DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL215741480M
Compliance #: HL215748964C

Date Concluded: March 6, 2024

Name, Address, and County of Licensee Investigated:
TFF Care LLC
4200 Lakeland Avenue North
Robbinsdale, MN 55422
Hennepin County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name:
Maerin Renee, 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 alleged perpetrator (AP), facility licensed staff, neglected the resident when the AP failed to timely assess the resident following a fall. This caused a delay in the resident's hospitalization, where he was diagnosed with a left hip fracture.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident had a fall in his room and was later admitted to the hospital for a fractured rib. Following the fall, the AP assessed the resident, the family was updated in the residents plan of care, and care was coordinated with the resident's primary care provider.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the family. The investigation included review of the resident records, hospital records, the facility internal

investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff interactions with residents in the facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia with behavioral disturbance, and unstable gait. The resident's service plan included assistance with activities of daily living, meals, and medication management. The resident's assessment indicated the resident was at risk for elopement, had a pattern of wandering, was at risk for falls, and his decision-making status was moderately impaired.

Review of the incident report for the resident's fall indicated the resident had fallen in the early morning hours, and the on-call nurse and family member were notified. The resident was able to move all extremities without pain, although a skin tear to his left elbow was noted. It was noted prior to the fall the resident had displayed increased confusion.

The residents progress notes indicated the day before the fall the resident had displayed increased confusion and declining cognition. The following day, early in the morning, the resident fell and sustained a small skin tear. Staff were instructed to take vital signs, complete an incident report, and call back with any concerns. Later that night, the AP was on call and was notified by staff the resident's ability to transfer did not seem as strong. The resident was talking and moving upper extremities, but transfers were difficult. The AP directed staff to make the resident comfortable and provide the resident with pain medication.

The progress notes indicated the following morning the AP documented she called to check on the resident's status. The AP was told transfers were not at baseline, and the AP called the resident's family member to discuss. The family member said she would visit that day to check on the resident. The AP visited the resident in his apartment, and he did not appear to be in pain as he sat in his recliner. The resident did not allow the AP to perform range of motion to his left leg. The resident's family member arrived later, and the resident's primary care provider ordered a urinalysis and urine culture, due to the resident's increasing confusion and possible infection. When labs were not going to be able to be completed in a timely manner, the primary care provider suggested the resident be sent to the emergency department for further evaluation. Later that night, the family member called the AP and informed her the resident was admitted to the hospital for a fractured hip. Progress notes indicated the resident did not return to the facility after his hospitalization but moved to a long-term care facility due to his need for a higher level of care.

Review of the facility's internal investigation indicated the nurse who was notified of the fall stated the resident did not complain of pain at the time of the fall. The AP, who was on call the following evening, stated she was informed that the resident's abilities were declining, and a call was placed to the family member. The family member wanted to come to the facility before any decisions were made and wanted to contact the resident's provider for an opinion. The internal investigation indicated staff followed the fall policy.

Review of hospital records indicated the resident had surgery for treatment of a left femur fracture. On x-ray, degenerative changes of both hips were noted. The resident was discharged to a skilled nursing facility in the care of hospice services. His rehabilitation potential was described as poor. Inpatient physical therapy (PT) documented the resident was limited by significant cognitive impairments. PT described the resident as impulsive, with poor safety awareness. Inpatient occupational therapy (OT) documented the resident was oriented to self only and presented with severe cognitive impairments that impacted motor planning and safety awareness.

When interviewed, the AP said she was on call and received a call from staff stating the resident was not able to transfer like he usually was. The previous day's fall was not reported to the AP, as that call had been taken by the previous day's on-call nurse. The AP worked the next day and checked on the resident. The AP said the resident was sitting in his recliner, in no apparent distress. The resident did not appear to want to be bothered, and given his cognitive status, the AP did not press the matter. The AP called the family member, who said she would visit the resident later that day. The AP had left for the day when the family member arrived, so the family member called her and said the resident was confused and did not want to get out of his recliner. The AP had staff check vital signs. The family member called the resident's primary care provider to assess for a possible urinary tract infection, and then it was decided the resident would go to the hospital for further evaluation.

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, unable due to cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
No action taken.

