Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL379603701M
Compliance #: HL379604084C

Date Concluded: December 31, 2024

Name, Address, and County of Licensee Investigated:
Twins Home Care Service
13413 Parkwood Drive
Burnsville, MN 55337
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Erin Johnson-Crosby, RN
Special Investigator

Finding: Not Substantiated

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

Initial Investigation Allegation(s):
The facility neglected the resident when they admitted the resident and failed to provide care in accordance with physician's orders.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Due to a lack of information and documentation provided it was unable to be determined if neglect occurred and the resident discharged from the facility the following day.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record(s), hospital records, pharmacy records, staff schedules, law enforcement report, and related facility policies and procedures. Also, the investigator observed staff interactions with residents.

The resident had diagnoses which included traumatic brain injury, right sided weakness, and sepsis. The resident's assessment indicated the resident required assistance with bathing, dressing, gastrostomy tube (feeding tube), safety checks, toileting, and medication administration. The assessment further indicated the resident was cognitively intact and independent with decision making.

The resident discharged to the facility following a hospital stay. Prior to discharge, physician's orders were faxed to the facility and medications were sent with the resident upon discharge.

The next day, police were contacted regarding concerns for the resident's safety at the facility. The police report indicated the resident contact information was not updated in the hospital's system and the resident was discharged to the wrong facility. The report indicated the resident wanted to return to the facility he resided at prior to the hospital stay, but reported he was not concerned for his safety and was comfortable spending another night at the current facility while transportation was arranged.

The resident was discharged and transported back to his previous facility the next day.

During an interview, the facility nurse stated she was contacted by hospital staff about the resident discharging to the facility, so she went to the hospital to assess the resident. Hospital staff reported that they were unable to contact the case manager or family members prior to discharge and contacted her to pick up the resident. Hospital staff faxed a medication list and discharge orders to the pharmacy. The nurse stated she attempted multiple times to get the resident's medications, tube feedings, and belongings after admission but the previous facility refused. The nurse stated that all cares and medications were provided as ordered during the resident's stay at the facility.

During an interview, the nurse who worked at the resident's previous facility stated the resident was sent to the hospital because he was not feeling well. The hospital called three days later to let them know the resident would be returning and that discharge orders were faxed. The nurse did not follow up with the hospital until the next day and then found out the resident was discharged to a different facility. The nurse stated the facility that had the resident contacted them multiple times for the residents' belongings and medications, but facility staff told them they did not have any supplies for the resident. The RN stated he was not present when the resident returned but completed an assessment the next day and did not have any concerns. The RN stated their facility staff did not send with the correct paperwork to the hospital.

The resident declined to be interviewed and did not recall the incident.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

"Not Substantiated" means:

An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
“Neglect” means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No, declined.
Family/Responsible Party interviewed: No, resident declined.
Alleged Perpetrator interviewed: Not applicable.

Action taken by facility:
The resident returned to his prior facility residence the next day.

Action taken by the Minnesota Department of Health:

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37960	A. BUILDING: _____ B. WING _____	C 12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINS HOME CARE SERVICE LLC	13413 PARKWOOD DRIV BURNSVILLE, MN 55337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL379604084C/#HL379603701M On December 5, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were four residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for #HL379604084C/#HL379603701M, tag identification 0470, 1620.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. 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 which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL	

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure sufficient staffing to meet the scheduled and reasonably foreseeable	0 470	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have	

