Health Regulation Division
Investigative Public Report

Maltreatment Report #: HL20297079M
Compliance #: HL20297080C

Date Concluded: May 13, 2021

Name, Address, and County of Facility Investigated:
TFF Care LLC
3675 Plymouth Blvd # 100
Plymouth, MN 55446
Hennepin County

Name, Address, and County of Housing with Services location:
TFF Care – Copperfield Hill -The Lodge
4200 40th Avenue North
Robbinsdale, MN 55422

Facility Type: Home Care Provider

Investigator Name:
John Sheridan-Giese, RN, Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:
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.

Allegation(s):
It is alleged: The facility neglected to provide supervision and monitoring of the client after family and facility staff reported a decline in the client's memory. The client was permitted to leave the facility campus alone for hours on unmonitored walks. During an unmonitored walk, the client fell and fractured an orbital bone (facial bone).

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The client had a diagnosis of dementia and worsening memory loss. The client had a history of increasing behaviors leading up to the incident. The facility failed to provide supervision, monitoring and assessments of the client as her cognitive condition worsened.

The client record was reviewed. Investigators reviewed staff schedules, personnel files, policies and procedures, and complaint reports. The investigation included interviews with unlicensed

staff, administrative staff, and nursing staff. The investigator toured the facility and attempted to interview the client; however, due her cognitive decline, the client was not interviewed. The complainant and client's family member were also interviewed.

The client's medical diagnoses included senile dementia, spinal stenosis, dizziness, and positional vertigo. The client's services included medication management and assistance with activities of daily living (ADLs). The client was independent with walking.

The client lived at the facility for seven (7) months prior to the incident in the assisted living section. The client's daughter (who was also the client's power of attorney) relocated the client to the facility due to the client's increased need for assistance with ADLs and the client's declining memory.

One day, the client was permitted to leave the facility's premises unmonitored. The client returned to the facility with injuries. Other clients reported to facility staff the client had sustained bruising to her left eye. Facility staff called emergency services, and the client was transported to the emergency room for treatment. The client sustained superficial lacerations requiring sutures and a fracture to the bone around her left eye (orbital fracture). The client did not recall falling and did not have a history of falling.

Review of the client's record indicated the client had a history of leaving the facility's premises, unmonitored, to go for walks. On several occasions, the client would become lost and would ask members of the community (whom she did not know) to assist her back to the facility. The client would often attempt to bring these people back to her apartment. Staff would intervene and would not allow them to enter the facility with the client. Staff indicated it was increasingly difficult for the client to understand that she was not allowed to have visitors due to COVID-19 precautions. At times, staff would go outside and look for the client because she had not returned to the facility.

During one incident, an unknown female attempted to enter the facility with the client. Staff did not recognize her and called police. When asked by staff who this person was, the client said, "I don't know."

During an interview, the family said the client moved to the facility due to concerns the client's dementia was worsening. The client could no longer take care of herself. The family said they spoke to facility staff regarding moving the client from assisted living to memory care on multiple occasions, as the client could not remember instances 15 minutes after the instance occurred. The family was concerned the client was wandering outside of the facility and into other clients' rooms in the assisted living.

During an interview, the registered nurse said she was responsible for assessing clients, and the client was permitted to leave the facility premises. The registered nurse stated there were no concerns regarding the client's cognition, safety, or leaving the premises unmonitored. The

registered nurse said she found out about the client's incident the following day, and she observed bruising to the left side of the client's face and a small laceration to the client's left eye, which required sutures. She said was aware the client had a broken bone near her left eye (left orbital fracture). The registered nurse said the client was not receiving routine assessments regarding her cognition, and the client had a change of behavior two weeks prior to the incident. She said the client was not cleaning her room and attempted to bring back members of the community to her apartment. The registered nurse also said the client would go down by the lake frequently because walking alleviated the client's back pain.

During an interview, the client's care coordinator said the client (prior to admission to the facility) scored on a MnChoices assessment (Department of Human Services (DHS) assessment for clients needing long-term services and supports) as having moderate dementia. The care coordinator said she would be concerned if the facility was allowing the client to leave the premises unmonitored, considering the client's dementia diagnosis. The care coordinator said the client was moved from assisted living to memory care a week after the incident where she obtained the facial fracture.

