Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H80377382M
Compliance #: H80375522C

Date Concluded: March 17, 2026

Name, Address, and County of Licensee Investigated:
Home Health Care Inc.
800 Boone Avenue North, Suite 200
Golden Valley, MN 55427
Hennepin County

Facility Type: Home Health Agency (HHA)

Evaluator's Name: Holly German, 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 alleged perpetrator (AP) neglected the client when they failed to provide appropriate care and services to the client who acquired several wounds.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. While the AP, a registered nurse, failed to initiate interventions for the client's fragile skin, failed to document the client's wounds and update the client's medical provider on the client's condition and wounds, the client's medical condition also made him susceptible to decreased skin integrity. Other nurses provided care to the client prior to the AP taking over the client's care and there was no wound interventions or fall interventions in place, although there was reported falls and attempted interventions reported by an unlicensed personnel (ULP). The client sustained a fall at home that caused bleeding in his head that led to his death.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, death record, hospital records, facility incident reports, personnel files, staff schedules, and related facility policy and procedures.

The client received home health care services in their home. The client's diagnoses included hypertension with heart disease, atrial fibrillation, dementia, and pressure ulcer of left buttock. The client's service plan included assistance with walking, bathing, dressing and meals. The client's plan of care indicated the client was disoriented and required assistance with walking.

The client's plan of care indicated a skilled nurse was to evaluate and develop a plan of care through assessment and evaluation of health conditions, including dementia. A nurse was required to identify changes in the client's condition and intervene to minimize complications.

The client's medical provider (MD) directed the nurse to perform a fall assessment and implement interventions to decrease the client's risk of falls. The orders directed the nurse to observe and assess the client's skin status to identify changes, intervene to minimize complications, and report significant changes in the status of the client's skin to the MD for early intervention. The orders were signed by the AP for implementation.

The client's clinical visit notes indicated a fall assessment was not completed due to it not being applicable.

The client's medical record lacked evidence of fall prevention interventions attempted and lacked evidence of wound prevention interventions attempted.

The client's wound assessment completed by a registered nurse prior to the AP taking over care and assessment of the client indicated one active wound to the client's left buttock.

The subsequent wound assessment completed seven days later by the AP indicated no skin problems were identified but included notation of four skin tears to the arms and a wound on the left buttock.

A subsequent wound assessment completed six days later indicated the AP documented two of the skin tears had resolved and were healed.

Another six days later, a wound assessment completed by the AP indicated the other two skin tears and the buttock wound as healed. The assessment indicated one new skin tear to the client's elbow was noted.

Two days later, a wound assessment completed by the AP indicated only one skin tear to the client's elbow was present.

The next four wound assessments completed by the AP indicated one skin tear to the client's elbow was present.

A subsequent wound assessment completed by the AP included notation of a bruise to the client's face

Five days later, a wound assessment completed by the AP indicated a new skin tear to the client's thigh, in addition to the elbow skin tear and face bruise.

The subsequent wound assessments completed by the AP until the client was hospitalized only noted one skin tear to the client's thigh. No wound assessments completed by the AP indicated the client had open wounds to the legs, feet or buttocks (coccyx).

The client's hospital records indicated the client was brought to the emergency room by the unlicensed personnel (ULP) due to a noted increase in weakness and confusion after a fall that the client sustained the day before. The hospital record indicated the client was observed to have multiple significant open wounds on legs, coccyx, and back, with black eschar (dead tissue) on the left heel and significant bruising on right heel. The record indicated the client was diagnosed with a severe bleed in his head, and comfort measures were recommended. The record indicated the client returned to his home with hospice services.

The client's death record indicated the cause of death was closed head trauma. The client died 17 days after a fall.

During an interview, a ULP, who was also the client's family member, stated he noticed a decline in the client and requested additional caregiver hours through the agency, but the agency did not have anyone to provide additional support. The ULP stated he hired another agency who provided two additional caregivers who assisted in the care of the client. The ULP stated the client sustained multiple falls. The ULP stated the client took blood thinning medication, and had several bruises that appeared, and even had large bruises on his body in the morning on the side of his body he had slept on. The ULP stated the client often bumped himself against furniture, walls, and doorways that led to multiple wounds and skin tears. The ULP stated the client developed pressure wounds while not mobile for a few months. The ULP stated staff attempted to change the client's position frequently, but even the smallest movement created a wound to the client's paper-thin skin. The ULP stated the client received wound care two to three times a week from a nurse and they discussed how to prevent wounds, but the ideas did not work.

