Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

December 16, 2022

Administrator
BAYADA HOME HEALTH CARE INC
3033 Campus Drive, #E280
PLYMOUTH, MN 55441

RE: Event ID: 5E5AB-H1

Dear Administrator:

An extended survey was completed at your agency on December 2, 2022 for the purpose of assessing compliance with Federal certification regulations. At the time of survey, the survey team from the Minnesota Department of Health, Health Regulation Division noted one or more deficiencies and found that your agency was not in substantial compliance with the participation requirements. The findings from this survey are documented on the electronically delivered form CMS 2567.

At the time of this survey, it was determined that the following Condition of Participation was found not met:

G700 42CFR 484.75 Skilled Professional Services

Since these deficiencies limit your capacity to provide adequate care to patients, you must respond within ten calendar (10) days with your plan of correction. The plan must be specific, realistic, include the date certain for correction of each deficiency and be signed and dated by the administrator or other authorized official of the agency. An acceptable plan of correction must contain the following elements:

The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited;

- **The procedure for implementing the acceptable plan of correction for the specific deficiency cited;**

- What correction action(s) will be accomplished for those patients found to have been affected by the deficient practice;
- How you will identify other patients having the potential to be affected by the same deficient practice and what corrective action will be taken;

- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements, i.e., what quality assurance program will be put into place;
- The title of the person responsible for implementing the acceptable plan of correction; and,
- The date by which the correction will be completed.

If your agency has failed to achieve compliance by the date certain, sanctions including but not limited to fines of up to $10,000.00 per day, may be recommended for imposition to the Centers for Medicare and Medicaid Services (CMS) Regional Office. Informal dispute resolution (IDR) for the cited deficiencies will not delay imposition of any recommended enforcement actions. A change in the seriousness of the noncompliance at the time of the revisit may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

The plan of correction should be directed to:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

Failure to submit an acceptable written plan of correction of Federal deficiencies within ten calendar days of your receipt of this notice may result in imposition of sanctions, decertification and/or a loss of Federal reimbursement. Additionally, your continued certification is contingent upon corrective action. If, upon a revisit within forty-five (45) days of the survey exit date, correction is not ascertained, we will have no recourse except to recommend to the Centers for Medicare and Medicaid Services Chicago Region V Office that sanctions be imposed.

HOME HEALTH AIDE TRAINING AND/OR COMPETENCY EVALUATION PROHIBITION

Federal Law, as specified in 42 CFR **484.80(f)(3)**, prohibits any home health agency from offering and/or conducting a home health aide training and/or competency evaluation program which, within the previous two years, has been found:

(A) Out of compliance with requirements of 42 CFR **484.80(f)(3);**

(B) To permit an individual that does not meet the definition of “home health aide” as specified in §484.4 to furnish home health aide services (with the exception of licensed health professionals and volunteers);

(C) Has been subject to an extended (or partial extended) survey as a result

of having been found to have furnished substandard care (or for other reasons at the discretion of CMS or the State);

(D) Has been assessed a civil monetary penalty of not less than $5,000 as an intermediate sanction;

(E) Has been found to have compliance deficiencies that endanger the health and safety of the HHA's patients and has had a temporary management appointed to oversee the management of the HHA;

(F) Has had all or part of its Medicare payments suspended; or

(G) Under any Federal or State law within the 2-year period beginning on October 1, 1988--

(1) Has had its participation in the Medicare program terminated;
(2) Has been assessed a penalty of not less than $5,000 for deficiencies in Federal or State standards for HHAs;
(3) Was subject to a suspension of Medicare payments to which it otherwise would have been entitled;
(4) Had operated under a temporary management that was appointed to oversee the operation of the HHA and to ensure the health and safety of the HHA's patients; or
(5) Was closed or had its residents transferred by the State.

Therefore, your facility is precluded from conducting a home health aide training and/or competency evaluation program for a period of two years beginning December 2, 2022.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.745, you have one opportunity to dispute condition-level survey findings warranting a sanction through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Home Health Agency Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies.

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of sanctions.

