Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered via Email

December 12, 2025

Administrator
TLC HOME CARE OF THE TWIN CITIES
1919 UNIVERSITY AVENUE SUITE 130
SAINT PAUL, MN 55104

Re: Event ID: 1DAC61-H1

Dear Administrator:

An abbreviated survey was completed at your agency on November 24, 2025, for the purpose of assessing compliance with Federal certification. At the time of survey, the survey team from the Minnesota Department of Health - Health Regulation Division, noted one or more deficiencies. Electronically attached is a copy of the Statement of Deficiencies (CMS-2567).

An acceptable plan of correction must contain the following elements:

- The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited;
- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
- The monitoring procedure to ensure that the plan of correction is effective, and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
- The title of the person responsible for implementing the acceptable plan of correction; and,
- The date by which the correction will be completed.

A provider or supplier is expected to take the steps necessary to achieve compliance within 60 days of the exit interview. If possible, please type your plan of correction to ensure legibility. Please make a copy of the form for your records and return the original to the following address within ten calendar days of your receipt of this notice:

**Annette Winters, Regional Supervisor Federal RR**

**Health Regulation Division**
**Minnesota Department of Health**
**625 Robert Street North**
**P.O. Box 64975**
**Saint Paul, Minnesota 55164-0975**
**Email: annette.m.winters@state.mn.us**
**Mobile: (651) 558-7558**

**Failure to submit an acceptable written plan of correction of Federal deficiencies within ten calendar days may result in decertification and a loss of Federal reimbursement. Additionally, your continued certification is contingent upon corrective action.**

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

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Administrator
TLC HOME CARE OF THE TWIN CITIES
1919 UNIVERSITY AVENUE SUITE 130
SAINT PAUL, MN 55104

Re: Event ID:1DAC61-H1

Dear Administrator:

A survey of the Home Care Provider named above was completed on November 24, 2025, for the purpose of assessing compliance with State licensing regulations. At the time of survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted no violations of the requirements under Minnesota Statutes Sections 144A.43 to 144A.482.

Attached is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 248030 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 11/24/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TLC HOME CARE OF THE TWIN CITIES | 1919 UNIVERSITY AVENUE SUITE 130 , SAINT PAUL, Minnesota, 55104 |

| (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) COMPLETION DATE |
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| G0000 | INITIAL COMMENTS<br><br>On 11/19/25 - 11/24/25 a complaint survey was conducted. The agency was found to have not met the requirements at 42 CFR. Part 484 for Home Health Agencies.<br><br>The cumulative eû ects of these û ndings resulted in the Home Health Agency's inability to ensure provision of quality of care.<br><br>The following complaints were reviewed: H80305664C / 2638983 & H80307867C / 109443 | G0000 | | |
| G0464 | Advise the patient of discharge for cause<br><br>CFR(s): 484.50(d)(5)(i)<br><br>(i) Advise the patient, representative (if any), the physician(s) or allowed practitioner(s), issuing orders for the home health plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) that a discharge for cause is being considered;<br><br>This ELEMENT is NOT MET as evidenced by:<br><br>Findings include:<br><br>P1's Home Health Plan of Care and Certification for certification period 6/20/25 – 8/18/25 indicated P1's diagnoses were Autistic disorder and unspecified intellectual disabilities. | G0464 | 1. The Administrator will follow up with the RN Annemarie and ask her to complete the discharge for the applicant.<br>2. RN Annemarie completed the discharge for P1 on 11/20/25<br>3. The Administrator will follow up with all nurses and review the discharge policy with them to ensure the correct processes are being followed through moving forward by 1/22/2026.<br>4. The Administrator will review discharges and ensure the discharge summaries and discharge OASIS are completed for each discharged applicant. | |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| | | |

