Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints
Investigative Public Report

Maltreatment Report #: HL20297066M
Compliance #: HL20297067C

Date Concluded: December 4, 2019

Name, Address, and County of Licensee Investigated:
TFF Care LLC
4200 40th Avenue North
Robbinsdale, MN 55422
Hennepin County

Name, Address, and County of Housing with Services location:
Copperfield Hill: The Lodge
4020 Lakeland Avenue North
Robbinsdale, MN 55422
Hennepin County

Facility Type: Home Care Provider

Investigator's Name: Paul Spencer, RN
Special Investigator

Finding: Substantiated, facility and individual 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 the client when the facility failed to provide supervision resulting in the client leaving the facility without supervision.

It is alleged: The alleged perpetrator (AP) neglected the client when the AP failed to provide supervision and falsely documented cares resulting in delayed identification the client left the facility.

Investigative Findings and Conclusion:
The neglect was substantiated. The facility and the AP were responsible for the maltreatment. The facility failed to identify the client as missing from the building for approximately 11 hours. The AP failed to provide evening cares and a reassurance check to the client.

The investigation included interviews with facility staff members, including administrative staff, nursing staff and unlicensed staff. The investigation included an onsite visit with observations and interviews with clients. The investigation included a review of client medical records and pertinent policies.

A review of the client's medical record indicated she admitted to a secured memory care unit at the facility in the morning the day the elopement occurred. The client's medical diagnoses included Alzheimer's disease and diabetes. The client's medical record indicated she was alert and oriented to name only.

The client's service plan indicated she required assistance to get ready for bed at 9:00 p.m. Additionally, the client's service plan indicated she required reassurance checks throughout the day to ensure her safety and well-being; these times included 12:00 midnight, 4:00 a.m., 6:00 a.m. and 10:15 p.m.

Review of facility documentation indicated the client left the secured memory care unit at approximately 8:00 p.m. by getting onto the elevator when a visitor, a spouse of a different client, left the unit and mistook the client as a visitor. The client took the elevator to the first floor and then walked out of the facility. At that time, the facility staff did not realize the client had left the facility. Within the next hour, the police found the client wandering the streets, but the client did not know where she lived therefore they brought her to the hospital. The client's hospital medical records indicated she arrived at the hospital at 8:59 p.m.

Further review of facility documentation indicated the AP, an unlicensed personnel (ULP) assigned to the client's cares at that time, falsely documented helping the client get ready for bed at 9:11 p.m. Additionally, the AP falsely documented completing the client's reassurance check scheduled for 10:15 p.m. at 9:12 p.m. Evening shift failed to communicate to the next shift (night shift) the client had admitted to the facility. Therefore, ULP-P (the night staff member) could not locate the client for the 12 midnight and the 4:00 a.m. reassurance checks and ULP-P documented the client had not admitted yet and failed to clarify with the nurse. When the day shift caregiver, ULP-Q, attempted to complete the 6:00 a.m. reassurance check, she could not locate the client. ULP-Q notified a registered nurse (RN-C). At approximately 7:15 a.m., (eleven hours after the client left the secured memory care unit) the facility identified the client as missing and initiated a search.

During an interview, RN-C stated she arrived at approximately 7:15 a.m. when the staff alerted her that the client could not be located. After initiating a search and calling the client's family, 911, and the facility management, she did locate the client at a local hospital. She learned police found the client wandering outside the previous evening and they brought her to the hospital. Upon reviewing security camera footage focused on the unit elevator, RN-C stated

she learned the client left the unit at approximately 8:00 p.m. the previous evening. RN-C stated the elevator required a code to enter, but the camera showed a visitor left the unit and the client got on the elevator with her. RN-C stated she later learned the visitor did not realize the client was a client living at the facility so she did not alert staff. RN-C stated she realized the AP falsified documentation when the AP documented completing cares for the client when the camera showed the client had already left the unit. RN-C also stated that no one from the evening shift reported to ULP-P the client had admitted. RN-C added that ULP-P should have contacted the on-call nurse, but did not (because care tasks generated for the client).

During an interview, the AP stated she worked the evening shift the day the client admitted to the facility. The AP stated when she completes reassurance checks she observes the resident by looking at and observing them. The AP stated she thought the client was in her room, but did not perform the reassurance check although she documented the reassurance check as complete. The AP stated she also documented cares she did not provide for the client. The AP did not know the client had left the facility. The AP stated she and her co-worker, ULP-H, did not do rounds and she was very tired that shift. The AP also stated she made a mistake by not the telling the night shift the client admitted to the facility.