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
Robbinsdale City Attorney
Robbinsdale Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21574	A. BUILDING: _____ B. WING _____	C 01/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TFF CARE LLC	4200 40TH AVENUE NORTH ROBBINSDALE, MN 55422

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.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: #HL215748964C/#HL215741480M On January 17, 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 174 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL215748964C/#HL215741480M, tag identification 2310.	0 000		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date	02310		

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02310	Continued From page 1 service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview, and record review, the facility failed to ensure the care and services were provided according to a suitable and up-to-date plan, and subject to acceptable health care and medical, or nursing standards, for one of one resident (R1) with records reviewed. The facility failed to develop and implement new interventions related to the root cause of R1's multiple falls. This resulted in harm for R1 when R1 had repeated falls and was diagnosed with a rib 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). The findings include: R1's diagnoses included, but were not limited to, dementia and osteoarthritis. R1's service plan dated July 11, 2023, indicated the resident required staff assistance with activities of daily living (ADL's), medication management, meals, required reorientation due to forgetfulness, and needed staff assistance with safety checks. R1's 90-day assessment, dated November 15,	02310		

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2023, indicated R1 was independent with bed mobility, and was able to get into and out of bed without assistance. The assessment indicated the resident was independent with toileting and could take himself to the restroom. Conversely, per the assessment, staff were instructed to provide standby assist during transfers due to unsteadiness and high risk for falls. The assessment indicated R1 had a balance problem while standing, unsteadiness, and back pain, and was to always use a walker, and a wheelchair for long distances. The assessment indicated R1 required no special monitoring, yet staff were also instructed to monitor R1 for any unsafe activity and notify a nurse with concerns.

R1 Falls:

Fall 1:
An incident report dated September 3, 2023, at 7:30 p.m., indicated R1 was found by staff on his apartment floor. R1 stated he had fallen attempting to get into bed. The incident report indicated actions needed to be taken were "implementation of new intervention (new intervention to be put into client's service plan)." The incident report indicated "see assessment details" when prompted for the date of last change in condition/fall assessment by a registered nurse (RN). The date of the last new intervention implementation was August 16, 2023. The incident report lacked content regarding any new fall prevention intervention(s) that were provided. R1's last updated service plan was dated July 11, 2023. R1's last RN/fall assessment was dated August 16, 2023, with no concerns regarding transfers documented.

R1's progress note dated September 4, 2023, at 12:19 p.m., indicated R1 fell to the floor while

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getting into bed. R1 said his back hurt, but not from the fall. R1 was able to stand without any increase in pain. Staff took vital signs and notified a family member.

Fall 2:
An incident report dated September 18, 2023, at 7:50 p.m., indicated R1 was found by staff on his apartment floor. The fall was described as unwitnessed and there was no statement from R1 documented. R1 complained of pain to his left thumb. R1 was able to move all extremities without pain except his left thumb. The incident report indicated actions needed to be taken were "none." The incident report indicated "see assessment detail" when prompted for the date of last change in condition/fall assessment by a registered nurse (RN). When prompted to enter the date of the last new intervention implementation and description, staff documented "no new interventions." The incident report lacked content regarding any new fall prevention intervention(s) that were provided. R1's last updated service plan was dated July 11, 2023. R1's last RN/fall assessment was dated August 16, 2023, with no documented concerns regarding transfers.

R1's progress note dated September 19, 2023, at 10:17 a.m., indicated R1 was sent to the hospital for evaluation of left wrist pain, swelling, and no range of motion. R1's progress note dated September 19, 2023, at 2:00 p.m., indicated R1 returned to the facility with diagnosis of a broken left arm. R1's arm was placed in a splint, and he was to follow up with orthopedics as soon as possible.

Fall 3:
An incident report dated September 27, 2023, at

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2:30 p.m., indicated R1 was found by occupational therapy (OT) on his apartment floor. There was no statement from R1 indicating how he had fallen. The incident report indicated actions needed to be taken were "update to the fall risk assessment by an RN." The incident report indicated the date of last change in condition/fall assessment by an RN was October 2, 2023 (this was added to the incident report on October 18, 2023, at 12:58 p.m.). The date of the last new intervention implementation, description of intervention, was documented as October 2, 2023 (this was added to the incident report on October 18, 2023, at 12:58 p.m.). No description of interventions was documented. At the time of this fall, the most recent RN/fall assessment was dated September 23, 2023. There was no RN/fall assessment dated October 2, 2023 in R1's record. The incident report lacked content regarding any new fall prevention intervention(s) that were provided. R1's last updated service plan was dated July 11, 2023. R1's last RN/fall assessment prior to the fall was dated August 16, 2023, with no concerns regarding transfers noted.

R1's progress note dated September 27, 2023, at 2:54 p.m., indicated R1 was found on the floor by OT, and the fall was unwitnessed. R1's walker was documented as not being close to him, and he had unwrapped the elastic bandage on his left arm. R1 said he did not hit his head and did not complain of pain. No injuries were noted. OT rewrapped R1's arm.