If you have any questions on this matter, please do not hesitate to call.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **247209**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/02/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYADA HOME HEALTH CARE INC	**3033 Campus Drive, #E280 , PLYMOUTH, Minnesota, 55441**

(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) COMPLETION DATE
G0000	INITIAL COMMENTS On 11/30/22 - 12/2/22 a complaint survey was conducted. The agency was found to have not met the requirements at 42 CFR. Part 484 for Home Health Agencies. The cumulative effects of these findings resulted in the Home Health Agency's inability to ensure provision of quality of care. Based on the severity of the deficiency citied the Condition of Participation: Skilled Professional Services 42 CFR 484.75 at G700 was found not met. H72096069C/94525 was substantiated deficiencies were issued at G710 as a result of the complaint investigation.	G0000		
G0700	Skilled professional services CFR(s): 484.75 Condition of participation: Skilled professional services. Skilled professional services include skilled nursing services, physical therapy, speech-language pathology services, and occupational therapy, as specified in §409.44 of this chapter, and physician or allowed practitioner and medical social work services as specified in §409.45 of this chapter. Skilled professionals who provide services to HHA patients directly or under arrangement must participate in the coordination of care. This CONDITION is NOT MET as evidenced by: Based on severity of the deficiency cited, the home health agency (HHA) failed to meet the Condition of Participation: Skilled Professional Services at 42 CFR 484.75. The agency failed to provide skilled professional services according to the plan of care approved by the medical provider for 1 of 1 patients (P1) who required a gait belt	G0700		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **247209**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/02/2022**

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G0700	Continued from page 1 with transfers. Refer to G710. The home health agency (HHA) failed to ensure staff adhered to the patients plan of care to maintain a safe environment by following fall precautions for 1 of 1 patient (P1) reviewed for skilled nursing services. P1 had multiple falls when nursing staff did not use a gait belt for transfers and failed to follow the agencies Fall Prevention Program resulting in a fractured arm.	G0700		
G0710	Provide services in the plan of care CFR(s): 484.75(b)(3) Providing services that are ordered by the physician or allowed practitioner as indicated in the plan of care; This ELEMENT is NOT MET as evidenced by: Based on interview and document review the home health agency failed to ensure staff adhered to the patients plan of care to maintain a safe environment by following fall precautions for 1 of 1 patient (P1) reviewed for skilled nursing services. P1 had multiple falls when nursing staff did not use a gait belt for transfers and failed to follow the agencies Fall Prevention Program resulting in a fractured arm. P1’s Home Health Certification and Plan of Care (485), dated 10/1/22 to 11/29/22, indicated P1 had diagnosis’s of congenital malform syndrome (deformities from birth), stenosis of the larynx (scarring in the throat limiting the larynx’s ability to open normally), spina bifida (a birth defect, in which the spinal cord fails to develop properly often leading to physical and intellectual disabilities depending on severity), P1 was ventilator dependent, required supplement oxygen and a feeding tube. P1 required the assistance of one staff member to transfer and a gait belt. P1 had function limitations of bowel and bladder incontinence, endurance, ambulation, speech, and dyspnea with minimal exertion. P1’s mental status indicated developmental delay. P1’s safety measures were oxygen precautions, seizure precautions, ambulation assistance, aspiration precautions, siderails up, 24-hour supervision, clear pathways, lock wheelchair with transfers, stand precautions, fall precautions and nursing following Covid protocols. P1’s goals were to	G0710		