During an interview, ULP-H stated she did work with the AP when the client left the facility unsupervised. ULP-H stated she did not communicate to the night shift that the client admitted and that was an error. ULP-H also stated the client's admission was not included in the communication book.

The facility reviewed and updated its policies and procedures for ensuring clients do not leave the facility unsupervised. The facility changed how visitors enter and exit the secured memory care unit. The facility also revised how new admissions are communicated from shift-to-shift. The AP is no longer employed at the facility.

In conclusion, neglect was substantiated.

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: No; unable to interview due to cognitive loss.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility reviewed and updated its policies and procedures for ensuring clients do not leave the facility unsupervised, along with how visitors enter and exit the secured memory care unit. The facility also revised how new admissions are communicated from shift-to-shift. The facility no longer employs the AP.

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. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

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

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 10/15/2019

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 October 14 and 15, 2019, the Minnesota Department of Health initiated an investigation of complaints HL20297065C, HL20297066M/HL20297067C, HL20297068M/HL20297069C, HL20297070M/HL20297071C and HL20297072M/HL20297073C. No citation are issued for HL20297065C and HL20297068M/HL20297069C. At the time of the survey, there were 227 clients receiving services under the comprehensive license. The following correction order is issued for HL20297066M/HL20297067C, HL20297070M/HL20297071C and HL20297072M/ HL20297073C, tag identification 0325.	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.	

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0 325 SS=G	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights: (14) the right to be free from physical and verbal abuse, 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 interview and document review, the licensee failed to ensure two of four clients reviewed (C1 and C2) were free from maltreatment. The facility neglected C1 when C1 left the secured memory care unit unsupervised and facility staff failed to identify C1 as missing for approximately 11 hours. The facility neglected C2 when C2 fell in her room and used her pendent to call for help; however, facility staff failed to respond to the pendent call for approximately seven hours during which C2 laid on the floor; C2 sustained a right humerus (arm) fracture from that fall. 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 for C1 include:	0 325		

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0 325	Continued From page 2 C1's medical record indicated she admitted on July 18, 2019, to the facility onto a secured memory care unit with diagnoses including Alzheimer's disease, diabetes, and hypertension. C1's was alert and oriented to name only. C1's progress note dated July 18, 2019, indicated C1's family brought her to the facility that morning. C1's service plan dated July 18, 2019, indicated C1 required assistance to get ready for bed scheduled at 9:00 p.m. daily. C1's service plan also indicated C1 required reassurance checks at 12:00 a.m. (midnight), 4:00 a.m., 6:00 a.m., and 10:15 p.m. daily. C1's services delivered report dated July 18, 2019, at 9:11 p.m., indicated unlicensed personnel (ULP)-E provided C1 assistance with evening cares scheduled for 9:00 p.m. C1's services delivered report dated July 18, 2019, at 9:12 p.m., indicated ULP-E completed C1's reassurance checked scheduled for 10:15 p.m. C1's service delivered report dated July 19, 2019, at 12:49 a.m., indicated ULP-P did not complete C1's reassurance check scheduled for 12:00 a.m. because C1 had not moved into the facility. C1's service delivered report dated July 19, 2019, at 4:38 a.m., indicated ULP-P did not complete C1's reassurance check scheduled for 4:00 a.m., because C1 had not moved into the facility. C1's service delivered report dated July 19, 2019, at 12:57 p.m., indicated ULP-Q did not complete C1's reassurance check scheduled for 6:00 a.m.	0 325		

