Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL379602862M
Compliance #: HL379604739C

Date Concluded: May 2, 2023

Name, Address, and County of Licensee Investigated:
Twins Home Care Service
13413 Parkwood Drive
Burnsville MN, 55337
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, 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) abused a resident when she poked and taunted the resident with a needle which caused physical pain, and emotional distress.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The resident said the AP did not poke him with a needle.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of resident records, employee files, and police reports. Also, the investigator toured the facility and observed staff interactions with other residents.

The resident resided in an assisted living facility. The resident's diagnoses included multiple personality disorder, depression, and anxiety. The resident's service plan included assistance

with dressing, grooming, bathing, housekeeping, laundry, medication, mobility, and meals. Also, the resident required assistance for behavior management and physical aggression. The resident's nursing assessment indicated the resident was able to communicate verbally and make his needs known to staff. The resident used an electric wheelchair and moved it by himself. The resident left the facility independently for outings or appointments.

The resident's progress notes indicated the resident was yelling and threatening staff regarding a heater in his room. The progress notes indicated the resident called 911 three times during the day for various reasons.

During an interview, the AP said the resident had aggressive behaviors including fighting, screaming, stealing, and starting fires. The AP said the resident's usual behavior was to call 911 and make untrue claims about the AP or facility staff. The resident would also request to go to the hospital frequently. The AP said she spoke to the resident's physicians about his behavior and attended care conferences with hospital physicians and case workers. The AP said she had a meeting with the resident and his family members regarding discharging the resident from the facility, but the resident agreed to change his behavior and attend counselling. The AP said the resident did not follow the physician's orders for medication or treatment management and his behavior escalated. The AP said there were no needles at the facility and dialysis staff performed all blood draws for the resident. The AP denied poking the resident with a needle and said no one reported to her there was a concern about it. The AP denied hitting, kicking, or poking the resident. The AP denied restricting the resident's movement.

During an interview, the resident said the AP did not poke him with a needle. The resident said he and the AP were arguing and the AP had an ink pen, or pencil, in her hand and was touching him. The resident said he moved his chair around so he could "fight back". The resident said the AP pulled her hands back and he thought the AP was going to stab him with the pen. The resident said he rolled his wheelchair into position so he could roll over her if she hit him. The resident said the AP had not done this before. The resident said the AP did not hit, or stab him with a pen, or needle. The resident said he was living in the hospital currently and not returning to the facility.

On the day of the incident, law enforcement records indicated the resident called 911 three times, but law enforcement did not write reports related to those calls. In addition, law enforcement received a call from the resident the day before. After the incident, law enforcement records indicated the resident continued to call 911 but there were inconsistencies in the resident's explanation of events.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2
"Abuse" means:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(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;
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: No. Family did not return calls.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility coordinated care with other service providers.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment. 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
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37960	A. BUILDING: _____ B. WING _____	C 04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWINS HOME CARE SERVICE LLC	13413 PARKWOOD DRIV BURNSVILLE, MN 55337

(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****** 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: #HL379604739C/#HL379602862M On April 14, 2023, 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 four residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL379604739C/#HL379602862M, tag identification 470.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License 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 144G.31 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 1 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the required staffing plan was developed, implemented, and evaluated for appropriateness of staffing levels as required. The licensee failed to ensure the staffing schedule was posted as required, potentially affecting all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 470		

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0 470	Continued From page 2 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On April 14, 2023, at 9:10 a.m., surveyor toured licensee's facility and did not notice a posted staffing plan or daily schedule. On April 14, 2023, at 9:29 a.m., unlicensed personnel (ULP)-B said the daily schedule was not posted. ULP-B said her schedule was in her phone. ULP-B said a manager sent her a text with her scheduled days and hours. ULP-B showed surveyor the text message with her hours and days listed. ULP-B said she was unaware of the schedule for other staff and said she would call a manager if she needed help with a mechanical lift. ULP-B said she has used the ceiling lift by herself. ULP-B said there was one resident currently who required a mechanical lift transfer. On April 14, 2023, at 10:01 a.m., ULP-C provided surveyor with a calendar and a staffing plan policy. ULP- C said, "it was hiding". The calendar failed to identify the month or year. The calendar listed scheduled shifts, but failed to identify the staff members working. The calendar indicated there would be a registered nurse (RN) every night from 11 p.m. to 7 a.m. The calendar indicated there was only one ULP scheduled each shift. The calendar indicated there were "gaps" in staff coverage. An example: Monday, no date, ULP 8-4, ULP 4-10, RN 11-7. The calendar	0 470		

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0 470	Continued From page 3 indicated there was no staff coverage for one hour between shifts 7:00 a.m. to 8:00 a.m., and 10:00 p.m. to 11:00 p.m. The staffing plan, no date, indicated one ULP would work 7:00 a.m. to 3:00 p.m., 3:00 p.m. to 11:00 p.m., and 11:00 p.m. to 7:00 a.m. The staffing plan indicated schedules would be posted in a central location in each building so that it was accessible to staff, residents, volunteers, and the public. The staffing plan indicated, "Names of staff will be redacted before posting." On April 14, 2023, at 11:40 a.m., registered nurse (RN)-A, said all Hoyer lifts or ceiling lifts required two staff for use. RN-A said one ULP worked during the night hours and would call a manager if they needed to use a mechanical lift. RN-A said the staffing plan was,"2, 2, 1." RN-A said she was the only nurse for both licensee's buildings. RN-A said she was on call 24-7. RN-A said she was generally in the building from 7:00 a.m. to 7:00 p.m. Licensee's, 4.06 staffing and scheduling Policy, dated October 10, 2021, indicated the daily staffing schedule would identify direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked and resident assignments. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		