During an interview, the client's medical provider (MD) stated the client's medical conditions had progressed a lot in the last year of the client's life. The MD stated the client had very fragile skin and various wounds that she received documents on a regular basis for wound care that she signed off on. The MD stated she did not assess the wounds in person and only saw pictures of the wounds after the client had passed away. The MD stated she signed off on wound care

orders based on the description provided of what they were doing for the wounds. The MD stated she did not know if the agency did or did not provide appropriate care to the client, or if the wounds were because of his age and poor protein intake for healing. The MD stated when she last saw the client, she did not see any signs of abuse of neglect, and the ULP was quick to keep her updated with any changes of the client. The MD stated she only received updates about the client from the ULP.

During an interview, registered nurse (RN)-1 stated new hired nurses received six weeks of orientation and received oversight from their preceptor in the first 60 days of employment. RN-1 stated it was the responsibility of the nurse to manage their clients with patient centered care, perform head-to-toe assessments, provide education, and communicate with the medical provider and any other care team member as needed for any concerns or change in condition. RN-1 stated it is the nurse's responsibility to initiate interventions for a client to prevent falls and wounds, and if they struggled to come up with interventions, or to receive interventions from the medical provider, they should contact their supervisor. RN-1 stated it was the nurse's responsibility to accurately document, initiate interventions, receive orders, and notify the client's provider for any new wound a client had. RN-1 stated she expected every client with a wound to have each wound described in detail with the interventions, and if a wound worsened, the medical provider to be updated. RN-1 stated the AP was no longer employed with the agency because the AP had not documented all the client's wounds, and there was no documentation the supervisor or medical provider had been updated on the wounds the client had. RN-1 stated she investigated another client the AP was assigned to who also had a decline in condition, and the AP did not include any of the client's decline or any update to that client's provider either.

During an interview, RN-2 stated new hire nurse training consisted of two days in the office doing learning modules followed by seven days out in the field with a preceptor to learn the role, the charting, and how to be a case manager. RN-2 stated she was the AP's supervisor and had weekly check-ins with the AP for the first five weeks. RN-2 stated that when nurses are assigned to their own clients, they are encouraged to do a full chart review to get familiarized with the client, and to see what they can also do for the client. RN-2 stated she did not recall the AP ever bringing forward any concerns or questions about the client, and she was not aware of the severity of the client's wounds until the client had been admitted to the hospital. RN-2 stated if a client had a wound or sustained a new wound, it is an expected standard of care for the nurse to update the clients MD to get the MD's recommendations and obtain new orders as well as provide education on the prevention of wounds. RN-2 stated those actions should be documented in the visit note or the care coordination note. RN-2 stated any new interventions were to be communicated to other caregivers either verbally during the visit or added to the care giver's plan of care for it to be seen there. RN-2 stated every wound a client had was to be assessed, documented, monitored, and communicated to the provider no matter the type of severity. RN-2 stated she did not recall any time the AP reached out to her with questions or concerns about the client and did not have any indication of concern about the AP's quality of work.

During an interview, the AP stated he received seven total days of training before he was in the field independently. The AP stated when he was assigned to the client, he followed the plan of care that was already in place. The AP stated the client spoke a foreign language. The ULPs also spoke that same foreign language and were not the best to relay information to him. The AP stated he had concerns about the client remaining in his home but was told by management the ULP family member declined for the client to move into a nursing facility. The AP stated he provided wound care and general assessment of the client one to two times a week. The AP stated the client had very fragile skin that bruised very easily with many skin tears and pressure wounds. The AP stated he provided wound care during each nursing visit. The AP stated the language interpreter he had with him took pictures of the client's wounds and sent them to the ULP to update him. The AP stated he did not recall how many pressure wounds the client had or where they were located. The AP stated it is standard practice to document each wound, and he did not know if all the wounds were new, or just old ones that re-opened. The AP stated he did not recall what the agency policy was for what he needed to do when a new wound was noted. The AP stated he never updated the medical provider about anything because the ULP took care of that. The AP stated he sometimes tried to wrap the client's arms with Kerlix (a woven gauze bandage) to try to prevent further breakdown of wounds. The AP stated he did not recall being aware of any falls the client had, but physical therapy and occupational therapy typically got involved as an intervention to prevent falls. The AP stated he did not know why the client went to the hospital, and he no longer worked for the agency because he chose a different career path.

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: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The AP is no longer employed by the agency.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a complaint survey under federal regulations, and substantiated facility 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.

You may also call 651-201-4200 to receive a copy via mail or email.

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

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 **01/22/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 , GOLDEN VALLEY, Minnesota, 55427**

(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
00000	Initial Comments The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H80377382M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	00000		

Office of Primary Care and Health Systems Management

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