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G0710	Continued from page 2 maintain and optimal ease of respiration and saturation >90%, tolerate feedings, maintain intact skin, and remain free from injury during hours of service. Client summary indicated all her goals had been met. Upon interview on 11/30/22, at 11:07 a.m. LPN-B stated she was in training with LPN-A on 11/18/22, and P1 had a fall around 3:15 p.m. LPN-B stated she was sitting next to P1 on the side of her bed and P1 fell forward landing on the floor. LPN-B stated she attempted to break the fall, but she fell too. LPN-B stated P1 was not wearing a gait belt, and she has never seen a gait belt in the house. LPN-B stated P1 had shoes on, P1 often leans to the left and she needs to be watched closely. LPN-B stated, “I think her transfer technique is dangerous, her walker is never in her bedroom, we don’t use a belt. LPN-B stated the fall was not reported to the agency. LPN-B stated both she and LPN-A assisted P1 up off the floor and ambulated her to her walker in the dining room. Upon interview on 12/1/22, at 11:03 a.m. during an interview FM-A stated P1 was in pain after the agency nurses shift on 11/18/22. FM-A found bruising on P1’s arm, as P1 was crying and pointing to her arm. P1 was taken to the emergency department and diagnosed with a fractured arm. On 11/18/22, at approximately 8:00 p.m. FM-A sent a text message to registered nurse (RN-A) indicating P1 was in the emergency room with a fractured arm and FM-A asked if something happened during P1’s shift on 11/18/22. FM-A reported RN-A responded to the text message immediately and indicated she would investigate the matter. FM-A stated she attempted to call the nurses who worked on 11/19/22 as she hadn’t heard back from the agency. FM-A stated LPN-A had worked with P1 for about four months and LPN-B was in training with LPN-A. FM-A stated she asked P1 if she and fallen. P1 made her sign language response for “yes.” She then asked her where she fell and P1 pointed to her room. FM-A brought P1 into her bedroom and P1 pointed to the left side of her bed to the floor. FM-A stated this is the third fall P1 had under the care of LPN-A. FM-A could not recall the exact date but was certain it was the end of August when LPN-A reported P1 had fallen in the bathroom being transferred to the toilet. FM-A stated P1 would stand-up with the assistance of one assistant. P1 would place her left arm on a grab bar and her right hand on the windowsill. P1	G0710		

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G0710	Continued from page 3 slipped that day and fell into a seated position onto the floor. There were no injuries reported. LPN-A was in the bathroom with P1. The family provided their own intervention of placing another grab bar on the windowsill FM-A stated in mid-September she witnessed LPN-A assisting P1 into her stander (a walker where she is strapped in to be able to stand or ambulate), LPN-A did not lock the stander and P1 fell, LPN-A grabbed P1's arm and broke the fall with her own body. P1 was not injured. Upon interview on 12/2/22, at 8:41 a.m. LPN-A stated on 11/18/21 while she was training LPN-B, LPN-B was assisting P1 after her afternoon nap. P1 was on the edge of her bed and fell to the floor. LPN-A stated she was in the room but did not see the fall. LPN-A stated P1 did not appear in any pain. LPN-A stated she and LPN-B lifted P1 off the floor placing their hands under her arms and legs. She stated P1 was not wearing a gait belt and LPN-A was not aware that she was supposed to be using the belt. LPN-A stated LPN-B told her P1 did not hit her head, LPN-A assessed her skin and did not notice any redness or bruising. LPN-A denied taking vital signs or reporting the fall to the agency. LPN-A stated she thought the agency policy was to call the agency if there was a fall with injury but stated she could not really remember her training. LPN-A confirmed P1 had two other falls when she was working with her. She stated in August she was transferring P1 to the toilet and P1 slipped and fell backwards onto LPN and they both fell to the floor. She stated she did report the fall to the P1's family, but not the agency since there was not an injury. LPN-A stated P1 was not wearing a gait belt during that fall. LPN-A stated the other fall happened a few weeks after the fall in the bathroom. LPN-A stated P1's walker is usually pushed up against the dining room table where P1 likes to color, so the stander does roll, however this time it was pushed back from the table and the walker slide forward, P1 lost her balance and LPN-A lowered P1 to the floor. P1 was lifted back up to the stander with LPN-A placing her arms under P1's arms without a gait belt. Upon interview on 12/2/22, at 10:29 a.m. RN-A stated she received three text messages on the evening of 11/18/22, from FM-A and was aware that P1 had a fracture. RN-A stated she notified the Director on 11/19/22. The agency was attempting to contact the LPN's who were in the home on 11/18/22. RN-A stated that she goes to the home	G0710		