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| G0464 | Continued from page 1<br>P1’s mental status was oriented, forgetful, and depressed. P1 was ordered to have skilled nursing every other week to observe and assess vital signs and to monitor respiratory status, gastrointestinal status, cardiopulmonary status, integumentary status, pain management, endocrine status, neurological status, renal/genitourinary status, observe and assess mental status and to observe and assess medication compliance, response, set-up medications and assist with ordering medications.<br><br>P1’s last skilled nursing visit note dated 8/21/25 indicated P1 lived alone in a condominium. He was oriented, but forgetful. He attended a day program five days a week. P1 had a history of seizure activity. He would have absent seizures that lead to grand mal seizures. He reported having difficulty starting urine stream. He needed assistance with medication regimen related to self-care deficit. P1’s medications were filled for two weeks. Registered nurse (RN)-A documented she was not able to accommodate P1’s requests to have his medications filled on Tuesday or Thursday mornings. She notified the scheduling staff at the HHA.<br><br>Email correspondence from the HHA administrative assistant to the Administrator and the director of nursing (DON) dated 10/6/25 at 2:42 p.m. indicated P1’s outside case manager (CM) called the HHA because she was told by RN-A that P1’s visits were passed along to another nurse. She was wondering who the nurse was and how to contact them. The assistance looked in P1’s file and found there was no primary nurse assigned to P1. The assistant reached out to RN-A that another agency will see P1 and for RN-A to discharge him.<br><br>Upon interview on 11/19/25 at 10:45 a.m. P1’s CM -A stated on 10/7/25 P1 notified her that he had not had his seizure medication in a few days, and he was unable to get a refill on his own. The CM assisted him to get the medication. P1 told the CM-A that he had been discharged from the agency. The CM called the agency and was told RN-A was unable was to see P1 and another agency nurse would be completing his nursing visits. When the HHA looked up the nurse who was supposed to be seeing P1 the agency revealed there was not a nurse scheduled for P1, and the HHA did not have one so P1 would need to be discharged. CM-A called P1’s county case worker (CW)-A to ask if P1 had a new HHA and was told he did not. CM-A stated when the HHA told her they needed to discharge. The agency failed to provide any | G0464 | | |

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| G0464 | Continued from page 2<br>discharge information to a new HHA or the case management team.<br><br>Upon interview on 11/19/25 at 12:27 p.m. RN-A stated she had completed nursing visits for P1, however due to scheduling conflicts she was unable to see him after the 8/21/25 visit. She was given the name of another HHA nurse who would see P1. RN-A was not aware that P1 had not been seen and did not recall being asked to discharge him.<br><br>Upon interview on 11/19/25 at 1:15 p.m. P1 stated he was not receiving any nursing services in home and had not seen a nurse since summertime and currently was not seeing a nurse. He stated was told by the nurse that he was discharged, and his day program had been assisting him with his medications.<br><br>Upon interview on 11/19/25 at 2:14 p.m. administrative assistant (AA)-A stated P1 must have been discharged because he was on the nursing schedule. She did not know a discharge date.<br><br>Upon interview on 11/24/25 at 8:30 RN-B (the former director of nursing) stated she had stepped down from her role as director of nursing (DON) and all she knew about P1 was that he was difficult to get a hold of. She thought P1's discharge was completed through the HHA and P1 had another agency.<br><br>Upon interview on 11/24/25 at 10:30 a.m. the Administrator stated she believed P1 had been discharged from the agency. She stated the case manager should be making sure all components of the discharge are completed along with the notifications of missed visits to the provider as they are taking place.<br><br>P1's Primary Care Physician did not respond to an interview request.<br><br>P2's Home Health Plan of care and Certification for certification period 11/9/25 – 1/7/26 indicated P2's diagnoses were low back pain, polyps of the colon, diabetes mellitus due to an underlying condition with hyperosmolarity but without nonketotic hyperglycemic- hyperosmolar coma (a severe complication of type 2 diabetes defined by extremely high blood | G0464 | | |