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0 470	Continued From page 2 unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis. This had the potential to affect all residents who resided at the facility. In addition, the licensee failed to develop and implement a staffing plan and evaluation for determining appropriate staffing levels to meet the needs of two of three residents (R2, R3). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On December 5th, 2024, a Minnesota Department of Health (MDH) investigator initiated a complaint investigation survey at the licensee. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated June 15, 2023, indicated two unlicensed personnel (ULP) would be scheduled for the day and evening shift and one ULP during the night shift. The licensee's undated staffing plan indicated the plan was completed by reviewing resident service plans, overall acuity level, scheduled and unscheduled needs, and staff competency. The plan indicated two ULP's would be scheduled 7:00 a.m. to 11:00 p.m., and one ULP would be scheduled 11:00 p.m. to 7:00 a.m.	0 470	been assigned to Minnesota State Statutes for Assisted Living Facilities. 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 which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 470	Continued From page 3 On December 5, 2024, at 10:15 a.m., upon entrance to the facility by the MDH investigator, the posted staff schedule was dated August 19, 2024 through August 25, 2024. The schedule indicated two ULP's and a registered nurse (RN) were scheduled. However, upon entrance to the facility only one ULP was working. On December 5, 2024, at 11:00 a.m., housing manager/ULP-A provided another schedule to the MDH investigator and stated that this was the correct schedule that shoudl be posted. The schedule was dated December 2 - December 8, 2024 and included the following: -The December 2nd schedule identified there was one staff onsite from 11:00 p.m. to 9:00 a.m., one staff scheduled 4:00 p.m. to 9:00 p.m., and no staff were scheduled from 9:00 p.m. to 11:00 p.m. -December 3, indicated there was one staff from 11:00 p.m. through 9:00 a.m., and no staff scheduled from 9:00 p.m. from 11:00 p.m. - December 4, indicated there was one staff from 11:00 p.m. through 9:00 a.m., and no staff scheduled from 9:00 p.m. from 11:00 p.m. - December 5, indicated there was one staff from 11:00 p.m. through 9:00 a.m. and no staff scheduled from 9:00 p.m. from 11:00 p.m. On December 5, 2024, at 10:30 a.m., housing manager (HM)/unlicensed personnel (ULP)-A stated there were two staff scheduled during the morning and evening shifts and one staff scheduled during the night shift. HM/ULP-A stated he was usually the second staff that provided direct care. HM/ULP-A stated he had	0 470		

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0 470	Continued From page 4 just left the facility to go grocery shopping. HM/ULP-A stated three out of four residents required two assist but one resident did not get out of bed. HM/ULP-A stated if there was an emergency at night, staff could contact him since he lived only six miles away and he would come in. HM/ULP-A confirmed that one staff was scheduled for the night shift but indicated there were two residents (R2, and R3) at the facility that required the assistance of two staff members. Review of R2's medical record included a diagnoses of traumatic brain injury (TBI), borderline personality disorder, and paraplegia (paralysis of the legs, and lower body). R2's assessment dated October 24, 2024, indicated R2 required assistance with dressing, bed mobility, transferring, managing behaviors, and medication administration. The assessment did not include a description of how assistance should be provided and how many staff were required to provide assistance based on R2's needs. R2's undated, unsigned service plan did not include a description of how assistance should be provided and how many staff were required to provide assistance to R2. On December 5, 2024, at 11:25 a.m., R2 stated staff used one staff and a ceiling lift to get him out of bed. Review of R3's record indicated R3's diagnoses included open leg wound, chronic sacral ulcer and spinal cord injury. R3's assessment dated November 20, 2024, indicated R3 was unable to walk but could transfer with supervision. The assessment also indicated R3 was a quadriplegic (paralysis that affects all extremities). The note under	0 470		

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0 470	Continued From page 5 evacuation acuity level indicated R3 required a lift for transfers. The assessment did not include a description of how assistance should be provided and how many staff were required. R3's undated, unsigned service plan did not include a description of services and how many staff were required to provide assistance to R3. On December 5, 2024, at 11:40 a.m., R3 stated he had not been out of bed for a long time due to wounds on his buttocks. On December 5, 2024, at 1:25 p.m., registered nurse (RN)/ licensed assisted living director(LALD)-B confirmed R2 required two staff to assist for transfers and was not aware why HM/ULP-B thought there were two residents that required two assist staff transfers. The MDH investigator reviewed R2, and R3's assessments and service plans with RN/LALD-B and RN/LALD-B confirmed the assessments and service plans did not include all required information and did not accurately reflect the needs of the residents or indicate the amount of staff assistance required to meet R2 and R3's needs. On December 5, 2024, at 2:00 p.m., RN/LALD-B stated the staffing plan was reviewed every six months. RN/LALD-B stated two staff were supposed to be scheduled during the day and evening but today the owner had to do something. RN/LALD-B stated if there was an emergency staff could call her since she lived about three miles away from the facility. RN/LALD-B stated R2 required two assist with a ceiling lift unless the power went out and then a mechanical lift would be utilized. RN/LALD-B confirmed the licensee should have two staff onsite at all times in order to meet the needs of	0 470		