During an interview, the client's physician said the client's diagnosis of senile dementia would worsen over time. The client's physician said the expectation was the facility would complete a significant change in condition assessment if an assessment was warranted. The client's physician said memory care offers a more protective environment, ideally, for clients with similar diagnoses and behaviors as that of the client.

During an interview, the director of nursing said she was responsible for client incident follow-up and managed all licensed nursing staff at the facility. The director of nursing said the client had no falls prior to the incident. The director of nursing said there were several prior instances involving the client being confused. The director of nursing said she was aware the client had attempted to bring people, unknown to the client, back to her apartment. The director of nursing said she was made aware of the client's incident with injuries the evening it occurred, and it was difficult to determine if the client fell or was assaulted, considering her cognition. The director of nursing said there was nothing noted in the client's comprehensive assessment nor did staff complete a significant change in condition assessment. She said staff would normally complete a significant change in condition assessment though one was not completed in the client's case. The director of nursing also said there was no neurological or cognitive testing on file for the client.

During an interview, an unlicensed staff person said he was often responsible for the client's cares. The unlicensed personnel said the client was forgetful and would receive her medication but continue to ask for her medication repeatedly. The unlicensed staff person said he would go outside and look for the client because she would get lost and did not remember how to get back to the facility. He said he reported to management the client wandered and would often forget her way back to the facility. On the day of the incident, he said he was called to tend to the client as the client was bleeding and had bruising around her left eye. He said he called the director of

nursing who directed him to call emergency services. The unlicensed staff person said the client returned to the facility and continued to leave the facility premises, unmonitored, until the client moved to memory care seven (7) days later.

The facility did not file a Minnesota Adult Abuse Reporting Center (MAARC) report, and the facility did not update the client's individual abuse prevention plan (IAPP) after the incident.

The investigator attempted to interview the client. Due to her condition, the client was not interviewed.

In conclusion, neglect was substantiated against the facility.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: Attempted, unable to be interviewed due to condition.
Family Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not applicable.

Action taken by facility: The facility completed an incident report, and the client was moved from assisted living to memory care.

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, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

The responsible party will be notified of their right to appeal the maltreatment finding.

cc: The Office of Ombudsman for Long-Term Care
Robbinsdale Police Department
Hennepin County Attorney's Office

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20297	A. BUILDING: ____ B. WING ____	C 03/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TFF CARE LLC	**3675 PLYMOUTH BOULEVARD, SUITE 100 MINNEAPOLIS, MN 55446**

(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****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to a survey. 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: On March 16, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL20297080C/#HL20297079M. At the time of the survey, there were 52 clients receiving services under the comprehensive license. The following correction orders are issued for #HL20297080C/#HL20297079M, tag indentification 0325, 0805, 0810, 0860, and 2015.	0 000	The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule number out of compliance are listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors ' 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/RULES.	
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (14) be free from physical and verbal abuse,	0 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20297	A. BUILDING: ______ B. WING ______	C 03/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TFF CARE LLC	**3675 PLYMOUTH BOULEVARD, SUITE 100 MINNEAPOLIS, MN 55446**

(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
0 325	Continued From page 1 neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of two clients (C1) reviewed was free from maltreatment. C1 was neglected. Findings include: On May 13, 2021, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and the license staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of tag 0325.	
0 805 SS=D	144A.479, Subd. 6(a) Reporting Maltrx of Vulnerable Adults/Minors Subd. 6.Reporting maltreatment of vulnerable adults and minors. (a) All home care providers must comply with requirements for the reporting of maltreatment of minors in section 626.556 and the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. Each home care provider must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced	0 805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20297	A. BUILDING: ______ B. WING ______	C 03/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TFF CARE LLC	**3675 PLYMOUTH BOULEVARD, SUITE 100 MINNEAPOLIS, MN 55446**

(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
0 805	Continued From page 2	0 805		

by:
Based on interview and record review, the licensee failed to immediately report (within 24 hours) to the Minnesota Adult Abuse Reporting Center (MAARC) for one of two clients (C1) reviewed. C1 had a dementia diagnosis, and the licensee staff permitted C1 to leave the licensee unsupervised. C1 sustained a physical injury which was not reasonably explained. The licensee did not report the incident to MAARC as required.

This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

Findings Include:

C1's medical record was reviewed. C1's medical diagnoses included, but were not limited to, senile dementia, spinal stenosis, dizziness, and positional vertigo.