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0 325	Continued From page 3 because C1 was not available. C1's progress notes dated July 19, 2019, at 7:46 a.m., indicated staff alert registered nurse (RN)-C that C1 could not be located on the unit or in the facility. RN-C notified C1's family, facility management, and called 911; the progress note further indicated C1 went to the hospital. Facility camera footage indicated C1 left the facility when she got on the elevator with the spouse of another client and left the unit. C1's hospital records dated July 19, 2019, at 11:02 a.m., indicated C1 presented to the hospital on July 18, 2019, at 8:59 p.m. after the police found C1 wandering the streets. During an interview on October 15, 2019, at 2:40 p.m., RN-C stated she arrived at approximately 7:15 a.m. on the morning of July 19, 2019, when the staff alerted her C1 could not be located. After initiating a search and calling C1's family, 911, and the facility management, she did locate C1 at a local hospital. She learned then, the police found C1 wandering outside the previous evening and since she could not state where she lived, they brought her to the hospital. Upon reviewing security camera footage focused on the unit elevator, RN-C stated she learned C1 left the unit at approximately 8:00 p.m. on July 18, 2019. RN-C stated the elevator required a code to enter, but the camera showed a visitor left the unit and C1 got on the elevator with her. RN-C stated she later learned the visitor did not realize C1 was a client living at the facility so she did not alert staff. RN-C stated she realized ULP-E falsified documentation when she documented completing cares for C1 when the camera showed C1 had already left the unit, therefore C1 was not present to receive cares or reassurance	0 325		

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0 325	Continued From page 4 checks. RN-C also stated no one from the evening shift reported to ULP-P C1 admitted. RN-C added ULP-P should have contacted the on-call nurse, but did not. During an interview on October 15, 2019, at 3:15 p.m., director of nursing (DON)-A stated she viewed the security camera footage showing C1 enter the elevator with the visitor and leave the memory care unit on July 18, 2019 at approximately 8:00 p.m. DON-A also stated she also viewed footage showing C1 get off the elevator on the first floor as she left the building. DON-A stated ULP-E falsely documented providing cares and a reassurance check for C1 after C1 had already left the building. DON-A further stated the evening shift did not communicate C1 admitted and ULP-P. DON-A stated ULP-P should have contacted the on-call nurse, but did not. DON-A stated the facility staff did not become aware of C1's absence until approximately 7:00 a.m. nearly 11 hours after C1 left. DON-A stated C1 was located at a hospital and returned to the facility. During an interview on November 13, 2019, at 9:30 a.m., ULP-E stated she worked the evening shift the day C1 admitted to the facility. ULP-E stated when she completes reassurance checks she observes the resident by looking at and observing them. She stated she thought C1 was in her room, but did not perform the reassurance check. ULP-E also stated she made a mistake when she did not tell the night shift C1 admitted to the facility. During an interview on November 14, 2019, at 10:10 a.m., ULP-H stated she worked with ULP-E when C1 left the facility unsupervised. ULP-H stated she did not communicate to the night shift	0 325		

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0 325	Continued From page 5 C1 admitted and that was an error. ULP-H also stated C1's admission was not included in the communication book. A review of ULP-E's personnel file included a document titled Educare Knowledge Assessment-Observing, Reporting, & Documenting Client Status dated April 3, 2019, indicated the facility trained ULP-E that falsifying information on client documents is not only a bad practice but also a criminal offense. A review of ULP-E's personnel file included a document titled Educare Knowledge Assessment-Problem Solving & Elopement dated April 3, 2019, indicated the facility trained ULP-E when wandering turns to elopement this is a significant problem that requires immediate attention. A facility-provided policy titled Missing Client dated August 6, 2018, indicated when a client is not where they can be reasonably be expected to be, staff promptly implement the missing client procedure. The procedure included notifying the nurse and initiation of a prompt and thorough search for the client. The findings for C2 include: C2' medical record indicated C2's medical diagnoses included chronic kidney disease, glaucoma, and dementia. C2 walked independently in her room and used a pendant to call facility staff for help as needed. C2's service plan dated August 1, 2019, included assistance with compression stockings twice a day, meal delivery three times a day and medication administration four times a day.	0 325		

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0 325	Continued From page 6 A review of the facility's documentation regarding this incident indicated staff found C2 at approximately 8:30 a.m.on the morning of August 4, 2019. C2's progress notes dated August 4, 2019, at 1:34 p.m., indicated a ULP found C2 on the floor in her apartment complaining of back, left leg, and right hand pain. The facility sent C2 to hospital for evaluation. C2's hospital record's indicated C2 received treatment for a right humerus (arm) fracture during the fall. An Alarm Response Report provided by the facility indicated C2's pendant activated at 1:55 a.m. on August 4, 2019 and cleared at 9:21 a.m. on August 4, 2019. During an interview on October 15, 2019, at 3:15 p.m., director of nursing (DON)-A stated the facility conducted an internal investigation into C2's fall and the delayed response to C2's pendant. DON-A stated C2 fell in her room overnight and could not get up so C2 activated her pendant to call facility staff for help, but none of the night shift staff responded. DON-A stated C2 had been on the floor for more than six hours, until day shift found her. The facility sent C2 to the hospital and later learned C2 sustained a right arm fracture from her fall. DON-A stated the facility determined from the time C2 activated her pendant along with C2's narrative that she laid on the floor most of the night. DON-A explained when a pendant activates, it sends a message to facility staff every 10 minutes for 50 minutes via pagers; after that the pages stop, but the pendant remains active in the system until someone clears it. DON-A stated there were two staff members who received the page: ULP-G and	0 325		

