Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL262067942M
Compliance #: HL262063900C

Date Concluded: May 28, 2025

Name, Address, and County of Licensee Investigated:
Legacy Home Health Care Inc
800 Boone Avenue North #195
Golden Valley, MN 55427
Hennepin County

Facility Type: Home Health Agency (HHA)

Evaluator's Name:
Maerin Renee, RN, Special Investigator

Finding: Substantiated, individual responsibility

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 the client fell and sustained a broken hip. The AP did not report the fall to a nurse, the home care agency, or family, resulting in a delay of care. The client required surgery to repair the hip fracture.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The client fell in her home while the AP was caring for her. The AP did not notify the family of the fall, nor did she notify the agency or call the on-call nurse for further guidance. The next day a family member arrived at the clients home and noticed the client was in pain. At that time the AP told the family member the client fell the day before, but she was "okay." The family member called 911, and the client was admitted to the hospital and was diagnosed with a right broken hip.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted family. The investigation included review of the client records, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures.

The client received comprehensive home care services in their home. The client's diagnoses included dementia and osteoporosis. The client's services included assistance with activities of daily living, meals, housekeeping, and laundry. The client's assessment indicated the client was a fall risk due to her age and diagnoses.

The facility's internal investigation indicated the client fell one afternoon in her home. The client told the AP, her live-in caregiver, her right leg hurt. The AP helped the client off the floor, and then helped her into her wheelchair. The AP said the client was not crying out in pain or grimacing. The AP reported the client had some bruising on her left leg.

A disciplinary action indicated the client fell one day and the AP helped her up off the floor. The AP did not report the fall to the agency when it happened, and she picked the client up without calling for help. The AP called a family member the next day for help transferring the client. The disciplinary action indicated the AP understood and was fully aware of the policy and protocol for falls and said she should have reported fall to agency.

The AP did not document the clients fall or any interventions provided on the client's care sheets for the timeframe reviewed.

The AP's training records indicated she received training in conditions to report to nurse, including significant mobility differences, pain; abuse and neglect for health care paraprofessionals; agency policies including Medical Information—When to Call (including falls/dizziness or lack of coordination); recognizing abnormal changes in body functioning and the importance of reporting such changes to a supervisor and/or nurse; and the Assisted Living Bill of Rights.

The client's hospital records indicated the client was admitted with complaints of fall and hip pain. The client was diagnosed with a right hip fracture, which was surgically repaired. The client was discharged to a transitional care unit (TCU) eight days later.

When interviewed, agency leaders said the client fell in her home and the AP did not report the fall to the agency or a family member, per policy. After the client fell, the AP said the client did not complain of pain until the following day, at which time the AP notified a family member. The family member called 911 and the client was transported to the hospital where she was diagnosed with a right hip fracture. The AP reported the fall to the agency two days later. The AP said she understood and was aware of the policy requiring her to notify a nurse and the agency at the time of a client fall. Agency leaders said there was an on-call nurse available every

day around the clock and the expectation was that the AP would call the on-call nurse to notify them of any client falls.

When interviewed, the AP said after the client fell, she notified a family member right away. The AP said she thought she called and notified someone at the agency, as well, but she could not remember.

When interviewed, a family member said the AP was the client's live-in caregiver. The family member said the AP telephoned her on a Sunday afternoon and told her to come over because the client needed to use the bathroom and would not get up to transfer. The family member arrived and saw the client sitting in a wheelchair, which was unusual for her. The family member lifted the client's right leg out of the wheelchair's footrest, and the client cried out in pain. It was then that the AP mentioned the client fell the day before, but the AP said she was okay. The family member called 911. The client was admitted to the hospital where she was diagnosed with a right broken hip. Hospital staff also noted bruises on the client's shins and chest, which the family member also was not aware of. The client's hip was repaired surgically, and she moved to a transitional care unit. The client never returned home. The family member was upset that the AP continued to provide cares to the resident, move her around, transfer her, with a broken hip and did not notify her or the agency about the client having fallen.

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

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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, due to cognitive status.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The agency counselled the caregiver and retrained her regarding falls protocols.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.
To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

You may also call 651-201-4200 to receive a copy via mail or email.
The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Golden Valley City Attorney
Golden Valley Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H26206	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEGACY HOME HEALTH CARE INC	800 BOONE AVENUE N STE 195 GOLDEN VALLEY, MN 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) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** HOME CARE PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL262063900C/#HL262067942M On May 6, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 114 clients receiving services under the provider's Comprehensive Home Care license. The following correction order is issued/orders are issued for #HL262063900C/#HL262067942M, tag identification 0325.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2).	
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment be free from physical and verbal abuse, neglect,	0 325		

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0 325	Continued From page 1 financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	0 325		