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G0710	Continued from page 4 every 60 days for the re-certification assessment and there is a question on the Oasis assessment that asks about prior falls. RN-A stated it is not her practice to specifically ask for falls, since those should have been reported prior to the assessment. She stated she asks in the summary if there had been any concerns and there were none reported by FM-A. RN-A denied knowledge that P1 was to use a gait belt with transfers. RN-A verified that the care plan she had written did indicated a transfer of one with a gait belt. RN-A stated when she had been to the house, she had not observed the family using a gait belt with P1. Upon interview on 12/2/22, at 10:55 a.m. the agency Director stated she received a text from RN-A on 11/19/22, at 10:39 a.m. indicating RN-A had received a text the following evening from FM-A indicating P1 had a broken arm and bruising on her legs. The Director stated she started to investigate the incident 11/19/22 through 11/20/22. She stated if for some reason the care plan changes or they cannot follow it, they need to notify the agency and see if a new order is warranted. The agency's policy titled Fall Prevention Program dated 12/19/22, [sic] indicated the agency has a comprehensive fall prevention program that is designed to reduce occurs of falls. It is proactive, risk-based that identified clients who are at risk for falls by providing ongoing monitoring and evaluation of current strategies. This includes assessment of risk and establishing interventions aimed at reducing injuries. 1. An initial screening is performed to evaluate a baseline. A set of tasks known as fall assessment tools including to test client's strength, balance, and gait. 2. Interventions, risk specific, include possible use of therapy, and the need to address the need for special equipment or training to improve safety. 3. Documentation, all client specific fall precautions and interventions are identified in the treatment plan. 4. Reporting of falls, all falls are to be reported via an incident report. A client follow-up visit is completed for client's who have falls occurring when agency staff are present. Falls resulting in injury that alters the client's previous status/function and clients who have had previous falls with in the prior three months. 5. Coordination of a client's fall prevention plan with all team members if the responsibility of the clinical manager, clinical associate or case	G0710		

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G0710	Continued from page 5 managing clinician to ensure follow through occurs on the safety plan of the client. The client's record will reflect communication among all team members and clear directions related to client safety. Any special training required to maintain the safety of the client and employee must be completed before the employee is permitted to work independently with that client.	G0710		

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December 16, 2022

Administrator
BAYADA HOME HEALTH CARE INC
3033 Campus Drive, #E280
PLYMOUTH, MN 55441

Re: Event ID:

Dear Administrator:

A survey of the Home Care Provider named above was completed on December 2, 2022, for the purpose of assessing compliance with State licensing regulations. At the time of survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted no violations of the requirements under Minnesota Statutes Sections 144A.43 to 144A.482.

Attached is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota State Department of Health

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00000	Initial Comments On 11/30/22 - 12/2/22 an abbreviated complaint survey was conducted. No licensing orders were issued during this survey.	00000		

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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Administrator
BAYADA HOME HEALTH CARE INC
3033 Campus Drive, #E280
PLYMOUTH, MN 55441

RE: Event ID: 5E5AB-H1

Dear Administrator:

An extended survey was completed at your agency on December 2, 2022 for the purpose of assessing compliance with Federal certification regulations. At the time of survey, the survey team from the Minnesota Department of Health, Health Regulation Division noted one or more deficiencies and found that your agency was not in substantial compliance with the participation requirements. The findings from this survey are documented on the electronically delivered form CMS 2567.

At the time of this survey, it was determined that the following Condition of Participation was found not met:

G700 42CFR 484.75 Skilled Professional Services

Since these deficiencies limit your capacity to provide adequate care to patients, you must respond within ten calendar (10) days with your plan of correction. The plan must be specific, realistic, include the date certain for correction of each deficiency and be signed and dated by the administrator or other authorized official of the agency. An acceptable plan of correction must contain the following elements:

The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited;

- **The procedure for implementing the acceptable plan of correction for the specific deficiency cited;**

- What correction action(s) will be accomplished for those patients found to have been affected by the deficient practice;
- How you will identify other patients having the potential to be affected by the same deficient practice and what corrective action will be taken;

- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements, i.e., what quality assurance program will be put into place;
- The title of the person responsible for implementing the acceptable plan of correction; and,
- The date by which the correction will be completed.

If your agency has failed to achieve compliance by the date certain, sanctions including but not limited to fines of up to $10,000.00 per day, may be recommended for imposition to the Centers for Medicare and Medicaid Services (CMS) Regional Office. Informal dispute resolution (IDR) for the cited deficiencies will not delay imposition of any recommended enforcement actions. A change in the seriousness of the noncompliance at the time of the revisit may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

The plan of correction should be directed to:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

Failure to submit an acceptable written plan of correction of Federal deficiencies within ten calendar days of your receipt of this notice may result in imposition of sanctions, decertification and/or a loss of Federal reimbursement. Additionally, your continued certification is contingent upon corrective action. If, upon a revisit within forty-five (45) days of the survey exit date, correction is not ascertained, we will have no recourse except to recommend to the Centers for Medicare and Medicaid Services Chicago Region V Office that sanctions be imposed.