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0 325	Continued From page 7 ULP-R. DON-A stated ULP-G had responsibility to respond to the pendant because ULP-G's assignment included C2. DON-A added ULP-R's assignment was in a different building and did not include C2; however, ULP-R should have contacted ULP-G via walkie-talkie when the page went off multiple times. DON-A stated both employees claimed they did not see the page. However, the facility did not identify any malfunction in the pendant or pager system. Finally, DON-A stated she reviewed security camera footage that showed ULP-G spending a lot of her shift down in a nurse's office located on the lower level when she should have been rounding on the floors including the third floor where C2 lived. DON-A stated the facility terminated ULP-G's employment. During an interview on November 14, 2019, at 10:49 a.m., executive director (ED)-J stated he reviewed the security camera footage regarding the investigation involving C2. ED-J stated the footage showed ULP-G spent a lot of her shift down in the nurse's office on the lower level of the building. A review of the facility's schedule dated August 3, 2019, indicated ULP-G was assigned to the area C2 lived starting at 10:00 p.m. and ending the next morning at 6:30 a.m. A review of the facility's payroll information indicated ULP-G punched in to begin work at 10:12 p.m. on August 3, 2019 and punched out at the end of the shift the next morning at 6:45 a.m. on August 4, 2019. During an interview on November 13, 2019, at 3:15 p.m., ULP-G stated she did not know C2 fell and she did not see the pendant come over her	0 325		

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0 325	Continued From page 8 pager. ULP-G stated she received other pendant messages on her pager, but she did not see this one. ULP-G stated she did rounds on three floors every two hours: the lower level, third floor, and fourth floor, but C2 was not included in the assigned rounds. ULP-G stated no one told her about C2's falls until days later. ULP-G stated she did not spend time downstairs in the office that shift, because she was upstairs answering pages. During an interview on November 14, 2019, at 12:20 p.m., C2's family member stated she discussed the incident with C2. The family member stated C2 said that when she fell she hurt too much to move and that she yelled for help but no one came. C2 felt ignored and resigned that she may die there on the floor. During an interview on November 15, 2019, at 1:45 p.m., C2 stated she fell in her apartment and she laid on the floor until morning. C2 stated she remembered laying on the floor for a long time, but no one came to help. She remembers being cold and in pain until someone finally came hours later in the morning. A facility-provided report titled Chore Recap by Chore Type dated August 3, 2019, at 10:00 p.m. indicated ULP-G acknowledged for the night shift from 10:00 p.m. to 6:30 a.m. that "[a]ll pendant pushes must be answered immediately. If you are unable to respond to a pendant immediately you must walkie other staff to respond. All staff are expected and required to assist in responding to pendants". A review of ULP-G's personnel file indicated ULP-G signed a position description that included the statement "respond promptly to all pendant pushes" on May 7, 2019. ULP-G's personnel file	0 325		

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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 9 included documentation of training regarding walkie-talkie use dated May 7, 2019. A facility-provided policy titled Pendant Response dated April 23, 2018, indicated when a pager goes off, staff who are responsible for that resident are to respond immediately to the resident who is paging. The same document indicated staff respond to all pendants in 15 minutes or less; staff who do not respond to pendant calls within 15 minutes will be required to provide information as to the reason for the delayed response. The same document also indicated if the responsible staff is unable to the pager, the responsible staff must use a phone or walkie to contact other staff to ask them to respond. A facility-provided policy titled Vulnerable Adult Reporting and Investigation Policy dated March 1, 2016, indicated suspected cases of abuse, neglect, or financial exploitation will be investigated in accordance with state and federal vulnerable adult laws. TIME FOR CORRECTION: SEVEN (7) DAYS	0 325		