C1's MnChoices assessment (Department of Human Services (DHS) assessment for clients needing long-term services and supports), dated January 30, 2020, indicated C1 needed daily assistance for increased vulnerability due to behaviors caused by C1's cognitive deficits. C1's assessment indicated, "someone always needs to be with [C1] to help with remembering, decision making or judgment when away from home." C1's assessment also indicated C1 scored 12 out of 30, which indicated moderate dementia.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20297	A. BUILDING: ______ B. WING ______	C 03/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TFF CARE LLC	**3675 PLYMOUTH BOULEVARD, SUITE 100 MINNEAPOLIS, MN 55446**

(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
0 805	Continued From page 3 C1's service plan dated February 10, 2020, indicated C1 required assistance with medication management, activities of daily living (ADLs), and daily safety checks. C1's service plan indicated staff were supposed to contact the nurse immediately if C1 could not be located. C1's care plan dated September 1, 2020, indicated C1 required full medication management and set-up, needed physical help during an emergency, and was at risk for falling. C1's Individual Abuse Assessment Plan (IAPP) dated September 1, 2020, indicated C1 was at risk of being abused. The licensee staff were to supposed to monitor for any signs of abuse and report to the registered nurse (RN) on-duty immediately. The RN on-duty would report any signs of abuse to MAARC. C1's IAPP indicated C1 required assistance with good decision making due to C1's lack of cognitive ability and memory impairment. Review of C1's fall report date September 21, 2020, indicated C1 fell outside of the licensee's community unwitnessed, and C1 returned to the licensee with a facial injury (left orbital fracture). C1 was transported to the emergency room via ambulance, was treated, and returned to the licensee the same day. C1 did not recall falling. C1 did not have a history of falling. C1's fall report indicated a more secure environment would mitigate the risk of future falls. During an interview on March 16, 2021, at 12:32 p.m., RN-D said a vulnerable adult is someone who could be taken advantage of compared to someone else. RN-D said typically a MAARC report would be filed for an unwitnessed fall,	0 805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20297	A. BUILDING: ______ B. WING ______	C 03/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TFF CARE LLC	3675 PLYMOUTH BOULEVARD, SUITE 100 MINNEAPOLIS, MN 55446

(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
0 805	Continued From page 4	0 805		

though RN-D was not aware if a report was generated for C1. RN-D said C1 did not receive routine assessments for her cognition. RN-D said after the fall incident, C1 was transferred to memory care.

During an interview on March 16, 2021, at 1:35 p.m., director of nursing (DON)-B said C1 was confused. DON-B said staff reported C1 had on several occasions attempted to bring back unknown individuals with her to the licensee after C1 had been allowed to leave the licensee unsupervised. DON-B said C1 did not comprehend that she was not allowed to have people come back with her. DON-B said C1 reported she fell, though it would be difficult to differentiate if C1 fell or was assaulted based on her cognition. DON-B said the licensee did not report the incident to MAARC.

During an interview on March 19, 2021, at 2:00 p.m., care coordinator (CC)-G said she was concerned C1 was allowed to leave the licensee unsupervised considering her moderate dementia diagnosis.

During an interview on March 23, 2021, at 8:57 a.m., medical doctor (MD)-F said dementia is a chronic condition, and C1's cognition would worsen over time. MD-F said that C1's score of a 12 out of 30 on the MnChoices assessment indicated significant impairment.

Review of the licensee policy titled, Vulnerable Adult Reporting and Investigation Policy, updated June 15, 2019, indicated the licensee's staff would report any suspected maltreatment to common entry point (CEP). The licensee's policy indicated staff would report any unexplained physical injury (unexplained bruises, skin tears,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20297	A. BUILDING: ____ B. WING ____	C 03/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TFF CARE LLC	3675 PLYMOUTH BOULEVARD, SUITE 100 MINNEAPOLIS, MN 55446

