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 #: HL35508001M
Compliance #: HL35508002C

Date Concluded: May 16, 2022
Updated: November 16, 2023

Name, Address, and County of Licensee Investigated:
Comfort Keepers Twin Cities
275 4th Street E Suite 345
St. Paul, MN 55101
Ramsey County

Facility Type: Home Care Provider

Evaluator's Name: Nicole Myslicki, RN
Special Investigator
Amended By: Matt Heffron, JD

Finding: Inconclusive

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 alleged perpetrator (AP) emotionally abused the client when the AP came to the client's home under the influence and threatened to harm the client.

Investigative Findings and Conclusion:
Abuse was ~~substantiated~~ inconclusive. The AP was responsible for the maltreatment. The AP reportedly threatened to strangle the client while she worked under the influence of alcohol during her shift at the client's home, however there was conflicting information as to whom the AP was speaking.

The investigation included interviews with facility staff members, including administrative staff and unlicensed staff. The investigation included review of the client's medical record. The investigation included review of the facility's policies and procedures related to workplace practices including alcohol and illegal drug use. The investigation also included review of the AP's personnel file. In addition, the investigator contacted law enforcement and reviewed the law enforcement report.

The client's diagnoses included Alzheimer's disease. The client received services in his home including meal preparation, light housekeeping, and organization. An assessment identified the client as independent with dressing and grooming, transfers, and toileting. The client required assistance with cooking and preparing food, bathing reminders and supervision, and redirection. An individual abuse prevention plan (IAPP) identified the client as vulnerable to physical abuse due to the client being unable to deal with verbally or physically aggressive persons.

A law enforcement report indicated the client went to a neighbor's house and asked him to call the police. The report indicated a neighbor overheard the AP threaten to strangle the client if she had to return to the house. The report described the AP as acting erratically, fidgeting, picking at her fingers, and displaying jerking movements under her eyes. The AP had a blood alcohol level of .212 and admitted to drinking vodka. The AP's spouse picked her up from the client's home, and neighbor looked after the client for the evening.

An incident report indicated the AP came to the client's home for her shift under the influence of alcohol and became aggressive. Law enforcement notified the facility of this incident. The facility removed the AP from the existing schedule pending investigation.

An email sent by the AP that same evening indicated she resigned.

During an interview, administrator-1 stated law enforcement contacted the facility from the client's home to report the client called law enforcement from a neighbor's house. Administrator-1 stated law enforcement reported the AP appeared to be under the influence of something, noted no physical harm, but the AP had been acting verbally aggressive to the client. Administrator-1 stated law enforcement stayed at the client's house until the AP's spouse picked up the AP. Administrator-1 stated administrator-2 worked a shift at the client's home the next day and talked with the client.

The facility's staff schedule indicated administrator-2 worked with the client the evening after the incident.

During an interview, administrator-2 stated the client remembered the incident during their conversation the following day but did not appear visibly distraught.

A facility policy titled Alcohol and Illegal Drug Use prohibited the consumption of alcohol while directly responsible for clients. The AP signed a position description which included the essential function of providing a safe and healthy environment for clients.

During an interview, the AP stated one of her duties included ensuring the client remained safe at home. The AP stated she drank vodka prior to her shift at the client's home and drank a glass

of wine with him at dinner. The AP stated the decision was against her better judgement and only happened one time. The AP denied threatening to strangle or choke the client.

During an interview, the neighbor stated she frequently visited the client, assisted with finances, and drove the client to appointments. The neighbor stated during one visit, the AP smelled of alcohol. The neighbor stated the AP would "freak out" and "go off the deep end" about things. The neighbor stated the client drank alcohol only on a rare occasion while at a restaurant and never kept alcohol in his house. Regarding the incident, the neighbor stated the client confided in her, stating the AP got mad at him, yelled at him, and tried to choke him. The neighbor stated she found a small, empty bottle of alcohol in the client's trash can the night of the incident.

During an interview, the client's family member stated the client became fearful for his safety after the AP began to "act strangely and totally inappropriate" at the client's home. The family member stated the client could not clearly express what exactly happened, except the language he heard was inappropriate and threatening. The family member stated the client has not expressed any fear or distrust of the other staff. The family member stated a general satisfaction with the facility and acted in the client's best interest.

Subsequent information from witnesses indicated the AP may have been speaking to someone else, on the phone, and not to the VA or anyone else physically present, when she threatened to strangle someone.

In conclusion, abuse was ~~substantiated~~ inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

Vulnerable Adult interviewed: No. The client declined to interview.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The AP was no longer employed by the facility. The facility created instructions for the caregivers to implement in case the AP returned to the client's home.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Washington County Attorney
Newport City Attorney
Washington County Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H35508	A. BUILDING: _____ B. WING _____	C 04/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT KEEPERS - TWIN CITIES	275 E 4TH STREET, STE 345 SAINT PAUL, MN 55101

(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****** AMENDED HOME CARE PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144A.43 to 144A.482, these correction orders are issued pursuant to a complaint investigation. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: HL35508001M/HL35508002C From April 8-26, 2022, the Minnesota Department of Health conducted a complaint investigation at the above provider, and a correction order was issued. At the time of the complaint investigation, there were 22 clients receiving services under the provider's Comprehensive license. On November 16, 2023, the correction orders were amended. As a result of the change, there are no correction orders for HL35508001M/HL35508002C.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the 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. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2).	