DEPARTMENT OF HUMAN SERVICES

July 16, 2024

Kahin Egal, Authorized Agent
Zane Care Inc.
7420 Unity Avenue North Suite 115A
Brooklyn Park, Minnesota 55443

License Number: 1106173 (245D – HCBS)

CORRECTION ORDER

Dear Kahin Egal:

On April 17-18, 2024, a licensing review of Zane Care Inc., located at 7420 Unity Avenue North Suite 115A, Brooklyn Park, Minnesota, was conducted to determine compliance with state and federal laws and rules governing the provision of home and community-based services to persons with disabilities and age 65 and older under Minnesota Statutes, Chapter 245D. As a result of this licensing review a Correction Order is being issued.

A. Reason for Correction Order

Pursuant to Minnesota Statutes, section 245A.06, if the Commissioner of the Department of Human Services (DHS) finds that the license holder has failed to comply with an applicable law or rule and this failure does not imminently endanger the health, safety, or rights of the persons served by the program, the Commissioner may issue a Correction Order to the license holder.

The following violation(s) of state or federal laws and rules were determined as a result of the licensing review. Corrective action for each violation is required by Minnesota Statutes, section 245A.06 and is hereby ordered by the Commissioner of Human Services.

1. Citation: Minnesota Statutes, section 245A.65, subdivision 2.

Violation: For three of seven persons whose records were reviewed (P3, P5, and P7), the license holder did not establish written program abuse prevention plans (PAPP) as required.

The license holder provided crisis respite services to P3, P5, and P7, at locations that were within the control of the license holder. The license holder failed to establish written PAPPs that assessed the population, the physical plant, and the environment within the control of the license holder and the location where licensed services were provided.

Corrective Action Ordered: Immediately, you must:

- establish written PAPPs for locations where licensed services are provided and are within your control;
- post the PAPP in a prominent location in the program;

- provide an orientation to the PAPP for P3, P5, and P7, and for all persons who are receiving services at these locations and maintain documentation of the orientation in each person's record; and
- provide staff persons providing direct support to clients at these locations with an orientation to the PAPPs.

On an ongoing basis, you must maintain compliance as required in this subdivision.

2. Citation: Minnesota Statutes, section 245D.05, subdivision 1, paragraph (b).

Violation: For three of seven persons whose records were reviewed (P2, P3, and P7), the license holder did not maintain documentation on how health needs will be met as required.

a. The license holder was assigned responsibility for meeting P2's health needs in their support plan. The license holder failed to maintain documentation on how P2's health needs would be met, including a description of the procedures the license holder would follow in order to:
   - provide medication administration according to this chapter;
   - monitor health conditions according to written instructions from a licensed health professional; and
   - use medical equipment, device, or adaptive aides or technology safely and correctly according to written instructions from a licensed health professional.

b. The license holder was assigned responsibility for meeting P3 and P7's health needs. The license holder failed to maintain documentation on how P3 and P7's health needs would be met, including a description of the procedures the license holder will follow in order to provide medication administration according to this chapter.

Corrective Action Ordered: Within 30 days of receiving this order, you must maintain documentation on how P2, P3, and P7's health needs will be met, including a description of the procedures you will follow in order to meet the person health needs identified above. On an ongoing basis, you must maintain compliance as required in this subdivision.

3. Citation: Minnesota Statutes, section 245D.05, subdivisions 1a and 2.

Violation: For four persons whose records were reviewed (P2, P3, P5, and P7), the license holder did not provide medication setup and medication administration as required.

a. The license holder was assigned responsibility for medication setup for P3 and P5. The license holder failed to document the dates of medication setup in P3 and P5's medication administration record. Additionally, the license holder failed to document the name of P5's medication in the medication administration record.
b. The license holder was assigned responsibility for medication administration for P2. The license holder failed to obtain written authorization from P2 or P2's legal representative before administering medications or treatment.

c. The license holder was assigned responsibility for medication administration for P2, P3, P5, and P7. The license holder failed to maintain the following information in P2, P3, P5, and P7's medication administration record:

- information on any risks or other side effects that are reasonable to expect, and any contraindications to its use. This information must be readily available to all staff administering the medication;
- the possible consequences if the medication or treatment is not taken or administered as directed;
- notation of when a medication or treatment is started, administered, changed or discontinued.

d. The license holder failed to implement medication administration procedures for P3 for the following:
   - P3 was prescribed trazodone 150mg 1 tab by mouth every night, however this was not documented on P3's MAR;
   - P3 was prescribed guanfacine ER 100mg 1 tab by mouth every day, however this was not documented on P3's MAR;
   - P3's was prescribed Hydroxyzine HCL 50mg tabs 1 and ½ tablets by mouth four times daily, however this was documented on P3's MAR as a PRN medication;
   - P3 was prescribed Ziprasidone HCL 80mg 1 capsule by mouth twice daily, however this was documented on P3's MAR has Ziprasidone 60mg 1 capsule by mouth twice daily;
   - P3 was prescribed Olanzapine 2.5mg 1 tablet by mouth twice daily as needed, however this was documented on P3's MAR as Zyprexa 2.5mg tablet take 1-2 tablet by mouth at bedtime; and
   - P3 was prescribed Sertraline 100mg 2 tablets by mouth daily, however this was documented on P3's MAR as Sertraline 100mg tablets 1.5 tablet by mouth once a day.