HOME HEALTH AIDE TRAINING AND/OR COMPETENCY EVALUATION PROHIBITION

Federal Law, as specified in 42 CFR **484.80(f)(3)**, prohibits any home health agency from offering and/or conducting a home health aide training and/or competency evaluation program which, within the previous two years, has been found:

(A) Out of compliance with requirements of 42 CFR **484.80(f)(3);**

(B) To permit an individual that does not meet the definition of “home health aide” as specified in §484.4 to furnish home health aide services (with the exception of licensed health professionals and volunteers);

(C) Has been subject to an extended (or partial extended) survey as a result

of having been found to have furnished substandard care (or for other reasons at the discretion of CMS or the State);

(D) Has been assessed a civil monetary penalty of not less than $5,000 as an intermediate sanction;

(E) Has been found to have compliance deficiencies that endanger the health and safety of the HHA's patients and has had a temporary management appointed to oversee the management of the HHA;

(F) Has had all or part of its Medicare payments suspended; or

(G) Under any Federal or State law within the 2-year period beginning on October 1, 1988--

(1) Has had its participation in the Medicare program terminated;
(2) Has been assessed a penalty of not less than $5,000 for deficiencies in Federal or State standards for HHAs;
(3) Was subject to a suspension of Medicare payments to which it otherwise would have been entitled;
(4) Had operated under a temporary management that was appointed to oversee the operation of the HHA and to ensure the health and safety of the HHA's patients; or
(5) Was closed or had its residents transferred by the State.

Therefore, your facility is precluded from conducting a home health aide training and/or competency evaluation program for a period of two years beginning December 2, 2022.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.745, you have one opportunity to dispute condition-level survey findings warranting a sanction through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies.

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of sanctions.

If you have any questions on this matter, please do not hesitate to call.

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Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 247209	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYADA HOME HEALTH CARE INC	3033 Campus Drive, #E280 , PLYMOUTH, Minnesota, 55441

(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) COMPLETION DATE
G0000	INITIAL COMMENTS On 11/30/22 - 12/2/22 a complaint survey was conducted. The agency was found to have not met the requirements at 42 CFR. Part 484 for Home Health Agencies. The cumulative effects of these findings resulted in the Home Health Agency's inability to ensure provision of quality of care. Based on the severity of the deficiency citied the Condition of Participation: Skilled Professional Services 42 CFR 484.75 at G700 was found not met. H72096069C/94525 was substantiated deficiencies were issued at G710 as a result of the complaint investigation.	G0000		
G0700	Skilled professional services CFR(s): 484.75 Condition of participation: Skilled professional services. Skilled professional services include skilled nursing services, physical therapy, speech-language pathology services, and occupational therapy, as specified in §409.44 of this chapter, and physician or allowed practitioner and medical social work services as specified in §409.45 of this chapter. Skilled professionals who provide services to HHA patients directly or under arrangement must participate in the coordination of care. This CONDITION is NOT MET as evidenced by: Based on severity of the deficiency cited, the home health agency (HHA) failed to meet the Condition of Participation: Skilled Professional Services at 42 CFR 484.75. The agency failed to provide skilled professional services according to the plan of care approved by the medical provider for 1 of 1 patients (P1) who required a gait belt	G0700		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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G0700	Continued from page 1 with transfers. Refer to G710. The home health agency (HHA) failed to ensure staff adhered to the patients plan of care to maintain a safe environment by following fall precautions for 1 of 1 patient (P1) reviewed for skilled nursing services. P1 had multiple falls when nursing staff did not use a gait belt for transfers and failed to follow the agencies Fall Prevention Program resulting in a fractured arm.	G0700		
G0710	Provide services in the plan of care CFR(s): 484.75(b)(3) Providing services that are ordered by the physician or allowed practitioner as indicated in the plan of care; This ELEMENT is NOT MET as evidenced by: Based on interview and document review the home health agency failed to ensure staff adhered to the patients plan of care to maintain a safe environment by following fall precautions for 1 of 1 patient (P1) reviewed for skilled nursing services. P1 had multiple falls when nursing staff did not use a gait belt for transfers and failed to follow the agencies Fall Prevention Program resulting in a fractured arm. P1's Home Health Certification and Plan of Care (485), dated 10/1/22 to 11/29/22, indicated P1 had diagnosis's of congenital malform syndrome (deformities from birth), stenosis of the larynx (scarring in the throat limiting the larynx's ability to open normally), spina bifida (a birth defect, in which the spinal cord fails to develop properly often leading to physical and intellectual disabilities depending on severity), P1 was ventilator dependent, required supplement oxygen and a feeding tube. P1 required the assistance of one staff member to transfer and a gait belt. P1 had function limitations of bowel and bladder incontinence, endurance, ambulation, speech, and dyspnea with minimal exertion. P1's mental status indicated developmental delay. P1's safety measures were oxygen precautions, seizure precautions, ambulation assistance, aspiration precautions, siderails up, 24-hour supervision, clear pathways, lock wheelchair with transfers, stand precautions, fall precautions and nursing following Covid protocols. P1's goals were to	G0710		