(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
0 805	Continued From page 5 lacerations, or fractures) to common entry point. The licensee's policy also indicated if within twenty-four (24) hours following the initial incident report, if the Director of Healthcare and/or Executive Director remained unsure whether a reportable maltreatment had occurred, the Director of Healthcare or Executive Director would make a report to CEP. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 805		
0 810 SS=G	144A.479, Subd. 6(b) Individual Abuse Prevention Plan (b) Each home care provider must develop and implement an individual abuse prevention plan for each vulnerable minor or adult for whom home care services are provided by a home care provider. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults or minors; the person'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 that person and other vulnerable adults or minors. For purposes of the abuse prevention plan, the term abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview, observation, and record review, the licensee failed to update an individual abuse prevention plan (IAPP) for one of two clients (C1) reviewed. C1 had a dementia diagnosis, and licensee staff permitted C1 to leave the licensee unsupervised. C1 sustained an unexplained and unwitnessed physical injury (left	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20297	A. BUILDING: ______ B. WING ______	C 03/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TFF CARE LLC	3675 PLYMOUTH BOULEVARD, SUITE 100 MINNEAPOLIS, MN 55446

(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
0 810	Continued From page 6	0 810		

orbital fracture).

This practice resulted in a level three violation (a violation that harmed a client'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 an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

Findings include:

C1's medical record was reviewed. C1's medical diagnoses included, but were not limited to, senile dementia, spinal stenosis, dizziness, and positional vertigo.

C1's MnChoices assessment (Department of Human Services (DHS) assessment for clients needing long-term services and supports), dated January 30, 2020, indicated C1 needed daily assistance for increased vulnerability due to behaviors caused by C1's cognitive deficits. C1's assessment indicated, "someone always needs to be with [C1] to help with remembering, decision making or judgment when away from home." C1's assessment also indicated C1 scored 12 out of 30, which indicated moderate dementia.

C1's service plan dated February 10, 2020, indicated C1 required assistance with medication management, activities of daily living (ADLs), and daily safety checks. C1's service plan indicated staff were supposed to contact the nurse immediately if C1 could not be located.

C1's care plan dated September 1, 2020,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20297	A. BUILDING: ____ B. WING ____	C 03/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TFF CARE LLC	3675 PLYMOUTH BOULEVARD, SUITE 100 MINNEAPOLIS, MN 55446

(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
0 810	Continued From page 7 indicated C1 required full medication management and set-up, needed physical help during an emergency, and was at risk for falling. C1's IAPP dated September 1, 2020, indicated C1 was at risk of being abused. The licensee staff were supposed to monitor for any signs of abuse and report to the registered nurse (RN) on-duty immediately. The RN on-duty would report any signs of abuse to MAARC. Licensed practical nurse (LPN)-K assessed C1 as vulnerable to abuse and indicated C1 required assistance with good decision making due to C1's lack of cognitive ability and memory impairment. LPN-K also labeled C1 as vulnerable because C1 consumed alcohol occasionally, and C1 was vulnerable due to C1's short term memory loss. C1's IAPP did not include any specific interventions to prevent physical abuse. C1's incident where she sustained an left orbital fracture occurred on September 21, 2020. C1's IAPP was not updated until after she moved to memory care on September 29, 2020. During this time, staff reported C1 was permitted to go outside on unmonitored walks. Licensee's incident report dated September 21, 2020, indicated C1 fell outside of the licensee's community unwitnessed, and C1 returned to the licensee with a facial injury (left orbital fracture). C1 was transported to the emergency room via ambulance, was treated, and returned to the licensee the same day. C1 did not recall falling. C1 did not have a history of falling. C1's fall report indicated a more secure environment would mitigate the risk of future falls. During an interview on March 16, 2021, at 1:35 p.m., director of nursing (DON)-B said she was responsible for the oversight of the clients'	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20297	A. BUILDING: ______ B. WING ______	C 03/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TFF CARE LLC	**3675 PLYMOUTH BOULEVARD, SUITE 100 MINNEAPOLIS, MN 55446**