   Additionally, during a tour of P3's service site, DHS licensors observed that the prescription bottle for P3's Topiramate 100mg tablets was empty. The license holder stated that P3 did not get the medication on that day despite staff signing the MAR that it was passed. The license holder was unable to determine how long P3 had not been receiving the medication. The license holder failed to ensure P3 took medications as prescribed.

e. The license holder did not establish a medication administration record for P7. The license holder failed to implement medication administration procedures to ensure P7 takes medications and treatments as prescribed.

Corrective Action Ordered: Within 30 days of receiving this order, you must:
- document the above mentioned information for P2, P3, P5, and P7; and
- obtain written authorization from P2 or P2's legal representative to administer medications and treatments.

On an ongoing basis, you must maintain compliance as required in this subdivision.

4. Citation: Minnesota Statutes, section 245D.05, subdivision 4.

Violation: For four persons whose records were reviewed (P2, P3, P5, and P7), the license holder did not review and report medication and treatment issues as required.

a. The license holder failed to review P2, P3, P5, and P7's medication administration record to identify medication administration errors at a minimum of every three months.

b. P5 frequently refused to take some of their prescribed medications. The license holder failed to report P5's refusal to take or receive medication or treatment, as they occurred, to P5's legal representative and case manager.

Corrective Action Ordered: Within 30 days of receiving this order, you must submit a detailed plan to your licensor on how you will achieve compliance in this subdivision. The plan must include details on how the identified designated coordinator and designated manager will fulfill their responsibilities in 245D.081. On an ongoing basis, you must maintain compliance as required in this subdivision.

5. Citation: Minnesota Statutes, section 245D.051, subdivision 1, paragraph (a).

Violation: For three persons whose records were reviewed (P3, P5, and P7), the license holder did not meet the conditions for psychotropic medication administration as required.

P3, P5, and P7 were prescribed psychotropic medications. The license holder failed to maintain documentation that included a description of the target symptoms that each psychotropic medication is to alleviate.

Corrective Action Ordered: Within 30 days of receiving this order, you must:
- submit a detailed plan to your licensor on how you will maintain compliance in this subdivision; and
- document the above mentioned information in P3, P5, and P7's records.

On an ongoing basis, you must maintain compliance as required in this subdivision.

6. Citation: Minnesota Statutes, section 245D.061, subdivision 9.

Violation: For one person whose record was reviewed (P3), the license holder did not implement the emergency use of manual restraint policy and procedure as required.

The license holder's emergency use of manual restraint policy and procedure stated that the program does not allow the emergency use of manual restraints and that alternative measures must be used by staff to achieve safety when a person's conduct poses imminent risk of physical harm to self or others. On November 21, 2023, the license holder failed to implement their emergency use of manual restraint policy and procedure when a staff person used a manual restraint during an incident involving P3.

Corrective Action Ordered: Immediately, upon receiving this order, you must implement your program's policies and procedures regarding the use of manual restraints.
Within 15 days of receiving this order, you must:
- for P3, submit the following information regarding the above-mentioned incident to DHS and the Office of the Ombudsman for Mental Health and Developmental Disabilities, as required under section 245.94, subdivision 2a:
  - the report required under subdivision 5;
  - the internal review and the corrective action plan required under subdivision 6; and

- the summary of the expanded support team review required under subdivision 7.

- provide training to all staff on the emergency use of manual restraint policy and procedure; and
- submit the training record for all staff to this licensor.

On an ongoing basis, you must maintain compliance as required in this subdivision.

7. Citation: Minnesota Statutes, section 245D.07, subdivision 2, paragraph (c).

Violation: For one person whose record was reviewed (P3), the license holder did not meet the requirements for service planning for basic support services as required.

The license holder failed to review P3's support plan addendum within 60 calendar days of service initiation.

Corrective Action Ordered: Within 30 days of receiving this order, you must submit a detailed plan to your licensor on how you will maintain compliance in this subdivision. On an ongoing basis, you must maintain compliance as required in this subdivision.

8. Citation: Minnesota Statutes, section 245D.071, subdivision 2.

Violation: For one person whose record was reviewed (P2), the license holder did not develop an individual abuse prevention plan (IAPP) as required in section 245A.65, subdivision 2.