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G0710	Continued from page 2 maintain and optimal ease of respiration and saturation >90%, tolerate feedings, maintain intact skin, and remain free from injury during hours of service. Client summary indicated all her goals had been met. Upon interview on 11/30/22, at 11:07 a.m. LPN-B stated she was in training with LPN-A on 11/18/22, and P1 had a fall around 3:15 p.m. LPN-B stated she was sitting next to P1 on the side of her bed and P1 fell forward landing on the floor. LPN-B stated she attempted to break the fall, but she fell too. LPN-B stated P1 was not wearing a gait belt, and she has never seen a gait belt in the house. LPN-B stated P1 had shoes on, P1 often leans to the left and she needs to be watched closely. LPN-B stated, “I think her transfer technique is dangerous, her walker is never in her bedroom, we don’t use a belt. LPN-B stated the fall was not reported to the agency. LPN-B stated both she and LPN-A assisted P1 up off the floor and ambulated her to her walker in the dining room. Upon interview on 12/1/22, at 11:03 a.m. during an interview FM-A stated P1 was in pain after the agency nurses shift on 11/18/22. FM-A found bruising on P1’s arm, as P1 was crying and pointing to her arm. P1 was taken to the emergency department and diagnosed with a fractured arm. On 11/18/22, at approximately 8:00 p.m. FM-A sent a text message to registered nurse (RN-A) indicating P1 was in the emergency room with a fractured arm and FM-A asked if something happened during P1’s shift on 11/18/22. FM-A reported RN-A responded to the text message immediately and indicated she would investigate the matter. FM-A stated she attempted to call the nurses who worked on 11/19/22 as she hadn’t heard back from the agency. FM-A stated LPN-A had worked with P1 for about four months and LPN-B was in training with LPN-A. FM-A stated she asked P1 if she and fallen. P1 made her sign language response for “yes.” She then asked her where she fell and P1 pointed to her room. FM-A brought P1 into her bedroom and P1 pointed to the left side of her bed to the floor. FM-A stated this is the third fall P1 had under the care of LPN-A. FM-A could not recall the exact date but was certain it was the end of August when LPN-A reported P1 had fallen in the bathroom being transferred to the toilet. FM-A stated P1 would stand-up with the assistance of one assistant. P1 would place her left arm on a grab bar and her right hand on the windowsill. P1	G0710		