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| G0464 | Continued from page 3<br>sugar levels, where coma did not occur). P1 was oriented and forgetful. P1 was ordered to have weekly skilled nursing visits to assess/monitor general health, mood, set-up meds and monitor compliance.<br><br>P2’s discharge summary dated 11/11/25 indicated P2 was discharged to her home the discharge reason was the nurse was unable to contact P2 throughout the months of October and November. The summary indicated P2 had been progressing toward her goals. Documentation under the title patient and/or family post discharge instructions indicated P2 was hospitalized (no dates indicated). RN-A requested HHA office staff obtain a discharge summary from the hospital, but did not receive any response from the office staff. The discharge summary did not have the providers signature and did not indicate if the document was faxed to the provider and when in the spaces provided. In addition, the note did not indicate any discharge planning measures or goals.<br><br>Upon interview on 11/20/25 at 9:20 a.m. RN-A stated P2 had been in and out of the hospital. She stated the practice of the HHA was when the HHA is unable to see the patients for any reason when the certifications become due the agency is required to discharge the patients. She did not provide any discharge planning because the discharge was not planned.<br><br>Upon interview on 11/20/25 at 2:24 p.m. P2’s primary care providers certified medical assistant (CMA) stated the last correspondence the clinic had with the HHA was a recertification fax on 9/9/25. There was no communication with the clinic regarding missed visits, discharge planning or an actual discharge.<br><br>Upon interview on 11/20/25 at 8:30 a.m. RN-B stated she was not aware whether P2 was still a patient or not since she stepped down from the director of nursing position, she had not been tracking discharges.<br><br>An agency policy titled Policy on Client Discharged undated indicated: Clients will be discharged from services when requests were not within the scope of the agency's resources, policies, and procedures. the HHA's discharge criteria included the following:<br><br>1. The client has reached the optimum rehabilitative potential. | G0464 | | |

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| G0464 | Continued from page 4<br>2. The client refuses services or requests that services be discontinued.<br><br>3. The client expires.<br><br>4. The client 18 years and older enters an inpatient facility for greater than a 24-hour time. If there are no significant changes in the Plan of Treatment, the discharge procedure may be waived at the discretion of the Director of Nursing or designee.<br><br>5. The client's service needs change requiring a referral to another provider.<br><br>6. The client's service needs cannot be met by the agency's resources.<br><br>7. The services are terminated by the client's physician through written order.<br><br>8. The client's responsible party refuses to comply with the provisions of the Plan of Care jeopardizing the health, safety and welfare of the client, caregiver, and/or agency staff.<br><br>9. The client is non-complaint with supervision. If the PCA/Aide/Homemaker is a family member and is non-complaint with supervision.<br><br>10. There is no payer for services. | G0464 | | |
| G0550 | At discharge CFR(s):<br><br>484.55(d)(3)<br><br>At discharge.<br><br>This ELEMENT is NOT MET as evidenced by:<br><br>Based on interview and record review the home health agency (HHA) failed to complete a comprehensive assessment including the Outcome and Assessment Information Set (Oasis) within two days of discharge for 1 of 3 patients (P1) reviewed for discharge.<br><br>Based on interview and record review the home health agency (HHA) failed to complete a comprehensive assessment including the Outcome and Assessment Information Set (Oasis) within two days of discharge for 1 of 3 patients (P1) reviewed for discharge.<br><br>Findings include: | G0550 | 1. The Administrator will have the RN Annemarie Coleman complete the discharge OASIS for P1.<br>2. The discharge OASIS for P1 was completed on 11/20/25.<br>3. The Administrator will review the discharge policy with each RN by 1/22/26, to ensure that discharge OASIS are completed within 2 days of patient discharges | 1/22/2026 |

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| G0550 | Continued from page 5<br><br>P1's Home Health Plan of Care and Certification for certification period 6/20/25 – 8/18/25 indicated P1's diagnoses were autistic disorder and unspecified intellectual disabilities.<br><br>P1's mental status was oriented, forgetful, and depressed. P1 was ordered to have skilled nursing every other week to observe and assess vital signs and to monitor respiratory status, gastrointestinal status, cardiopulmonary status, integumentary status, pain management, endocrine status, neurological status, renal/genitourinary status, observe and assess mental status and to observe and assess medication compliance, response, set-up medications and assist with ordering medications.<br><br>P1's last skilled nursing visit note dated 8/21/25 indicated P1 lived alone in a condominium. He was oriented, but forgetful. He attended a day program five days a week. P1 had a history of seizure activity. He would have absent seizures that lead to grand mal seizures. He reported having difficulty starting urine stream. He needed assistance with medication regimen related to self-care deficit. P1's medications were filled for two weeks. Registered nurse (RN)-A documented she was not able to accommodate P1's requests to have his medications filled on Tuesday or Thursday mornings. She notified the scheduling staff at the HHA.<br><br>Email correspondence from the HHA administrative assistant to the Administrator and the director of nursing (DON) dated 10/6/25 at 2:42 p.m. indicated P1's outside case manager (CM) called the HHA because she was told by RN-A that P1's visits were passed along to another nurse. She was wondering who the nurse was and how to contact them. The assistance looked in P1's file and found there was no primary nurse assigned to<br><br>P1.The assistant reached out to RN-A that another agency will see P1 and for RN-A to discharge him.<br><br>P1's medical record dated 10/9/25– 11/19/25 did not indicate a comprehensive assessment or OASIS was completed by the HHA.<br><br>Email correspondence dated 11/19/25 at 2:56 p.m. from the HHA administrator indicated P1 was transferred to | G0550 | | |