(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
0 810	Continued From page 8 assessments. DON-B said C1 was confused. DON-B said staff reported C1 had on several occasions attempted to bring back unknown individuals with her to the licensee after C1 had been allowed to leave the licensee unsupervised. DON-B said C1 did not comprehend that she was not allowed to have people come back with her. DON-B said C1 reported she fell, though it would be difficult to differentiate if C1 fell or was assaulted based on her cognition. DON-B said there were no updates made to C1's assessments. During an interview on March 16, 2021, at 12:32 p.m., RN-D said she was responsible for client assessments. RN-D said C1 suffered bruising to the left side of her face, a small laceration to her left eye and a left orbital fracture. C1 required sutures at the emergency room. RN-D said she did not perform routine cognitive assessments with C1. RN-D said after the incident, C1 was transferred to memory care. During an interview on March 18, 2021 at 3:21 p.m., unlicensed personnel (ULP)-J said he often worked with C1 and assisted with C1's medication management and ADLs. ULP-J said C1 would forget she already took her medication and would repeatedly ask for medications. ULP-J said C1 was not able to take care of herself and often would not change her clothes or clean her apartment. ULP-J said C1 would go outside and there would be times staff could not find her. ULP-J said C1 would forget her way back and would ask strangers for help, often bringing the strangers back with her. ULP-J said C1 would wander into other clients' rooms. He said he thought C1 should have had more supervision. During an interview on March 19, 2021, at 1:00	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20297	A. BUILDING: ______ B. WING ______	C 03/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TFF CARE LLC	**3675 PLYMOUTH BOULEVARD, SUITE 100 MINNEAPOLIS, MN 55446**

(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
0 810	Continued From page 9	0 810		

p.m., family member (FAM)-I said C1 moved from Arizona to Minnesota to be closer to FAM-I because C1's memory was deteriorating. FAM-I indicated prior to admission to the licensee, C1 was forgetting conversations, when to take her medications, and C1's short term memory was poor. FAM-I indicated that RN-D and housing director (HD)-L, after C1's admission on February 26, 2020, had reminded FAM-I that C1 would need to go to memory care by the summer of 2020. FAM-I said the topic of C1 going to memory care was a frequent conversation with RN-D and HD-L. FAM-I indicated after C1's incident on September 21, 2020, RN-D and HD-L called FAM-I and said C1 needed to go to memory care because not moving C1 would be considered negligent. C1 remained in her assisted living apartment until September 29, 2020, when she moved to a memory care apartment.

Licensee policy titled, Initial and On-Going Nursing Assessment of Clients, updated August 17, 2020, indicated the licensee is required to reassess clients with a change of condition and when a client returned from a hospital. The policy indicated change of conditions included, but were not limited to, broken bones and a pattern of significant behavioral changes (including confusion). The policy also indicated the RN was required to assess the client's areas of vulnerability and susceptibility to maltreatment. The licensee's policy also indicated the RN would use the IAPP to identify the specific measures to minimize the risk of maltreatment to the client, the RN would incorporate the abuse prevention plan and interventions into the client's comprehensive care plan.

TIME PERIOD FOR CORRECTION: Seven (7) days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20297	A. BUILDING: ___ B. WING ___	C 03/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TFF CARE LLC	3675 PLYMOUTH BOULEVARD, SUITE 100 MINNEAPOLIS, MN 55446

(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
0 860 SS=G	144A.4791, Subd. 8 Comprehensive Assessment and Monitoring Subd. 8.Comprehensive assessment, monitoring, and reassessment. (a) When the services being provided are comprehensive home care services, an individualized initial assessment must be conducted in person by a registered nurse. When the services are provided by other licensed health professionals, the assessment must be conducted by the appropriate health professional. This initial assessment must be completed within five days after the date that home care services are first provided. (b) Client monitoring and reassessment must be conducted in the client's home no more than 14 days after the date that home care services are first provided. (c) Ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client and cannot exceed 90 days from the last date of the assessment. The monitoring and reassessment may be conducted at the client's residence or through the utilization of telecommunication methods based on practice standards that meet the individual client's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure nursing staff performed and documented cognitive assessments for one of two clients (C1) reviewed. C1 had a dementia diagnosis with increased behaviors (wandering), and the licensee permitted C1 to leave the licensee unsupervised. C1 sustained an unexplained and unwitnessed physical injury (left orbital fracture).	0 860		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20297	A. BUILDING: ______ B. WING ______	C 03/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TFF CARE LLC	3675 PLYMOUTH BOULEVARD, SUITE 100 MINNEAPOLIS, MN 55446

(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
0 860	Continued From page 11	0 860		

This practice resulted in a level three violation (a violation that harmed a client'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 an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

The findings include:

The Alzheimer's Association document titled, Campaign for Quality Residential Care, dated 2009, indicated regular formal assessment is key to appropriate management of a client's care. The article indicated equally important is ongoing monitoring and assessment, particularly upon return from the hospital or upon a significant change in a client's condition. Ongoing assessments and making the appropriate referrals for clients with dementia can help mitigate certain behaviors and injuries. The document also indicated, wandering may be detrimental when it results in a client leaving the premises, or entering unsafe areas or another client's space, which could result in injuries, dehydration, weight loss, excessive fatigue or agitation, or even death.

