Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL385389185M
Compliance #: HL385386744C

Date Concluded: May 2, 2024

Name, Address, and County of Licensee Investigated:
American Family Care LLC
1074 139th St East
Rosemount, MN 55068
Dakota County

Facility Type: Home Care Provider

Evaluator's Name:
Lisa Coil, RN Special Investigator

Finding: Inconclusive

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 facility neglected the client when the facility did not refill the client's medications. The client ran out of medications, had a seizure, and was hospitalized.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although the client may have missed some medications, there was conflicting information about who was responsible for monitoring and re-ordering the different types of medications.

The investigator conducted interviews with facility administrative staff. The investigator contacted the client and the client's case manager. The investigation included review of the client's record and related facility policy and procedures.

The client received comprehensive home care services. The client's diagnoses included history of traumatic brain injury and seizures. The client's service plan included assistance with medication set-up and re-ordering.

The client's assessment indicated the client was alert and oriented. The medication section of the assessment indicated the client could read medication names and dosages, knew what the medications were for, knew when to take the medications, was able to report symptoms, was able to pour liquids, could administer eye drops, and could administer inhaled medications. The assessment further indicated the client sometimes needed reminders to take medications on time, needed some assistance to open containers, and needed help to administer ear drops, injections, and suppositories.

The medication set-up and re-order record indicated the client was independent for liquids, inhalers, nasal sprays, powders, suppositories, and as needed medications. The record indicated a nurse initialed boxes for six oral medications from the start of services for approximately six weeks. However, the document also included a note which indicated the client had a former nurse, not employed by the licensee, set-up medications for one week during that time.

Skilled care notes indicated a nurse assessment was completed on the first day of service, on week three, four, five, and six. The sixth assessment was completed on the last day services were provided to the client.

During an interview, the client stated a nurse was supposed set-up and re-order medications. The client stated a nurse came and set up medications two times and never came again. The client stated she ran out of medications and would have to call family and/or friends to help refill medications. The client stated she was hospitalized overnight because she ran out of seizure medication during the time the licensee was providing services to her.

During an interview, an administrative staff member stated the client received nursing services for assessments and medication set up. The administrative staff member stated the client was on liquid and powder medications which were not possible to be set-up, so the client was independent with those. The administrative staff member stated since the client was independent with the refrigerated liquid medications, the client was responsible to notify the nurse if those medications needed to be refilled; sometimes the nurse would also check the supply on hand. The administrative staff member stated the nurse completed medication set-up every week, except the week the client had another nurse do it, until about week six when the client told them not to come to her home anymore.

In conclusion, the Minnesota Department of Health determined neglect was 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.

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: Yes.
Family/Responsible Party interviewed: No.
Alleged Perpetrator interviewed: N/A.

Action taken by facility:
No action required.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H38538	A. BUILDING: _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN FAMILY CARE LLC	1074 139TH STREET EAST ROSEMOUNT, MN 55068

(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 CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, 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: #HL385386744C/#HL385389185M On April 4, 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 22 clients receiving services under the provider's Comprehensive Home Care license. The following correction order is issued/orders are issued for #HL385386744C/#HL385389185M, tag identification 0340.	0 000	Home Care Provider 144A. Minnesota Department of Health is documenting the State 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 evaluators' 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)	

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0 340	Continued From page 1	0 340		
0 340 SS=D	144A.44, Subd. 1(a)(17) Advance Notice of Changes at least ten days' advance notice of the termination of a service by a provider, except in cases where: (i) the client engages in conduct that significantly alters the terms of the service plan with the home care provider; (ii) the client, person who lives with the client, or others create an abusive or unsafe work environment for the person providing home care services; or (iii) an emergency or a significant change in the client's condition has resulted in service needs that exceed the current service plan and that cannot be safely met by the home care provider This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide at least ten calendar days advance notice of the termination of services for one of one client (C1). 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). The findings include: C1's record indicated the client began receiving services from the licensee on September 16, 2023, due to diagnoses that included traumatic brain injury and seizures.	0 340		

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0 340	Continued From page 2 C1's service agreement signed on September 16, 2023, indicated C1 received services from the licensee that included skilled nursing visits and homemaker services. The service agreement indicated the skilled nursing visits included nursing assessments and medication set-up. C1's client intake form dated September 15, 2024, indicated C1 needed assist with medication set-up and re-ordering; G/J tube management: feedings, medications, flushing, dressings changes; putting on AFO braces, TED socks and shoes; changing bed linens, cleaning bathroom, and doing laundry. An email correspondence dated October 31, 2024, at 11:26 a.m., from one of the licensee's owners (O)-A to C1's case manager (CM)-C, indicated the licensee was suspending C1's services starting October 31, 2024, due to unpaid bills. During an interview on April 4, 2024, at 1:30 p.m., O-A stated the licensee worked with the client for 45 days without getting paid. O-A stated the licensee communicate with CM-C and C1 about discharge throughout October because the licensee could not continue to provide services without pay; however the licensee continued nursing services through October 20, 2023. O-A also stated the licensee never really discharged C1 but on October 31, 2023, CM-C told the licensee to just end services for C1 as she had found a personal care assistant. During an interview on April 12, 2024, at 2:30 p.m., C1 stated a nurse was supposed to come once or twice a week to set up medications. C1 stated there were times a nurse never even came	0 340		

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0 340	Continued From page 3 once a week because the licensee was not getting paid for services. C1 stated the second time the homemaker came, C1 sent her home early and a homemaker never came again. C1 stated the licensee told her if she could not use the homemaker for the total number of hours scheduled then they could not send a homemaker to her home. C1 further stated the licensee completely stopped coming, and she had to have someone else come and fill her medications. C1 stated she never received a notice of termination of services. The licensee-provided Minnesota Home Care Bill of Rights for Clients of Licensed Only Home Care Providers, dated December 2019, indicated on page one, number 17, a client who receives home care services in the community has a right to at least a ten-day advance notice of the termination of a service by a provider. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		