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| G0550 | Continued from page 6<br>another agency. In a subsequent email 11/19/25 at 3:33 p.m. she indicated P1's case manager reached out to the HHA to let them they were transferring him to a new agency as the agency nurse was unable to reach him to schedule nursing visits. She indicated she would follow-up with an HHA nurse to get his discharge completed.<br><br>Upon interview on 11/19/25 at 10:45 a.m. P1's CM stated on 10/7/25 P1 notified her that he had not had his seizure medication in a few days, and he was unable to get a refill on his own. The CM assisted him to get the medication. P1 told the CM that he had been discharged from the agency. The CM called the agency and was told RN-A was unable was to see P1 and another agency nurse would be completing his nursing visits. When the HHA looked up the nurse who was supposed to be seeing P1 the agency revealed there was not a nurse scheduled for P1, and the HHA did not have one so P1 would need to be discharged.<br><br>Upon interview on 11/19/25 at 12:27 p.m. RN-A stated she had completed nursing visits for P1, however due to scheduling conflicts she was unable to see him after the 8/21/25 visit. She was given the name of another HHA nurse who would see P1. RN-A was not aware that P1 had not been seen and did not recall being asked to discharge him.<br><br>An HHA policy on Oasis requirements was requested, however the agency sent the agencies submission reports and direction for exporting Oasis documents. | G0550 | | |
| G0958 | Clinical manager<br><br>CFR(s): 484.105(c)<br><br>Standard: Clinical manager.<br><br>One or more qualified individuals must provide oversight of all patient care services and personnel. Oversight must include the following--<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on interview and record review the home health agency (HHA) failed to ensure one or more qualified individuals; licensed physician, physical therapist, speech-language pathologist, occupational therapist, audiologist, social worker, or a registered nurse provided oversight of all patient care services and | G0958 | 1. The Administrator will continue to search for a new RN to replace the previous DON of the agency.<br>2. The Administrator will search for a new DON with the goal of filing the position by 1/22/26. | 1/22/2026 |

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| G0958 | Continued from page 7<br>personnel when the administrator was fulling the duties of the clinical manager.<br><br>Findings included:<br><br>The HHA’s organizational chart dated 1/1/25 indicated registered nurse (RN)-B as the director of nursing (clinical manager). The Administrators credentials were Masters or Public Health, MPH.<br><br>During the survey entrance on 11/19/25 at 10:45 a.m. the administrative assistant (AA)-A identified registered (RN)-B as the clinical manager and stated she would on vacation and could not be reached until 11/24/25. She stated the contact person would be the administrator.<br><br>Upon interview on 11/24/25 at 8:30 a.m. RN-B stated she was no longer the clinical manager and had stepped down 4/2025. Since April until present she had a part-time<br><br>position at the home health agency.<br><br>Upon interview on 11/24/25 at 10:30 a.m. the Administrator stated RN-B had stepped back from her clinical manager role 4/2025. Between the two of them they have been managing the day to day functioning of the HHA. RN-B has kept on a part-time status at the HHA as she had another job. The Administrator who lives in California stated she covered as clinic manager when RN-B was absent. The clinical manager position had been posted, but not yet filled. The Administrator stated she was not a nurse.<br><br>A policy regarding the clinical manager was requested however none was provided. | G0958 | | |