The license holder failed to develop an IAPP for P2 that included an individualized assessment of P2's susceptibility of abuse according to Minnesota Statutes, section 626.557, subdivision 14. P2's IAPP indicated that P2 was not susceptible to abuse or at risk of abusing other vulnerable adults, however, this assessment was not consistent with other information in P2's record.

Corrective Action Ordered: Within 30 days of receiving this order, you must:

- review and revise P2's IAPP to include:
  - an individualized assessment of P2's susceptibility to abuse by other individuals, including other vulnerable adults and the person's risk of abusing other vulnerable adults; and
  - statements of measures, with specific actions, your program will take to minimize the risk of abuse within the scope of the licensed service(s);
- review P2's IAPP with P2, their legal representative, and case manager; and
- submit evidence of the review to your licensor.

On an ongoing basis, you must maintain compliance as required in this subdivision.

10. Citation: Minnesota Statutes, section 245D.071, subdivision 3.

Violation: For one person whose record was reviewed (P6), the license holder did not meet service planning and delivery requirements as required.

P6's intensive services were initiated on January 23, 2024. The license holder failed to:

- meet with the person, the person's legal representative, the case manager, and other members of the support team or expanded support team within 45 days of service initiation to determine:

- the scope of the services to be provided to support the person's daily needs and activities;
- the person's desired outcomes and the supports necessary to accomplish the person's desired outcomes;
- the person's preferences for how services and supports are provided, including how the provider will support the person to have control of the person's schedule;
- whether the current service setting is the most integrated setting available and appropriate for the person;
- how services must be coordinated across other providers licensed under this chapter serving the person and members of the support team or expanded support team to ensure continuity of care and coordination of services for the person;
- A discussion of how technology might be used to meet the person's desired outcomes. The coordinated service and support plan or support plan addendum must include a summary of this discussion. The summary must include:
  - a statement regarding any decision that is made regarding the use of technology; and
  - a description of any further research that needs to be completed before a decision regarding the use of technology can be made.

Corrective Action Ordered: Within 30 days of receiving this order, you must:

- meet with P6, P6's case manager, and other members of the support team or expanded support team to determine the information listed above; and
- submit evidence of this meeting to your licensor.

On an ongoing basis, you must maintain compliance as required in this subdivision.

11. Citation: Minnesota Statutes, section 245D.071, subdivision 4, paragraph (b).

Violation: For three persons whose records were reviewed (P2, P4, and P6), the license holder did not implement service outcomes and supports as required.

The license holder maintained service plans in P2, P4, and P6's records that documented the supports and methods the license holder would implement to collect data on the P2, P4, and P6's outcomes. The license holder failed to implement the identified supports and methods as the license holder failed to collect data on P2, P4, and P6's outcomes.

Corrective Action Ordered: Immediately upon receiving this order, you must:

- start collecting data on P2, P4, and P6's outcomes per the supports and methods developed and documented in their service plan; and
- submit a detailed plan to your licensor on how you will maintain compliance in this subdivision moving forward. This plan must include how the identified designated coordinator and designated manager will fulfil the duties related to this failure as required in 245D.081.

On an ongoing basis, you must maintain compliance as required in this subdivision.

12. Citation: Minnesota Statutes, section 245D.095, subdivision 3.

Violation: For two persons whose records were reviewed (P2 and P5), the license holder did not maintain service recipient records as required.

a. The license holder failed to maintain current orders for medications, treatments, or medical equipment and progress or daily log notes in P2's service recipient record.

b. The license holder failed to maintain current orders for medication, treatments, or medical equipment in P5's service recipient record.

Corrective Action Ordered: The license holder corrected this area of non-compliance onsite. On an ongoing basis, you must maintain compliance as required in this subdivision.

13. Citation: Minnesota Statutes, section 245D.10, subdivision 4.

Violation: For one person whose record was reviewed (P4), the license holder did not provide written or electronic copies of policies and procedures, as required.

Regarding P4, whose intensive services were initiated on March 29, 2023, the license holder failed to inform P4 and their case manager and provide copies of the following policies and procedures within five days of service initiation:

- grievance policy;
- temporary service suspension policy;
- service termination policy;
- emergency use of manual restraints policy; and
- data privacy policy.

Corrective Action Ordered: Within 30 days of receiving this order, you must:

- inform P4 and their case manager of the above-mentioned policies and provide copies of the policies; and
- maintain documentation of the above mentioned information in P4's record.

On an ongoing basis, you must maintain compliance as required in this subdivision.

