MN DEPARTMENT OF HEALTH

Client Observation and Record Review

STATE EVALUATION: TEMPORARY COMPREHENSIVE AND COMPREHENSIVE LICENSED HOME CARE PROVIDERS (144A)

Provider Information

Provider:

Date of Survey:

HFID:

Time of Survey:

Client Information

Name:

Start of Services:

Identifier:

Current Service Plan date:

Diagnoses:

Surveyor

Surveyor(s):

Discharged Client Record Review

☐ Discharge summary (144A.4794, Subd. 3 (14))

☐ Disposition of medications (144A.4792, Subd. 22 (c))

☐ If service plan terminated, appropriate time frame and appropriate notices of termination provided (144A.4791, Subd. 10 (a-b).

☐ Discharged Date:

Comments:

Client Daily Life Review

Caregiver Observed:

Throughout the survey, surveyors observe staff as they provide services to clients. Surveyors interview staff and clients to evaluate and validate surveyor observations and findings. Areas reviewed include but are not limited to:

☐ Client was free from physical and verbal abuse.

☐ Care and services were provided in accordance with accepted medical and nursing standards.

☐ Current standards of practice for infection control were followed, including but not limited to appropriate hand hygiene, handling and transporting linen to prevent spread of infection and the use of protective gloves when appropriate.

☐ Client was treated with courtesy, respect, and client's rights were not violated.

☐ Staff listened and were responsive to client requests. (Note staff interaction with both communicative and non-communicative client).

☐ Client's bathing, dressing, grooming, and toileting needs were met.

☐ Client was free from physical and/or chemical restraints.

☐ Other observations/interviews as deemed necessary (i.e., behaviors, cognition, mobility, demeanor, environment, etc.).

Comments:

Client Record Review

Surveyors review client records to determine if documentation standards were met related to evaluation and assessments and the services the client received.

Individual abuse prevention plan (IAPP) (144A.479, Subd. 6 (b))

☐ An individualized assessment of client's susceptibility to abuse by other individuals;

☐ Assessment of the client's risk of abusing other vulnerable adults or minors; and

☐ Statements of the specific measures to be taken to minimize the risk of abuse to the client and other vulnerable adults or minors and risk of self-abuse.

☐ Date of most current IAPP:

Comments:

Assessments: (144A.4791, Subd. 8 (a)(b)(c))

☐ Initial RN assessment completed within 5 days of starting services. Date:

☐ Reassessment no more than 14 days of starting services. Date:

☐ Ongoing client assessment at least every 90 days. Date(s):

☐ Or with a change in condition. Date(s):

Comments:

Service Plan: (144A.4791, Subd. 9 (a)(b)(c)(d)(e)(f))

☐ Service plan was completed within 14 days of start of services and revised as needed. Date:

☐ Service plan had all required content.

☐ All services were provided and documented (ADLs, IADLs, medications and treatments) as noted in the client's service plan.

Comments:

Documentation of client's receipt and review of:

- ☐ Minnesota Home Care bill of rights. (144A.4791, Subd. 1) Date:
- ☐ Statement of home care services (144A.4791, Subd. 3) Date:
- ☐ Written complaint notice. (144A.4791, Subd. 11 (a)(b)(c)) Date:
- ☐ Documentation of complaints received, if applicable, and resolution.
- ☐ Client records were kept confidential and secure. (144A.4794, Subd. 1 (b))
- ☐ Entries in client's record were current, authenticated, and legible. (144A.4794, Subd. 1 (a))
- ☐ Significant changes or incident(s) and the actions taken in response were documented, (i.e. client falls, post-hospital, ER visits, any client deterioration). (144A.4791, Subd. 8 (c))
- ☐ Client-specific written instructions were present for delegated nursing procedures. (144A.4792, Subd. 7; and 144A.4793, Subd. 4)

Comments:

Medication Management Services

(144A.4792, Subd. 1-23)

Surveyors review client record for compliance related to medication administration including all prescribed, non-prescribed, over the counter and dietary supplements taken by the client.

- ☐ RN developed and implemented an individual medication management record prior to provision of services. Date:
- ☐ Medication plan was current, and the service plan was updated (if needed).
- ☐ Current or annual reassessment occurred. Date:
- ☐ Individualized medication monitoring occurred when client had symptoms/issues related to medication.

Record included the following items:

- ☐ Medication management services provided by nurse and unlicensed personnel (ULP) (included PRN).
- ☐ Type of medication storage system, based on client's needs.
- ☐ Specific written instructions for client's medication administration.
- ☐ Person responsible for monitoring medication supplies and refills.
- ☐ Medication management tasks that may be delegated to ULPs.
- ☐ Procedures for staff to notify an RN when problems arose.
- ☐ Any client-specific requirements (i.e., parameters: blood sugar, blood pressure, pulse, etc.).
- ☐ Medication Reconciliation was completed by nurse, licensed health professional, or authorized prescriber.
- ☐ Medication administration delegated to unlicensed personnel and documented client specific instructions.

☐ Medication administration records were complete; medications were administered as ordered and documented correctly, or if not administered reasons were documented. (Record includes reasons to use PRN medications and their effectiveness.)

☐ Medication set-up and administration were documented.

☐ Documentation of medication administration was completed for client who was away from home.

☐ Prescriber's orders were written and dated for medications administered and orders were complete.

☐ Medication orders were renewed at least every twelve months.

☐ Verbal orders were received only by a nurse or pharmacist, were entered into the client record and forwarded for signature by licensed prescriber.

☐ Electronically transmitted orders were recorded, communicated to the RN and placed in client record.

Comments:

Treatment and Therapy Management Services

(144A.47.93, Subd. 1-6)

Client's record (including the service plan and treatment administration records) was reviewed for all prescribed treatments and therapies administered by the provider's employee(s).

Examples of treatments and therapies include but are not limited to using oxygen or a breathing apparatus or pulse oximetry, blood glucose checks or tube feedings, applying TED hose or splints, providing physical/occupational/speech-language therapy exercises, or wound care. Surveyors will also review maintenance procedures for equipment used in treatments and therapies.

Type(s) of treatment or therapy:

☐ RN or appropriate LHP developed a treatment and/or therapy record (before services were provided). Date:

☐ Treatment plan is current and included on the service plan.

Record included the following items:

☐ Written statement of treatments and therapies to provide.

☐ Written instructions for each treatment or therapy.

☐ A list of the treatment or therapy tasks delegated to ULPs.

☐ Procedures to notify an RN or other LHP professional when problems arose with treatments or therapies.

☐ Client-specific instructions related to documentation of all treatments and/or therapies administered, or reason not administered, verified as administered and monitored to prevent complications or adverse reactions.

☐ Provider orders current and renewed annually for all provided treatments or therapies.

Comments:

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12/29/2022

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