C1's medical record was reviewed. C1's medical diagnoses included, but were not limited to, senile dementia, spinal stenosis, dizziness, and positional vertigo.

C1's MnChoices assessment (Department of Human Services (DHS) assessment for clients needing long-term services and supports) dated January 30, 2020, indicated C1 needed daily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20297	A. BUILDING: ______ B. WING ______	C 03/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TFF CARE LLC	3675 PLYMOUTH BOULEVARD, SUITE 100 MINNEAPOLIS, MN 55446

(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
0 860	Continued From page 12 assistance for increased vulnerability due to behaviors caused by C1's cognitive deficits. C1's assessment indicated, "someone always needs to be with [C1] to help with remembering, decision making or judgment when away from home." C1's assessment also indicated C1 scored 12 out of 30, which indicated moderate dementia. C1's service plan dated February 10, 2020, indicated C1 required assistance with medication management, activities of daily living (ADLs), and daily safety checks. C1's service plan indicated staff were supposed to contact the nurse immediately if C1 could not be located. The service plan also indicated C1's memory impairment was in the form of daily confusion, C1 was mainly oriented to self, and required behavioral intervention from staff. C1's care plan dated September 1, 2020, indicated C1 required full medication management and set-up and needed physical help during an emergency and was at risk for falling. C1's Individual Abuse Assessment Plan (IAPP) dated September 1, 2020, indicated C1 was at risk of being abused. The licensee staff were to monitor any signs of abuse and report to the registered nurse (RN) on-duty immediately. The RN on-duty would report any signs of abuse to the Minnesota Adult Abuse Reporting Center (MAARC). Licensed practical nurse (LPN)-K assessed C1 as vulnerable to abuse and indicated C1 required assistance with good decision making due to C1's lack of cognitive ability and memory impairment. LPN-K also labeled C1 as vulnerable because C1 consumed alcohol occasionally, and C1 was vulnerable due	0 860		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20297	A. BUILDING: ______ B. WING ______	C 03/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TFF CARE LLC	**3675 PLYMOUTH BOULEVARD, SUITE 100 MINNEAPOLIS, MN 55446**

(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
0 860	Continued From page 13 to C1's short term memory loss. C1's IAPP did not include any specific interventions to prevent physical abuse. Licensee's incident report dated September 21, 2020, indicated C1 fell outside of the licensee's community unwitnessed, and C1 returned to the licensee with a facial injury (left orbital fracture). C1 was transported to the emergency room via ambulance, was treated, and returned to the licensee the same day. C1 did not recall falling. C1 did not have a history of falling. C1's fall report indicated a more secure environment would mitigate the risk of future falls. C1's medical record did not include any significant change in condition assessments. In email correspondence dated May 3, 2021, at 11:53 a.m., DON-B indicated there was no cognitive testing or assessments on file for C1. During an interview on March 16, 2021, at 12:32 p.m., RN-D said she was responsible for client assessments. RN-D said C1 suffered bruising to the left side of her face, a small laceration to her left eye and a left orbital fracture. C1 required sutures at the emergency room. RN-D said she did not perform routine cognitive assessments with C1. RN-D said after the incident, C1 was transferred to memory care. During an interview on March 16, 2021, at 1:35 p.m., director of nursing (DON)-B said she was responsible for the oversight of the clients' assessments. DON-B said C1 was confused. DON-B said staff reported C1 had on several occasions attempted to bring back unknown individuals with her to the licensee after C1 had been allowed to leave the licensee unsupervised.	0 860		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20297	A. BUILDING: ______ B. WING ______	C 03/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TFF CARE LLC	3675 PLYMOUTH BOULEVARD, SUITE 100 MINNEAPOLIS, MN 55446