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0 470	Continued From page 6 the residents who required two staff assistance. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 470		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN)	01620		

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01620	Continued From page 7 completed accurate and individualized assessments of resident needs, preferences, and all required content identified per the Uniform Assessment Tool for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 31, 2021 the licensee submitted an application for Assisted Living Licensure and signed on the application that the licensee read and understood Minnesota State Chapter 144G and Minnesota Rules Chapter 4659 regarding the provisions governing Assisted Living licensure and was granted an Assisted Living Facility (ALF) license. On December 5th, 2024, a Minnesota Department of Health (MDH) investigator initiated a complaint investigation survey at the licensee. R1 Review of R1's record indicated that R 1 had a history of stroke with right sided paralysis. R1's December 5th, 2024 assessment indicated R1 required assistance with bed mobility, transfers, ambulation and use of a wheelchair. The assessment also identified R1 needed assistance from sitting to standing and required two staff or "one strong one" with gait belt and walker.	01620		

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01620	Continued From page 8 R2 R2's diagnoses included traumatic brain injury (TBI), borderline personality disorder, and paraplegia (paralysis of the legs, and lower body). R2's assessment dated October 24, 2024, indicated R2 required assistance with dressing, bed mobility, transferring, managing behaviors, and medication administration. The assessment did not include a description of how assistance should be provided and how many staff were required to provide assistance based on R2's needs. R2's undated, unsigned service plan did not include a description of how assistance should be provided and how many staff were required. The assessment did not include per Assisted Living Facilities: Minnesota Rules Chapter 4659.0150 Uniform Assessment Tool, the components required in subpart 2, section A-N. On December 5, 2024, at 11:25 a.m., R2 stated staff used one staff and a ceiling lift to get him out of bed. R3 R3's diagnoses included open leg wound, chronic sacral ulcer and spinal cord injury. R3's assessment dated November 20, 2024, indicated R3 was unable to walk but could transfer with supervision. The assessment also indicated R3 was a quadriplegic (paralysis that affects all extremities). The note under evacuation acuity level indicated R3 required a lift for transfers. The assessment did not include a description of how assistance should be provided	01620		

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01620	Continued From page 9 and how many staff were required. R3's undated, unsigned service plan did not include a description of services and how many staff were required to provide assistance to R3. The assessment did not include per Assisted Living Facilities: Minnesota Rules Chapter 4659.0150 Uniform Assessment Tool, the components required in subpart 2, section A-N. On December 5, 2024, at 11:40 a.m., R3 stated he had not been out of bed for a long time due to wounds on his buttocks. On December 5, 2024, at 1:25 p.m., registered nurse (RN)/ licensed assisted living director(LALD)-B stated resident assessments were completed every 30 days and with a change of condition. RN/LALD-B stated R2 required two staff to assist for transfers and was not aware why HM/ULP-B thought there were three residents that required two assist staff transfers. RN/LALD-B stated she did not know what information was required for assessments and confirmed the assessments completed for R1, R2, and R3 were inaccurate. Minnesota Assisted Living Licensure Rules Chapter 4659 includes the following information regarding the Uniform Assessment utilized to comprehensively evaluate a resident's needs: Subpart 1. Definition. For purposes of this part, "Uniform Assessment Tool" means an assessment tool that meets the requirements of this part and is used by a licensee to comprehensively evaluate a resident's or prospective resident's physical, mental, and cognitive needs.	01620		

