Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL20973820 7M
Compliance #: HL209735375C

Date Concluded: March 6, 2024

Name, Address, and County of Licensee Investigated:
Baywood Home Care
6465 Wayzata Blvd. STE: 150
Minneapolis, MN 55426
Hennepin County

Facility Type: Home Care Provider

Evaluator's Name: Lori Pokela R.N.
Special Investigator

Finding: Not Substantiated

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 facility neglected client when the facility did not provide appropriate care for the client's worsening wounds.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Facility staff provided wound care in accordance with physicians' orders and in coordination with a wound care agency. When the client's wounds worsened and staff became concerned about infection, the client was transferred to the hospital for further evaluation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the client's case manager. The investigation included a review of the client's record, hospital records, personnel files, staff schedules, and facility policy and procedures.

The client received comprehensive home care services in their home. The client's diagnoses included spinal cord injury, paraplegia, and neurogenic bladder. The client's service plan included assistance with activities of daily living (ADLs), medication set-up, wound care, transfer assistance, and incontinence care. The client needed daily reminders from staff to offload (reposition) from his wheelchair. The client was independent with catheterization, electronic wheelchair mobility, and driving a vehicle. The client's assessment indicated the client was prone to chronic, posterior, scrotal, perineal, and anal wounds.

The client admitted to the home care agency with wounds on his heels and perineal area, some of which required dressing changes. An outside skilled nursing agency was also involved in management of the client's wounds.

Home care agency staff provided wound care to the client in accordance with the physician orders and the recommendations provided by the wound care agency. Home care agency staff informed and updated the wound care agency on the condition of the wounds and notified them if any changes or new wounds were observed.

The client's medical record identified that as the wounds progressed, home care agency staff continued with dressing changes and assessment of the wounds as directed by the wound care agency. When staff observed the wounds to have a foul odor, the client was transferred to the hospital due to concern for infection.

Hospital records indicated the client was treated for a wound infection with antibiotics. Following the client's hospitalization, home care agency nursing staff and the client's case manager determined that the client required a higher level of care to treat the wounds. The case manager was unable to secure a wound care provider to meet the client's needs, and the client was later transferred to an out-of-state rehabilitation hospital closer to family.

During an interview, facility administrative staff, nursing staff, and unlicensed staff stated wound care was provided in coordination with the wound care agency's orders and recommendations; however, they indicated the client was noncompliant with pressure relieving recommendations.

During an interview, the client stated he was admitted to the home care provider with small wounds that worsened in the months prior to his transfer to the hospital. The client reported no concerns with the wound care provided by the home care agency staff.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment 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: Yes
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
None.

Action taken by the Minnesota Department of Health:

The facility was found to be in 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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20973	A. BUILDING: _____ B. WING _____	C 01/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYWOOD HOME CARE	6465 WAYZATA BLVD SUITE 150 MINNEAPOLIS, MN 55426

(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: HL209735375C/HL209738207M On January 18, 2024, 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 72 clients receiving services under the provider's Comprehensive Assisted Living license. The following correction order is issued for HL209735375C/HL209738207M, tag identification: 0815.	0 000	Home Care Provider 144A. 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).	

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0 815	Continued From page 1	0 815		
0 815 SS=F	144A.479, Subd. 7 Employee Records The home care provider must maintain current records of each paid employee, regularly scheduled volunteers providing home care services, and of each individual contractor providing home care services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification, if licensure, registration, or certification is required by this statute or other rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff providing supervision; (4) documentation of annual performance reviews which identify areas of improvement needed and training needs; (5) for individuals providing home care services, verification that any health screenings required by infection control programs established under section 144A.4798 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. Each employee record must be retained for at least three years after a paid employee, home care volunteer, or contractor ceases to be employed by or under contract with the home care provider. If a home care provider ceases operation, employee records must be maintained for three years. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record	0 815		

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0 815	Continued From page 2 contained all of the required content for three of three unlicensed personnel, (ULP)-C, (ULP)-H and (ULP)-N with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-C: ULP-C was hired January 19, 2023 to provide direct care and services to the licensee's clients. ULP-C's employee file lacked evidence of competencies regarding orientation to nursing delegated tasks including wound care. A licensee provided email dated February 5, 2024 at 8:09 a.m, sent by the licensee's administrative personnel, (ADM)-E included a response by registered nurse, (RN)-B, that indicated ULP-C received wound training at a client's (C1) wound care clinic appointment on August 4, 2023. This same emailed document indicted ULP-C was trained on competencies by an RN on August 13, 2023. ULP's personnel file lacked evidence of this training. ULP-H: ULP-H was hired on May 12, 2022 to provide direct care and services to the licensee's clients. ULP-H's employee file lacked evidence of	0 815		

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0 815	Continued From page 3 competencies regarding orientation to nursing delegated tasks including wound care. A licensee provided email dated February 5, 2024 at 8:09 a.m, sent by the licensee's administrative personnel, (ADM)-E included a response by registered nurse, (RN)-B, indicated ULP-H received wound training at a client's (C1) wound care clinic appointment on June 30, 2023 and August 4, 2023. ULP H's personnel file lacked evidence of this training. ULP-N: ULP-N was hired on November 29, 2021 to provide direct care and services to the licensee's clients. ULP-N's employee file lacked evidence of competencies regarding orientation to nursing delegated tasks including wound care. During an interview on January 19, 2024 at 4:20 p.m., registered nurse (RN)-B stated that at one time employee competencies were in paper form but had recently been changed to electronic files. RN-B acknowledged the ULP files reviewed did not include documentation of the requested training. A licensee provided policy titled: Supervision of Unlicensed Staff Providing Delegated Tasks, dated December 28, 2019 indicated unlicensed staff provided delegated tasks to clients will be supervised by an R.N. and the R.N. would document that supervision in the employee's personnel file. No further information was provided.	0 815		

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0 815	Continued From page 4 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 815		