(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
0 860	Continued From page 14 DON-B said C1 did not comprehend that she was not allowed to have people come back with her. DON-B said C1 reported she fell, though it would be difficult to differentiate if C1 fell or was assaulted based on her cognition. DON-B said there were no updates made to C1's assessments. During an interview on March 18, 2021 at 3:21 p.m., unlicensed personnel (ULP)-J said he often worked with C1 and assisted with C1's medication management and ADLs. ULP-J said C1 would forget she already took her medication and would repeatedly ask for medications. ULP-J said C1 was not able to take care of herself and often would not change her clothes or clean her apartment. ULP-J said C1 would go outside and there would be times staff could not find her. ULP-J said C1 would forget her way back and would ask strangers for help, often bringing the strangers back with her. ULP-J said C1 would wander into other clients' rooms. and he thought C1 required more supervision. During an interview on March 19, 2021, at 1:00 p.m., family member (FAM)-I said C1 moved from Arizona to Minnesota to be closer to FAM-I because C1's memory was deteriorating. FAM-I indicated prior to admission to the licensee, C1 was forgetting conversations, when to take her medications and C1's short term memory was poor. FAM-I indicated that RN-D and housing director (HD)-L, after C1's admission on February 26, 2020, had reminded FAM-I that C1 would need to go to memory care by the summer of 2020. FAM-I said the topic of C1 going to memory care was a frequent conversation with RN-D and HD-L. FAM-I indicated after C1's incident on September 21, 2020, RN-D and HD-L called FAM-I and said C1 needed to go to memory care	0 860		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20297	A. BUILDING: ______ B. WING ______	C 03/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TFF CARE LLC	3675 PLYMOUTH BOULEVARD, SUITE 100 MINNEAPOLIS, MN 55446

(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
0 860	Continued From page 15	0 860		

because not moving C1 would be considered negligent. C1 remained in her assisted living apartment until September 29, 2020, when she moved to a memory care apartment.

During an interview on March 19, 2021, at 2:00 p.m., care coordinator (CC)-G said she was concerned C1 was allowed to leave the licensee unsupervised considering her moderate dementia diagnosis.

During an interview on March 23, 2021, at 8:57 a.m., medical doctor (MD)-F said dementia is a chronic condition, and C1's cognition would worsen over time. MD-F said C1's score of a 12 out of 30 on the MnChoices assessment indicated significant impairment.

Licensee policy titled, Initial and On-Going Nursing Assessment of Clients, updated August 17, 2020, indicated the licensee is required to reassess clients with a change of condition and when a client returned from a hospital. The licensee policy indicated change of conditions included, but were not limited to, broken bones and a pattern of significant behavioral changes (including confusion). The licensee policy also indicated nursing staff, at a minimum, will identify the reason for the reassessment, contributing factors and cause of the change of condition, interventions to address the risk and minimize a reoccurrence, and update the service plan as necessary to meet the client's needs.

Licensee policy titled, Monitoring of Clients and Their Services, updated August 18, 2020, indicated the licensee would reassess the client whenever the client returned from the hospital or has a change in condition. The licensee's policy indicated a change of condition assessment is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20297	A. BUILDING: ______ B. WING ______	C 03/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TFF CARE LLC	**3675 PLYMOUTH BOULEVARD, SUITE 100 MINNEAPOLIS, MN 55446**

(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
0 860	Continued From page 16 required when a client's cognitive or behavioral status is expected to last longer than 30 days and client's will be reassessed on an ongoing basis. Licensee policy titled, Assessment of Mental Status, updated August 1, 2014, indicated the licensee's nursing staff would initiate a mental status assessment as determined necessary. The licensee's policy indicated the assessment follow-up would be based on score, client's service level, and as determined necessary and appropriate by nursing staff. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 860		
02015 SS=D	626.557, Subd. 3 Timing of Report Subd. 3.Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe	02015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20297	A. BUILDING: ____ B. WING ____	C 03/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TFF CARE LLC	3675 PLYMOUTH BOULEVARD, SUITE 100 MINNEAPOLIS, MN 55446

(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
02015	Continued From page 17 that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the	02015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20297	A. BUILDING: ______ B. WING ______	C 03/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TFF CARE LLC	**3675 PLYMOUTH BOULEVARD, SUITE 100 MINNEAPOLIS, MN 55446**

(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
02015	Continued From page 18	02015		

licensee failed to immediately report (within 24 hours) to the Minnesota Adult Abuse Reporting Center (MAARC) for one of two clients (C1) reviewed. C1 had a dementia diagnosis, and the licensee staff permitted C1 to leave the licensee unsupervised. C1 sustained a physical injury which was not reasonably explained. The licensee did not report the incident to MAARC as required.

