*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** H72094083M **Date Concluded:** February 20, 2024

**Name, Address, and County of Licensee Investigated:**
Bayada Home Health Care Inc.
3033 Campus Drive; #E280
Plymouth, MN 55441
Hennepin County

**Facility Type:** Home Health Agency (HHA) **Evaluator's Name:** Michele Larson, 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 the AP failed to follow the client's plan of care and the client fell from the bed. The client fractured (broke) her left arm and sustained significant bruising to her left arm.

**Investigative Findings and Conclusion:**
The Minnesota Department of Health determined neglect was inconclusive. Although the client had a fractured and bruised left arm, due to conflicting information provided by the AP and a licensed practical nurse (LPN), the cause of the injury could not be determined. During a federal investigation, it was determined the AP and LPN failed to use a gait belt when transferring the client. It could not be determined if the use of a gait belt could have prevented the injury. A federal citation was issued for the failure to report.

The investigator conducted interviews with facility staff members, including administrative staff, and nursing staff. The investigation included review of the resident's record, federal survey notes, the facility internal investigation, and personnel records.

The client resided in her home with family and received comprehensive home care services from the home care agency. The client's diagnoses included congenital malformation syndrome (birth deformities), spina bifida (spinal birth defect), and stenosis of the larynx (scarring in the voice box). The client required assistance from one staff for pivot transfers. The client used a wheelchair and walker for mobility with staff assistance. The client was able to make her needs known through gestures, simple sign language, yes/no answers, and some sounds. The client required 24/7 care.

The client's progress notes two days prior to the injury indicated the LPN observed the AP complete client cares while the AP trained the LPN on the client's routine. The note indicated the AP walked the client positioned directly behind the client with her arms under the client's armpits for balance and stability.

A report indicated one evening the client's family member noticed the client had significant bruising to the left upper arm. The client was unable to verbalize what happened, but when asked if she fell, the client pointed to the bed and floor indicating the client fell out of bed.

A nurse visit note indicated that evening the client's family notified the agency they brought the client to a hospital for an evaluation for complaints of pain and bruising of the client's left upper arm following care provided to the client by the AP and LPN.

The hospital record indicated that same evening, family brought the client to a hospital for an evaluation for limited range of motion of the client's left arm, pain, and a large bruise on the client's left upper arm.  The record indicated the client was diagnosed with a fractured left humerus (upper arm bone). The client returned home the same evening.

During an interview, the AP stated she was training the LPN on the client cares that day. The AP stated she was in the room when the LPN transferred the client. The AP said the LPN was not able to maintain the center of gravity so, the LPN lowered the client to the ground. The AP stated the client was seated cross legged on the floor and did not fall. The AP said she and the LPN lifted the client off the floor, assessed the client for injuries, and continued with the client's care.

During an interview, the LPN stated she reviewed the client's care plan, and the client could transfer with one person. The LPN stated she was being trained to provide care to the client by the AP. The LPN stated when attempting to transfer and walk with the client, as she was instructed by the LPN, the client fell. The LPN stated when she attempted to catch the client, she also fell. The LPN stated the client was assessed for injury prior to lifting the client off the floor. The LPN stated the client had no signs of injury or complaints of pain.

During an interview, the nurse stated the family member notified her of the client's injuries following the shift with the AP and LPN. The nurse said staff were trained to notify the nurse with any incidents.

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. Unable to interview due to cognitive function.
**Family/Responsible Party interviewed**: Yes.
**Alleged Perpetrator interviewed**: Yes.

**Action taken by facility:**
The AP was 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<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED<br>**11/30/2023** |
|---|---|---|---|

| 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 |
|---|---|---|---|---|
| 00000 | Initial Comments<br><br>The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H72094083M, 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 |
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