Fall 4:
An incident report dated October 26, 2023, at 6:10 a.m., indicated R1 was found by staff on the floor in his apartment. He was unable to tell staff how he had fallen. The incident report indicated the last change in condition/fall assessment by an

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02310	Continued From page 5 RN was completed on August 16, 2023. The date of the last new intervention implementation, and description of the intervention, was documented as August 16, 2023. There was no documentation of a description of new interventions implemented. Action needed to be taken in response to the fall was documented as "update to the fall risk assessment by an RN." R1's last updated service plan was dated July 11, 2023. R1's last RN/fall assessment was dated August 16, 2023, with no concerns regarding transfers noted. R1's progress note dated October 26, 2023, at 6:43 a.m., indicated R1 was found on the floor between the dresser and his bed. R1's walker was not within reach. No concerns were noted. Fall 5: An incident report dated November 10, 2023, at 12:00 p.m., indicated R1 was found by staff on the floor in his apartment. R1 said he was walking and then he fell. The incident report did not indicate the last change in condition/fall assessment by an RN completed, only "see assessment details." The date of the last new intervention implementation, and description of the intervention was only documented as "see assessment details." There was no documentation of a description of new interventions implemented. Action needed to be taken in response to the fall was documented as "update to the fall risk assessment by an RN." R1's last updated service plan was dated July 11, 2023. R1's last RN/fall assessment was dated August 16, 2023, with no concerns regarding transfers noted. R1's progress note dated November 10, 2023, at 3:06 p.m., indicated R1 was found lying on the	02310		

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floor of his apartment. R1 said he was trying to walk, and he fell. No injuries were noted.

Fall 6:
An incident report dated November 14, 2023, at 6:45 a.m., indicated R1 was found by staff on the floor in the dining room. Staff heard R1 fall but did not see it. The incident report did not indicate the last change in condition/fall assessment by an RN completed, only "see assessment details." The date of the last new intervention implementation, and description of the intervention was only documented as "see assessment details." There was no documentation of a description of new interventions implemented. Action needed to be taken in response to the fall was documented as "update to the fall risk assessment by an RN." R1's last updated service plan was dated July 11, 2023. An RN/fall assessment was completed on November 15, 2023. R1 was upgraded to standby assistance as needed with transfers and instructed to always use a walker, and a wheelchair as needed.

R1's progress note dated November 14, 2023, at 6:41 a.m., indicated R1 was walking into another room, pushed the door, and fell. No injuries or pain were noted.

Fall 7:
An incident report dated November 17, 2023, at 1:00 a.m., indicated R1 was found on the floor when staff were doing rounds. R1 was able to move all extremities without pain, but staff noted a skin tear to his left elbow. The incident report did not indicate the last change in condition/fall assessment by an RN completed, only "see assessment details." The date of the last new intervention implementation, and description of the intervention was only documented as not

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applicable. There was no documentation of a description of new interventions implemented. Action needed to be taken in response to the fall, documented on November 28, 2023, at 9:14 a.m., indicated "will wait until resident return from hospital/TCU." R1's last updated service plan was dated July 11, 2023. R1's last RN/fall assessment was dated November 15, 2023.

R1's progress note dated November 18, 2023, at 8:08 a.m., indicating the on-call nurse received notice from staff on November 17, 2023, at 10:00 p.m., that R1's ability to transfer was not as strong as usual. R1 was moving his upper extremities but transferring to his recliner was difficult. A progress note dated November 18, 2023, at 9:10 a.m., indicated nurse received word that R1's transfers were not at baseline. A progress note dated November 18, 2023, at 2:40 p.m., indicated R1 would not let the nurse complete range of motion to his left leg. A progress note dated November 18, 2023, at 7:15 p.m., indicated R1 was sent to the hospital for further evaluation. A progress note dated November 19, 2023, at 2:54 p.m., indicated R1 was going to have surgery to repair a left hip fracture.

During an interview on January 17, 2024, at 1:20 p.m., registered nurse (RN)-A stated R1 did experience frequent falls, and interventions included R1 using a walker. The majority of R1's falls occurred in his apartment, so it was difficult to manage. On January 29, 2024, at 4:48 p.m., RN-A stated there were no additional RN/fall assessments for this timeframe, nor were there any changes to the service plan during this timeframe. The most recent individual abuse prevention plan (IAPP) was dated September 23, 2023.

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02310	Continued From page 8 The facility's Falls Prevention and Rection policy, dated August 1, 2021, indicated if a resident was assessed as being at a high risk for falls, the nurse would identify any needed interventions and work with the client and caregivers to incorporate interventions into the client's care/service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		