This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

Findings Include:

C1's medical record was reviewed. C1's medical diagnoses included, but were not limited to, senile dementia, spinal stenosis, dizziness, and positional vertigo.

C1's MnChoices assessment (Department of Human Services (DHS) assessment for clients needing long-term services and supports), dated January 30, 2020, indicated C1 needed daily assistance for increased vulnerability due to behaviors caused by C1's cognitive deficits. C1's assessment indicated, "someone always needs to be with [C1] to help with remembering, decision making or judgment when away from home." C1's assessment also indicated C1 scored 12 out of 30, which indicated moderate dementia.

C1's service plan dated February 10, 2020,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20297	A. BUILDING: ______ B. WING ______	C 03/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TFF CARE LLC	**3675 PLYMOUTH BOULEVARD, SUITE 100 MINNEAPOLIS, MN 55446**

(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
02015	Continued From page 19	02015		

indicated C1 required assistance with medication management, activities of daily living (ADLs), and daily safety checks. C1's service plan indicated staff were supposed to contact the nurse immediately if C1 could not be located.

C1's care plan dated September 1, 2020, indicated C1 required full medication management and set-up, needed physical help during an emergency, and was at risk for falling.

C1's Individual Abuse Assessment Plan (IAPP) dated September 1, 2020, indicated C1 was at risk of being abused. The licensee staff were to supposed to monitor for any signs of abuse and report to the registered nurse (RN) on-duty immediately. The RN on-duty would report any signs of abuse to MAARC. C1's IAPP indicated C1 required assistance with good decision making due to C1's lack of cognitive ability and memory impairment.

Review of C1's fall report date September 21, 2020, indicated C1 fell outside of the licensee's community unwitnessed, and C1 returned to the licensee with a facial injury (left orbital fracture). C1 was transported to the emergency room via ambulance, was treated, and returned to the licensee the same day. C1 did not recall falling. C1 did not have a history of falling. C1's fall report indicated a more secure environment would mitigate the risk of future falls.

During an interview on March 16, 2021, at 12:32 p.m., RN-D said a vulnerable adult is someone who could be taken advantage of compared to someone else. RN-D said typically a MAARC report would be filed for an unwitnessed fall, though RN-D was not aware if a report was generated for C1. RN-D said C1 did not receive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20297	A. BUILDING: ______ B. WING ______	C 03/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TFF CARE LLC	3675 PLYMOUTH BOULEVARD, SUITE 100 MINNEAPOLIS, MN 55446

(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
02015	Continued From page 20 routine assessments for her cognition. RN-D said after the fall incident, C1 was transferred to memory care. During an interview on March 16, 2021, at 1:35 p.m., director of nursing (DON)-B said C1 was confused. DON-B said staff reported C1 had on several occasions attempted to bring back unknown individuals with her to the licensee after C1 had been allowed to leave the licensee unsupervised. DON-B said C1 did not comprehend that she was not allowed to have people come back with her. DON-B said C1 reported she fell, though it would be difficult to differentiate if C1 fell or was assaulted based on her cognition. DON-B said the licensee did not report the incident to MAARC. During an interview on March 19, 2021, at 2:00 p.m., care coordinator (CC)-G said she was concerned C1 was allowed to leave the licensee unsupervised considering her moderate dementia diagnosis. During an interview on March 23, 2021, at 8:57 a.m., medical doctor (MD)-F said dementia is a chronic condition, and C1's cognition would worsen over time. MD-F said that C1's score of a 12 out of 30 on the MnChoices assessment indicated significant impairment. Review of the licensee policy titled, Vulnerable Adult Reporting and Investigation Policy, updated June 15, 2019, indicated the licensee's staff would report any suspected maltreatment to common entry point (CEP). The licensee's policy indicated staff would report any unexplained physical injury (unexplained bruises, skin tears, lacerations, or fractures) to common entry point. The licensee's policy also indicated if within	02015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20297	A. BUILDING: ______ B. WING ______	C 03/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TFF CARE LLC	**3675 PLYMOUTH BOULEVARD, SUITE 100** **MINNEAPOLIS, MN 55446**

(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
02015	Continued From page 21 twenty-four (24) hours following the initial incident report, if the Director of Healthcare and/or Executive Director remained unsure whether a reportable maltreatment had occurred, the Director of Healthcare or Executive Director would make a report to CEP. TIME PERIOD FOR CORRECTION: Seven (7) days.	02015		