.0805?


   This guide is intended as an overview and is not a substitute for the home care rules and statutes.

2. Question: I have questions about the Class F home care provider regulations. Who can I call?

   Answer: The Home Care & Assisted Living Program staff members are available to answer your questions and may be reached at 651-201-5723.

See also > Facility & Provider Compliance Home
Quality Assurance in Assisted Living

Problem Statement: Concerns about the quality and costs of housing with services (HWS) and assisted living services (AL) are being raised with increasing frequency by some external stakeholders. Some of these concerns appear to have arisen from anecdotal information, others may call for a reexamination of existing of disclosure requirements, provider practices and administration of oversight functions such as home care surveys. Examples of these concerns include:

- For several years, the LTC Ombudsman has talked about her concerns about HWS and AL, but in testimony this year at House and Senate hearings, she said that discrimination against Elderly Waiver clients residing in assisted living was widespread. The specific discriminatory practice that she called out was requiring residents to move into double or “triple” bed rooms when they ran out of money and converted to the EW program. This resulted in an immediate response from the House chair of the Health and Human Services Finance Committee.

- Policy makers have talked about the role of assisted living in Medicaid "spend down" for a number of years and suggestions have been raised in the past about a moratorium on new development of assisted living or equalization of rates in assisted living. One of the 2012 House amendments—which was not introduced at the committee hearing—would have imposed a moratorium on new buildings offering assisted living services.

- A recent fire started in a building by an AL client resulted in an OHFC substantiated complaint. Concerns about fire safety have been a focus of the Fire Marshal's 2010-2011 stakeholder meetings and remain a concern for fire marshals.

- Following last year's tornadoes, a family member voiced concern that her mother's building did not have sufficient staff to help all residents move to a safe place. MN Nurses Association also frequently raises issues about staffing levels in home care/HWS settings.

- OHFC substantiated reports have identified on-going problems with oversight of clients, especially those with dementia. There also has been some concern expressed within the provider community itself that “memory care” services lack definition from setting to setting, even though this is a commonly used term in marketing materials. and the media are quick to report on any tragedies.

- Last year MDH only completed 91 regular home care surveys. With 1,000+ non-Medicare Class A and Class F home care agencies now licensed, survey frequency could be every ten years or more. In addition, there have been growing complaints from members that those surveys which are conducted are performed within a “nursing home” regulatory framework and that surveyors lack training in the fundamentals of housing with services. Some home care survey findings seem to indicate a serious lack of understanding of the licensing requirements by RNs and the home care agencies and members generally have indicated that they would welcome more frequent surveys as part of overall performance improvement.

These issues and concerns and the opportunity for overall performance improvement make it imperative that the provider associations be proactive in developing policy proposals supported by reliable data.
Better Data is needed to document the public policy issues:

- Data is not collected in any consistent basis for most of housing with services, particularly for private pay HWS residents. Currently, HWS and non-Medicare home care providers are not required to submit any data reports to the state. The provider associations will examine the data they have available and will identify what additional data is needed to answer important policy questions.
- DHS has some data for waiver clients, but this data has not been fully shared or analyzed. We will seek more data from DHS.
- Data about the frequency of surveys of non-Medicare licensed home care providers and the number of providers who have not been surveyed for more than three years has not been readily available from MDH.

Questions for Discussion:

Aging Services of Minnesota and Care Providers of Minnesota will begin a joint process to develop a proactive policy platform to improve and maintain quality in Housing with Services and Assisted Living. The Minnesota Home Care Association will be invited to work with us and discussions may include state agency staff, legislators, and other stakeholders as appropriate. Following are some of the key questions for discussion and policy development:

1) Housing with Services and Home Care Services; Disclosures

- Are HWS providers clearly disclosing the terms of the lease, including information about whether people will need to move if they can no longer pay the rent and what may result in a termination of the lease/residency agreement?
- Are HWS residents educated about the buildings' emergency/disaster plans, their responsibility during an emergency situation, and limitations of the buildings' plan and staff?
- Do home care providers accurately disclose what services they will provide, the limits of their services and the costs of their services?
- Do consumers want more detailed information about fees and charges than is currently available in the Uniform Consumer Information Guide and in the typical marketing materials?
- Should there be standards for the managers of HWS and home care programs? Class A and Class F home care agencies must have an RN to assess clients, train and supervise staff and delegate nursing tasks, but still some home care programs may have inadequate policies and procedures. What is the best way to improve the quality of these programs and the skills of the RNs in charge?
- Are dementia care providers following the HWS disclosure requirements as well as those in chapter 325F.72? Are families informed about the systems offered to prevent unescorted wandering outside the dementia care setting and any limitations of the system? Are families informed regarding how staffs are trained to meet the residents' special needs?

2) Home Care Surveys

- How can the public be assured that home care services meet the licensing requirements and other applicable standards under the Nurse Practice Act, Vulnerable Adults Act, etc.? Is
there another approach to addressing quality in these settings, or can home care surveys be improved or the frequency increased?

- How can the home care survey process be modified so that surveys are more frequent and make the best possible use of existing state resources?
- Can MDH surveyors be better trained to for the specific limits of the authority of home care licensing with regard to the home where clients live—which is a non-institutional setting?
- Providers are often reluctant to challenge survey findings because of the cost in staff time. Thus, the same issues may then catch multiple providers without being surfaced in a policy discussion. Can we work with MDH to create a more standardized approach to identifying and resolving differences in interpretation of licensing requirements? An informal appeals process? Regular meetings with the provider associations on licensing issues and interpretation of requirements?

2) Payment Issues

- Can the lead agency expect or require a waiver provider to provide services that are not authorized in the waiver service plan and that are not reimbursed?
- Can the lead agency refuse to reassess a client even though the provider has identified a change in condition? Several counties will only assess clients at their annual assessment date.
- What is policy makers' response if a private pay person refuses to pay for services that the professionals believe the client needs?
- How will lead agencies deal with waiver clients whose needs cannot be met within the caps for their waiver services?
- If waiver clients become ineligible for waiver services after LOC is implemented, what are the implications for termination of the service and the housing contracts?
- Policies for the Group Residential Housing program are not readily available in any written form. Posting of clear, written policies or a FAQ document would be helpful to both providers and counties.
- Will waiver clients' choice of where to live be dictated by state policy or the lead agency, even when no public assistance program is paying for housing costs?

3) Physical Plant

- Will the pending fire codes be consistent with mandates on landlords by the Fair Housing Act?
- Will the pending fire codes offer guidance regarding acceptable systems to prevent unescorted wandering for persons with dementia?
- What percent of HWS providers do not have sprinkler systems? How many residents do they have and where are they located?
- What is the extent of shared HWS rooms? Are there any bedrooms shared by three residents?
- How can the neighborhood kitchen concept be incorporated into the food code? (e.g. allowing for a home-like appearance) How can residents be involved in life activities, such as help with cooking, in a way that is safe and that supports their quality of life?
4) Emergency/Disaster Planning

- Should the law be amended to include emergency/disaster planning requirements for HWS, or should the provider groups develop and widely disseminate best practices for emergency/disaster planning?
- Are there best practices that can be identified and disseminated?