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01620	Continued From page 10 Subp. 2. Assessment tool elements. Each facility must develop a uniform assessment tool. The facility may use any acceptable form or format for the tool, such as an online or a hard-copy paper assessment tool, as long as the tool includes the elements identified in this subpart. A uniform assessment tool must address the following: A. the resident's personal lifestyle preferences, including: (1) sleep schedule, dietary and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life; (2) spiritual and cultural preferences; and (3) advance health care directives and end-of-life preferences, including whether a person has or wants to seek a "do not resuscitate" order and "do not attempt resuscitation order" or "physician/provider orders for life-sustaining treatment" order; B. activities of daily living, including: (1) toileting pattern, bowel, and bladder control; (2) dressing, grooming, bathing, and personal hygiene; (3) mobility, including ambulation, transfers, and assistive devices; and (4) eating, dental status, oral care, and assistive devices and dentures, if applicable; C. instrumental activities of daily living, including: (1) ability to self manage medications; (2) housework and laundry; and (3) transportation; D. physical health status, including: (1) a review of relevant health history and current health conditions, including medical and nursing diagnoses; (2) allergies and sensitivities related to	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37960	A. BUILDING: _____ B. WING _____	C 12/05/2024

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01620	Continued From page 11 medication, seasonality, environment, and food and if any of the allergies or sensitivities are life threatening; (3) infectious conditions; (4) a review of medications according to Minnesota Statutes, section 144G.71, subdivision 2, including prescriptions, over-the-counter medications, and supplements, and for each: (a) the reason taken; (b) any side effects, contraindications, allergic or adverse reactions, and actions to address these issues; (c) the dosage; (d) the frequency of use; (e) the route administered or taken; (f) any difficulties the resident faces in taking the medication; (g) whether the resident self administers the medication; (h) the resident's preferences in how to take medication; (i) interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications; and (j) provide instructions to the resident and resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications; (5) a review of medical, dental, and emergency room visits in the past 12 months, including visits to a primary health care provider, hospitalizations, surgeries, and care from a postacute care facility; (6) a review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months;	01620		

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01620	Continued From page 12 (7) weight; and (8) initial vital signs if indicated by health conditions or medications; E. emotional and mental health conditions, including: (1) review of history of and any diagnoses of mood disorders, including depression, anxiety, bipolar disorder, and thought or behavioral disorders; (2) current symptoms of mental health conditions and behavioral expressions of concerns; and (3) effective medication treatment and nonmedication interventions; F. cognition, including: (1) a review of any neurocognitive evaluations and diagnoses; and (2) current memory, orientation, confusion, and decision-making status and ability; G. communication and sensory capabilities, including: (1) hearing; (2) vision; (3) speech; (4) assistive communication and sensory devices including hearing aids; and (5) the ability to understand and be understood; H. pain, including: (1) location, frequency, intensity, and duration; and (2) effectiveness of medication and nonmedication alternatives; I. skin conditions; J. nutritional and hydration status and preferences; K. list of treatments, including type, frequency, and level of assistance needed; L. nursing needs, including potential to receive nursing-delegated services;	01620		

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01620	Continued From page 13 M. risk indicators, including: (1) risk for falls including history of falls; (2) emergency evacuation ability; (3) complex medication regimen; (4) risk for dehydration, including history of urinary tract infections and current fluid intake pattern; (5) risk for emotional or psychological distress due to personal losses; (6) unsuccessful prior placements; (7) elopement risk including history or previous elopements; (8) smoking, including the ability to smoke without causing burns or injury to the resident or others or damage to property; and (9) alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician; N. who has decision-making authority for the resident, including: (1) the presence of any advance health care directive or other legal document that establishes a substitute decision maker; The licensee's Assessments, Reviews, and Monitoring policy dated November 18, 2021, indicated the RN would conduct an assessment of the residents physical and cognitive needs. The policy did not include when an assessment was required and what information should be included in the assessment. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		