14. Citation: Minnesota Statutes, section 245D.09, subdivisions 4 and 4a.

Violation: For three of four staff persons whose records were reviewed (SP1, SP3, and SP4), the license holder did not provide orientation and training as required.

a. SP4 worked with P2, who required medication administration. The license holder failed to ensure SP4 successfully completed medication administration training, from a training curriculum developed by a registered nurse or appropriate health professional, before performing medication administration. Additionally, the license holder failed to ensure SP4 reviewed and received instruction on medication administration procedures assigned to the license holder for P2 that included how to use medical equipment, devices, or adaptive aides or technology safely and correctly according to written instructions from a licensed health professional.
b. Regarding SP1 who was hired on November 19, 2023, the license holder failed to provide the following orientation training within 60 days of hire:

- data privacy requirements according to sections 13.01 to 13.10 and 13.46, the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), and staff responsibilities related to complying with data privacy practices. The license holder provided this training to SP1 on February 29, 2024;
- the service recipient rights and staff responsibilities related to ensuring the exercise and protection of those rights according to the requirements in section 245D.04. The license holder provided this training to SP1 on February 28, 2024;
- the program abuse prevention plan according to the requirements in 245A.65, subdivision 3;
- the principles of person-centered service planning and delivery as identified in section 245D.07, subdivision 1a, and how they apply to direct support service provided by the staff person. The license holder provided this training to SP1 on February 29, 2024;
- the safe and correct use of manual restraint on an emergency basis according to the requirements in section 245D.061 and what constitutes the use of restraints, time out, and seclusion, including chemical restraint. The license holder provided this training to SP1 on February 29, 2024;
- staff responsibilities related to prohibited procedures under section 245D.06, subdivision 5, why such procedures are not effective for reducing or eliminating symptoms or undesired behavior, and why such procedures are not safe;
- basic first aid. The license holder provided this training to SP1 on February 29, 2024; and
- strategies to minimize the risk of sexual violence, including concepts of healthy relationships, consent, and bodily autonomy of people with disabilities. The license holder provided this training to SP1 on February 28, 2024.

c. Regarding SP3, who was hired on November 3, 2023, the license holder failed to provide the following orientation training within 60 days of hire:
    - data privacy requirements according to sections 13.01 to 13.10 and 13.46, the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), and staff responsibilities related to complying with data privacy practices. The license holder provided this training to SP3 on February 8, 2024;
    - the service recipient rights and staff responsibilities related to ensuring the exercise and protection of those rights according to the requirements in section 245D.04. The license holder provided this training to SP3 on February 8, 2024;
    - the program abuse prevention plan according to the requirements in 245A.65, subdivision 3;
    - the principles of person-centered service planning and delivery as identified in section 245D.07, subdivision 1a, and how they apply to direct support service provided by the staff person. The license holder provided this training to SP3 on February 8, 2024;
    - the safe and correct use of manual restraint on an emergency basis according to the requirements in section 245D.061 and what constitutes the use of restraints, time out, and seclusion, including chemical restraint. The license holder provided this training to SP3 on February 8, 2024;
    - staff responsibilities related to prohibited procedures under section 245D.06, subdivision 5, why such procedures are not effective for reducing or eliminating symptoms or undesired behavior, and why such procedures are not safe;
    - basic first aid; and
    - strategies to minimize the risk of sexual violence, including the concepts of healthy relationships, consent, and bodily autonomy of people with disabilities.

Corrective Action Ordered: Within 30 days of receiving this order, you must:

- audit all staff orientation training records;
- submit the results of the audit to your licensor;
- submit a detailed plan of how you will maintain compliance in this subdivision; and
- provide SP1, SP3, and SP4 with the above mentioned training.

On an ongoing basis, you must maintain compliance as required in this subdivision.

If you fail to correct the violations specified in the Correction Order within the prescribed time lines the Commissioner may issue an Order of Conditional License or may impose a fine and order other licensing sanctions pursuant to Minnesota Statutes, sections 245A.06 and 245A.07.

Submissions required as part of a corrective action ordered must be sent to your Licensor at:

1. By secure email at lacey.l.walsvik@state.mn.us; or
2. If you are unable to submit corrective action ordered securely through email, you can mail or fax using the information below:

Commissioner, Department of Human Services
ATTN: Lacey Walsvik
Licensing Division
PO Box 64242
St. Paul, MN 55164-0242

B. Right to Request Reconsideration

If you believe any of the citations are in error, you have the right to request that the Commissioner of Human Services reconsider the parts of the Correction Order that you believe to be in error. The request for reconsideration must be in writing and received by the Commissioner within 20 calendar days after receipt of this report. Your request for reconsideration must be sent to:

Commissioner, Department of Human Services
ATTN: Legal Unit
Licensing Division
PO Box 64242
St. Paul, MN 55164-0242

Please note that a request for reconsideration does not stay any provisions or requirements of the Correction Order. The Commissioner's disposition of a request for reconsideration is final and not subject to appeal under Minnesota Statutes, chapter 14.

If you have any questions regarding this Correction Order, please contact me as soon as possible.

Lacey Walsvik, HCBS Licensor
Licensing Division
Office of Inspector General
651-431-3667