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G0710	Continued from page 3 slipped that day and fell into a seated position onto the floor. There were no injuries reported. LPN-A was in the bathroom with P1. The family provided their own intervention of placing another grab bar on the windowsill FM-A stated in mid-September she witnessed LPN-A assisting P1 into her stander (a walker where she is strapped in to be able to stand or ambulate), LPN-A did not lock the stander and P1 fell, LPN-A grabbed P1's arm and broke the fall with her own body. P1 was not injured. Upon interview on 12/2/22, at 8:41 a.m. LPN-A stated on 11/18/21 while she was training LPN-B, LPN-B was assisting P1 after her afternoon nap. P1 was on the edge of her bed and fell to the floor. LPN-A stated she was in the room but did not see the fall. LPN-A stated P1 did not appear in any pain. LPN-A stated she and LPN-B lifted P1 off the floor placing their hands under her arms and legs. She stated P1 was not wearing a gait belt and LPN-A was not aware that she was supposed to be using the belt. LPN-A stated LPN-B told her P1 did not hit her head, LPN-A assessed her skin and did not notice any redness or bruising. LPN-A denied taking vital signs or reporting the fall to the agency. LPN-A stated she thought the agency policy was to call the agency if there was a fall with injury but stated she could not really remember her training. LPN-A confirmed P1 had two other falls when she was working with her. She stated in August she was transferring P1 to the toilet and P1 slipped and fell backwards onto LPN and they both fell to the floor. She stated she did report the fall to the P1's family, but not the agency since there was not an injury. LPN-A stated P1 was not wearing a gait belt during that fall. LPN-A stated the other fall happened a few weeks after the fall in the bathroom. LPN-A stated P1's walker is usually pushed up against the dining room table where P1 likes to color, so the stander does roll, however this time it was pushed back from the table and the walker slide forward, P1 lost her balance and LPN-A lowered P1 to the floor. P1 was lifted back up to the stander with LPN-A placing her arms under P1's arms without a gait belt. Upon interview on 12/2/22, at 10:29 a.m. RN-A stated she received three text messages on the evening of 11/18/22, from FM-A and was aware that P1 had a fracture. RN-A stated she notified the Director on 11/19/22. The agency was attempting to contact the LPN's who were in the home on 11/18/22. RN-A stated that she goes to the home	G0710		

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G0710	Continued from page 4 every 60 days for the re-certification assessment and there is a question on the Oasis assessment that asks about prior falls. RN-A stated it is not her practice to specifically ask for falls, since those should have been reported prior to the assessment. She stated she asks in the summary if there had been any concerns and there were none reported by FM-A. RN-A denied knowledge that P1 was to use a gait belt with transfers. RN-A verified that the care plan she had written did indicated a transfer of one with a gait belt. RN-A stated when she had been to the house, she had not observed the family using a gait belt with P1. Upon interview on 12/2/22, at 10:55 a.m. the agency Director stated she received a text from RN-A on 11/19/22, at 10:39 a.m. indicating RN-A had received a text the following evening from FM-A indicating P1 had a broken arm and bruising on her legs. The Director stated she started to investigate the incident 11/19/22 through 11/20/22. She stated if for some reason the care plan changes or they cannot follow it, they need to notify the agency and see if a new order is warranted. The agency's policy titled Fall Prevention Program dated 12/19/22, [sic] indicated the agency has a comprehensive fall prevention program that is designed to reduce occurs of falls. It is proactive, risk-based that identified clients who are at risk for falls by providing ongoing monitoring and evaluation of current strategies. This includes assessment of risk and establishing interventions aimed at reducing injuries. 1. An initial screening is performed to evaluate a baseline. A set of tasks known as fall assessment tools including to test client's strength, balance, and gait. 2. Interventions, risk specific, include possible use of therapy, and the need to address the need for special equipment or training to improve safety. 3. Documentation, all client specific fall precautions and interventions are identified in the treatment plan. 4. Reporting of falls, all falls are to be reported via an incident report. A client follow-up visit is completed for client's who have falls occurring when agency staff are present. Falls resulting in injury that alters the client's previous status/function and clients who have had previous falls with in the prior three months. 5. Coordination of a client's fall prevention plan with all team members if the responsibility of the clinical manager, clinical associate or case	G0710		

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G0710	Continued from page 5 managing clinician to ensure follow through occurs on the safety plan of the client. The client’s record will reflect communication among all team members and clear directions related to client safety. Any special training required to maintain the safety of the client and employee must be completed before the employee is permitted to work independently with that client.	G0710		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered via Email

December 16, 2022

Administrator
BAYADA HOME HEALTH CARE INC
3033 Campus Drive, #E280
PLYMOUTH, MN 55441

Re: Event ID:

Dear Administrator:

A survey of the Home Care Provider named above was completed on December 2, 2022, for the purpose of assessing compliance with State licensing regulations. At the time of survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted no violations of the requirements under Minnesota Statutes Sections 144A.43 to 144A.482.

Attached is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota State Department of Health

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00000	Initial Comments On 11/30/22 - 12/2/22 an abbreviated complaint survey was conducted. No licensing orders were issued during this survey.	00000		

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE