Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

August 29, 2024

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

RE: Event ID: 63C4B-H1

Dear Administrator:

A partial extended survey was completed at your agency on August 7, 2024 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(s) of Participation were found not met:

G940 42 CFR 484.105 Organization and Administration of 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) location. 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, Regional Operations Supervisor, Federal Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

Please make a copy of your plan of correction for your records.

Failure to submit an acceptable written plan of correction of Federal deficiencies within ten calendar days may result in decertification and 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 (CMS) Location that your certification be terminated, November 5, 2024.

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 August 7, 2024.

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
Health.HRD.Appeals@state.mn.us

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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@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 08/07/2024

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 7/31/24, 8/01/24,8/05/24, 8/06/24 and 8/07/24 a complaint survey was conducted. This resulted in a partial extended survey at Bayada Home Health Care. 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. The following complaints were reviewed: H72096363C/108607. The Condition of Participation: Organization and Administration of Services at 42 CFR 484.105 at G984 was found not met.	G0000		
G0488	Immediate reporting of abuse by all staff CFR(s): 484.50(e)(2) Any HHA staff (whether employed directly or under arrangements) in the normal course of providing services to patients, who identifies, notices, or recognizes incidences or circumstances of mistreatment, neglect, verbal, mental, sexual, and/or physical abuse, including injuries of unknown source, or misappropriation of patient property, must report these findings immediately to the HHA and other appropriate authorities in accordance with state law. This ELEMENT is NOT MET as evidenced by: Based on interview and document review the home care agency failed to report an allegation of neglect for 2 of 2 patients (P1 and P2) reviewed when it was alleged registered nurse (RN)-A inverted a tracheostomy placement and failed to provide adequate emergency medical intervention during a respiratory failure event. Findings include:	G0488		

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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G0488	Continued from page 1 P1's plan of care (POC) with certification period from 7/10/24 to 9/07/24, indicated P1 was diagnosed with dependence with respirator, attention to tracheostomy, gastrostomy, and seizure disorder. The POC further indicated P1 was to receive skilled nursing (SNV) 8-24 hours a day, 5- 7 days per week, up to 168 hours. The POC also indicated P1 was Full Code and did not have an advanced directive. The POC further directed staff P1 was to receive 1.5 liters (L) of continous oxygen via trach/vent and 1-3 L as needed and titrate up to maintain saturations of 93% or greater. Place client on vent if requiring 3 L for two hours or more during the day. Oxygen (O2) can also be applied for comfort. Monitor signs or symptoms of respiratory distress or respiratory illness and/or seizure activity. P1's Abuse and Neglect Tool revised 8/03/24, indicated "client had a Hypoxic/decannulation event on 7-19-2024. Client hospitalized. Discharged home on 7-22-24. Re-hospitalized on 7-31-24 for uncontrolled seizures. Discharged home on 8-03-24." The report further indicated there was no indicators of abuse, yet the patient was susceptible to abuse by other individuals, including other vulnerable adults or children assessed. Patient was assessed and no abused noted. A Coordination of Services Note dated 7/19/24, completed by CM-B indicated CM-B received phone call from licensed practical nurse (LPN)-A on 7/19/24 at 3:30 a.m., and LPN-A reported P1's sisters just called her in a panic let her know that [P1] was being taken to the ER for a hypoxic event d/t (due to) saturations in "the 20's" (normal level for oxygen level is 95 to 100%), "Family member (FM)-A stated the trach was all of the way out, per EMT (emergency medical technician) and FM-A stated she told the night nurse RN-A, and RN-A was surprised. On the call FM-A stated RN-A was not doing CPR correctly and she did not know anything!" During interview on 8/01/24 at 3:10 p.m. the agency administrator stated she thought P1's incident was more of a medical emergency versus abuse or neglect at the time. The administrator stated cooperate completed an investigation and there were discrepancies with what the patient's family members were saying what happened compared to the nurse's report, so a report was not made. The administrator did state she was aware P1's case manager did file a report to the state agency.	G0488		

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G0488	Continued from page 2 P2's POC with certification period from 6/17/24 to 8/15/24, indicated P2 was diagnosed with paralysis of vocal cords, epilepsy, and hydrocephalus (neurological disorder caused by an abnormal buildup of cerebrospinal fluid in the ventricles (cavities) deep within the brain). P2's POC further indicated P2 received skilled nursing visits 8-24 hours per day, 3-7 days a week for 60 days. In addition, P2 had a tracheostomy tube and to maintain patency of Bivona (silicone tube construction allows the tube to remain flexible in the trachea) 6.0 cuffed trach inflated with one cubic centimeter (CC's) of water. P2's Abuse and Neglect Tool dated 7/12/24, indicated P2 felt safe at home, and there were no concerns with caregivers. In addition, the tool indicated there was no other concerns during the home visit. A Coordination of Services Note dated 7/07/24, completed by clinical manager (CM)-A indicated RN-A performed an unscheduled trach change for P2 as his high-pressure alarm was going off during the night shift on his ventilator machine. The CM-A stated he received a phone call from RN-B who noticed a vocalized sound from P2 that was different from normal and checked his trach and it was tied upside down, and the cuff was not inflated. The note indicated it was not sure how long the trach was upside down and the trach was placed with a new one and tied appropriately and inflated with a balloon with one milliliter (ml) sterile water and all vitals were within normal limits. The note further indicated the CM-A had RN-A came in 7/08/24 at 9:30 a.m. for retraining in the agencies lab to complete education and return demonstration for tracheostomy care and emergency protocols. RN-A completed all tasks successfully. During interview on 8/01/24 at 3:05 p.m., agency administrator stated a report was not made to the state agency in regard to P2 due to feeling it was an error, not abuse or neglect just an error on the nurse’s part. Agency Policy revised 2/08/23, indicated a field employee, who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained will, immediately report the information to the office Director, Clinical Manager, or Client Services Manager	G0488		

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G0488	Continued from page 3 who will then report the information to the common entry point either by telephone and verbal report, or electronic reporting. In addition, the law protects anyone under the age of 18 who is the subject of physical and sexual abuse, neglect, and endangerment which a parent, guardian, or custodian has inflicted, may inflict, permitted another person, or had reason to know another person may inflict. These such incidents must be reported to the Minnesota Department of Human Services.	G0488		
G0940	Organization and administration of services CFR(s): 484.105 Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished. This CONDITION is NOT MET as evidenced by: Based on the number and/or severity of the deficiencies cited the home health agency failed to meet the Condition of Participation: Organization and Administration of Services at 42 CFR 484.105. The agency failed to provide timely call to 911, emergency medical services. Findings include: Refer to G984: Based on interview and document review the agency failed to ensure emergency medical services (EMS) 911 were initiated timely for 1 of 1 patient (P1) when P1 had an acute respiratory event. In addition, the registered nurse (RN)-A did not follow the agency training for respiratory emergencies.	G0940		
G0984	In accordance with current clinical practice CFR(s): 484.105(f)(2)	G0984		

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G0984	Continued from page 4 All HHA services must be provided in accordance with current clinical practice guidelines and accepted professional standards of practice. This ELEMENT is NOT MET as evidenced by: Based on interview and document review the agency failed to ensure emergency medical services (EMS) 911 were initiated timely for 1 of 1 patient (P1) when P1 had an acute respiratory event. In addition, the registered nurse (RN)-A did not follow the agency training for respiratory emergencies. Findings include: P1's plan of care (POC) with certification period from 7/10/24 to 9/07/24, indicated P1 was diagnosed with dependence with respirator, tracheostomy, gastrostomy, and seizure disorder. The POC further indicated P1 was to receive skilled nursing visits (SNV) 8-24 hours a day, 5- 7 days per week, up to 168 hours. The POC further indicated P1 was Full Code and did not have an advanced directive. The POC directed staff P1 was to receive 1.5 liters (L) of continuous oxygen via trach/vent and 1-3 L as needed and titrate up to maintain saturations of 93% or greater. Place client on vent if requiring 3 L for two hours or more during the day. O2 can also be applied for comfort. Monitor signs or symptoms of respiratory distress or respiratory illness and/or seizure activity. The POC indicated in the event of emergency obstruction of the airway, Accidental decannulation, or malfunction of the trach tube, attempt to reinsert routine trach size, if unsuccessful, reposition the head and neck and try again. If still unsuccessful, insert the 5.0 x 44 downsized trach, if still unsuccessful, thread the #10 French suction catheter through the smaller sized trach and use as a guide to assist in placing the smaller sized trach, either leave the catheter in and use to supply oxygen or remove and provide support with the hand ventilator and mask to either the intact natural air supply or the tracheal stoma. Administer CPR and activate emergency medical services (EMS). Notify the case manager (CM), primary care giver and physician for all unplanned trach changes. P1’s Treatment Record (TAR) dated from 7/18/24 to 7/19/24, indicated the following treatments were not signed off while RN-A was working. RN-A started her shift on 7/18/24 at 4:30 p.m. and ended at 7/19/24 at 3:14 a.m. when the paramedics arrived. It could not be verified that treatments were completed while RN-A was	G0984		

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G0984	Continued from page 5 working. -SN (Skilled nurse) to assess client Q shift for suspect of abuse by another individual, including caregivers, and self-abuse pm (evening shift). -SN to document verification of rotated pulse oxygen every 4 hours and as needed. -Pulse oximeter continuous high heart rate 170 beats per minute (BPM) low heart rate 50 BPM, low oxygen saturation rates (o2 sats) 90% high 100% continuous pulse oximetry to be on when leaving the client in care of primary care giver (PCG), check alarm settings and function prior to reporting. -Trach tie changes q shift and as needed when soiling. -change 2 x 2 dressing with trach tie dressing q shift. -trach care by SN and secretions for client every 8 hours evening shift. -safe suction depth via 10 FR suction Cath 14 CM or the thick red line in the hub. -Ambi Vest (coughs or huff coughs to clear the mucus. Sessions last about 20 to 30 minutes.) every evening. -cough and assist to be completed with three rounds breaths a cycle stetting with exhale and inhale. -when ventilator on make sure whisper swivel/exhalation valve is in place with Flextend. -At 11:00 p.m. verify trach cuff is inflated when on vent and deflated when client is off the vent. -SN to consistently verify that the tubing circuit does not have too much water, drain the water away from the patient and into the sterile water bottle that is on the floor by the humidifier. The ambulance run sheet dated 7/19/24 indicated EMS received a call at 3:09 a.m. to dispatch to P1's home for a breathing problem. EMS arrived on scene at 3:14 a.m., finding P1 lying in bed, P1 was connected to the turned off ventilator with no ventilations being provided. EMS departed P1's home at 3:35 a.m., and P1 was transferred to the hospital at 4:15 a.m. The EMS ambulance run sheet indicated two attempts to intubate P1 and were successful at 3:28 a.m. P1 desaturated during the transfer and was suctioned with no	G0984		

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G0984	Continued from page 6 improvement. P1's vital signs varied when EMS arrived until the hospital transfer. The first reading at 3:18 a.m. indicated a pulse (heart rate) at 132 and oxygen saturations (o2 sats) at 43%, the last reading at 3:40 a.m. indicated a pulse (heart rate) at 130 and oxygen saturations (o2 sats) at 7%. Per P1's TAR P1's vital parameters were high heart rate 170 beats per minute (BPM) low heart rate 50 BPM, low oxygen saturation rates (o2 sats) 90% low, high 100%. A Coordination of Services Note dated 7/19/24, completed by case manager (CM)-B indicated CM-B received phone call from licensed practical nurse (LPN)-A on 7/19/24 at 3:30 a.m., and LPN-A reported P1's family member (FM)-A just called her in a panic letting her know that [P1] was being taken to the ER for a hypoxic event d/t (due to) saturations in "the 20"s" (normal level for oxygen level is 95 to 100%), "Family member (FM)-A stated the trach was all of the way out. Per EMT (emergency medical technician) FM-A stated she told the night nurse RN-A, and RN-A was surprised. On the call FM-A stated RN-A was not doing CPR correctly and she did not know anything!" P1's hospital discharge summary dated 7/19/24, indicated P1 was admitted with diagnoses of acute hypoxic respiratory failure due to trach dislodgement, emergency medical services were called, P1 was intubated through his tracheostomy site, however saturations did not come up to normal ranges with his intubations. His saturations were as low as 9%. P1 was a subsequent transfer to the hospital and in the ED (emergency department) P1 was successfully intubated and his saturations came up. The neurologist consultation report indicated it was unclear the amount of neurological insult P1 had due to this hypoxic event. P1 had one seizure, however he was at his neurological base line per family members. The report indicated P1 was transferred to another hospital. P1's transferring discharge summary dated 7/22/24, indicated P1 was admitted on 7/19/24 for acute dislodgement of tracheostomy, prolonged hypoxic event with intractable epilepsy. The summary further indicated a follow up appointment with neurology on 7/31/24, which provided a new seizure action plan for the home health agency. P1's Abuse and Neglect Tool revised 8/03/24, indicated "client had a Hypoxic/decannulation event on 7-19-2024.	G0984		

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G0984	Continued from page 7 Client hospitalized. Discharged home on 7-22-24. Re-hospitalized on 7-31-24 for uncontrolled seizures. Discharged home on 8-03-24." The report further indicated there was no indicators of abuse, yet the patient was susceptible to abuse by other individuals, including other vulnerable adults or children assessed. Patient was assessed and no abused noted. During an interview on 7/31/24 at 9:15 a.m., agency administrator stated P1 had a medical emergency and was aware the incident was reported to the Minnesota Department of Health from P1's case manager. The administrator further stated P1's trach came out. P1 received 24 hours skilled nursing services from the agency, had a ventilator at night, and had a tracheostomy. The administrator further stated it was unknow what happened due to the conflicting information they received, and their legal department completed an investigation. The administrator stated the registered nurse (RN)-A who was involved, started with the agency at the branch office in St. Paul in January 2024, and then transferred to our office in June 2024 and was not sure of the reason. On the night of the incident P1's parents went on a vacation and needed a nurse the night of 7/19/24, so the client services manager (CSM) put out a message for staff if they wanted to pick up the shift. The administrator stated RN-A picked up the shift and received a home orientation from the day shift licensed practical nurse (LPN)-A at approximately 4:30 p.m. who was familiar with P1, and RN-A took over care around 5:00 p.m. The administrator further indicated about a month ago RN-A put a trach in a patient upside down and she was retrained on trach care and emergencies in the agency lab and completed return demonstration successfully. During an interview on 7/31/24 at 11:44 a.m., CM-B stated RN-A has not worked with any other patients since the incident occurred with P1. CM-B stated she was on-call 7/19/24 and spoke with FM-A. FM-A stated she had concerns with RN-A and called 911 during the incident. CM-B was notified of the incident around 3:30 a.m. by LPN-A. CM-B stated during the incident that occurred on 7/19/24, RN-A did not send P1's emergency bag, which was required for P1 to have his supplies, and P1's family members had to go back to his home to get the emergency bag for P1's tracheostomy size and equipment. During an interview on 7/31/24 at 12:55 p.m., CM-A stated he took over P1's case at the end of May 2024,	G0984		

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G0984	Continued from page 8 and was informed by FM-A she was trying to change P1 when his oxygen levels were getting low and began to Ambu bag (resuscitation in emergency situations to provide respiratory support to patients who are unable to breathe on their own) P1, and she was changing from breaths to cath to suction him. RN-A connected P1's oxygen to the Ambu bag, she connected the tubbing to the oxygen concentrator instead of the liquid oxygen. CM-A stated he teaches the nurses in class they should connect the Ambu bag directly to the portable oxygen tank to get immediate 100% oxygen and not use the concentrator during an emergency event. CM-A further stated he had concerns when RN-A was attempting to Ambu bag P1, the trach might not have been in place since his oxygen levels, according to the family members present in the room were going so low. CM-A stated he was concerned she was not checking for proper placement of the trach prior to using the Ambu bag. CM-A stated P1 was sent to the hospital and admitted with diagnosis of acute respiratory failure due to trach dislodgment and returned home on 7/22/24. During an interview on 7/31/24 at 2:22 p.m., RN-A stated she received 30 minutes of orientation from LPN-A prior to working on the night of the incident. RN-A stated P1 was more difficult than she had expected, she was not trained to the home, did not know where things were. It was reported P1 had increased secretions during the day. RN-A suctioned him and connected him to his ventilator around 11:00 p.m. Around 2:00 a.m. she turned P1 to change him, and his oxygen saturations went down to approximately 88% and the alarms on his machines started to go off. RN-A stated that was when she started to trouble shoot to try to figure out what to do to stop the alarms and yelled for P1's family members. RN-A stated just prior to yelling for the family members she had started to Ambu bag P1, his oxygen saturations went up and then right back down, when the family member entered P1's room things went crazy, and stated she didn't know what the oxygen saturations were or if P1 had a heart rate due to the positioning of P1 and started chest compressions. RN-A stated she then told a family member to call 911. RN-A stated she did not know where the emergency supplies were at in P1's home and did not send the emergency supply bag with P1 when P1 left with the paramedics. During an interview on 7/31/24 at 6:01 p.m., LPN-A stated she provided training to RN-A before she left her shift on 7/18/24, in the evening around 5:15 p.m. LPN-A stated she orientated RN-A for about 45 minutes	G0984		

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 08/07/2024

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

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G0984	Continued from page 9 and RN-A asked some questions about P1's ventilator and trach. LPN-A stated she asked RN-A how comfortable she felt with trach/vents and RN-A told her she felt fine. LPN-A stated RN-A called her a couple of times during her shift asking questions about ventilator connections. On 7/19/24 when the paramedics arrived the family member put LPN-A on the phone as RN-A could not provide them the needed information. RN-A did not want to provide the paramedics with P1's medical record at the home, which I told the paramedics to take. RN-A did not sign out any of the treatments during her shift for P1. During an interview on 7/31/24 at 7:34 p.m., family member (FM)-B stated RN-A woke her up at 2:45 a.m. on 7/19/24 yelling by knocking on the bedroom door and when FM-B walked into P1's room, P1 was purple in color. FM-B had never seen P1 like that, and all the alarms of the ventilator, oxygen tank were going off. FM-B stated she saw the oxygen saturation rate on P1's machine was at 20% and told RN-A she needed to Ambu bag P1 and after RN-A Ambu bagged P1, RN-A did chest compressions at 3:00 a.m. RN-A told me to call 911. FM-B stated at that point she thought his oxygen saturation rate was at 10%. During an interview on 8/06/24 at 9:15 a.m., the respiratory therapist (RT) from Pediatric Home Service (PHS) stated she was able to get readings from P1's ventilator from 7/18/24 to 7/19/24. RT stated review of the readings indicated on 7/18/24 at 11:36 p.m., P1's ventilator was turned on and problems started to appear at 2:42 a.m. on 7/19/24, and persist from 2:42 a.m. to 3:10 a.m., when the ventilator was turned off. The RT stated there was nine times the ventilator alarm was also placed on pause (silencing the alarm) and the RT stated they teach in their class to never silence the alarm during an emergency since it takes time away from a patient and the alarms are also to alert other family members in the home to assist for help. In addition, the RT stated RN-A should have called 911 or a family member immediately after using the Ambu-bag since that would be a sign the patient is losing oxygen to the brain. The RT stated from the readings noted an issue with low minute ventilation at 2:42 a.m. which means there was an airway leak either from the trach not being in place or the patients position and then the nurse needs to trouble shoot from repositioning and then check for trach placement. The low minute ventilation alarm continued to go on until the ventilator was shut off at 3:10 a.m. The RT further stated she was unable to retrieve the oxygen saturation	G0984		

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G0984	Continued from page 10 readings since it was too late once the machine was picked up since the data can only be retrieved up to 96 hours after an incident. During an interview on 8/06/24 at 10:15 a.m., CM-A stated RN-A has been removed from providing care with patients with Vent/Trach patients after the incident occurred with P1. In addition, the agency also has made a list of nurses that are only qualified to provide care for P1 in the future if P1 would need a nurse. CM-A stated they should be documenting treatments at the time they are being completed. Facility policy revised 8/13/2021, indicated Preparing for Emergencies each client with a tracheostomy tube is required to have an Emergency Airway Bag and a Go Bag, which is to be used for the storage for emergency airway equipment. It contains all essential equipment for an emergency tracheostomy change and provides for a consistent setup for every client with a tracheostomy. The policy further indicated during Handling Client Emergency, if the client's condition deteriorates, and they need immediate attention, the employee, client, or caregiver should proceed in the following manner: -Call emergency squad (911 in most areas) -Call the office and inform them of the situation; the office manage will them call the client's health care provider and family members if applicable; and stay with the client until help arrives.	G0984		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered via Email

August 29, 2024

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

Re: Event ID:63C4B-H1

Dear Administrator:

A survey of the Home Care Provider named above was completed on August 7, 2024, 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,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **08/07/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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00000	Initial Comments On 7/31/24, 8/01/24,8/05/24, 8/06/24 and 8/07/24 an abbreviated complaint 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