Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL343075942M
Compliance #: HL343078545C

Date Concluded: November 4, 2024

Name, Address, and County of Licensee Investigated:
Olydia Home Care Inc.
7243 Morgan Ave. North
Brooklyn Center, MN 55430
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brooke Anderson, RN
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 alleged perpetrator (AP), a facility staff member, neglected the resident when the plan of care was not followed and the AP poured apple juice in the resident's mouth causing aspiration (breathing in a foreign object into the lungs) resulting in hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident was hospitalized for choking on apple juice, the resident's careplan was followed at the time of the incident. The resident was treated with antibiotics, discharged back to the facility, and returned to his baseline health condition.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted hospital staff. The investigation included review of the resident record, hospital records, personnel files, staff

schedules, and related facility policies and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident had a diagnosis of tetraplegia (a form of paralysis that affects both arms and both legs). The resident's assessment indicated the resident was cognitively intact and was not susceptible to abuse by others. The resident's service plan included meal preparation and eating assistance but did not indicate the resident required the use of a straw to drink beverages.

Facility documentation indicated the resident requested to eat his meal outside on the deck. All food and drinks were provided to him per his request, and no signs of choking or aspiration where observed by staff. The AP used a straw to serve the resident his liquids, and the resident appeared comfortable while eating and drinking. After finishing his meal, the resident continued to socialize on the deck without showing any signs of distress. When the resident returned to his room, he mentioned he had difficulty breathing and requested assistance with his Continuous Positive Airway Pressure (CPAP) machine (a device that delivers consistent pressure to hold your airway open during sleep). Despite using the CPAP, the resident continued to experience discomfort and later requested for staff to call 911. However, before the AP returned to the resident's room, the resident called 911. The AP remained with the resident until paramedics arrived and transported the resident to the hospital.

Hospital records indicated the resident was admitted for choking on apple juice. Hospital documentation indicated the resident had abnormal lab results and a chest x-ray showed left-sided pneumonitis (swelling and irritation of lung tissue) unrelated to choking on apple juice. The resident was treated with antibiotics and discharged back to the facility.

During an interview, the AP denied pouring the apple juice in the resident's mouth. The AP stated the day of the incident, he assisted the resident with meal set-up which included putting a straw in the apple juice and bringing the straw up to the resident's mouth. The resident drank the apple juice independently with the use of a straw. After the meal, the resident went to his room and asked the AP to call 911, but did not report or indicate any signs of choking to the AP.

During an interview, the resident stated he had no concerns related to this incident.

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: No, per resident request.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The resident's care plan was updated following the incident.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

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
	34307	A. BUILDING: _____ B. WING _____	C 10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLYDIA HOME CARE INC	7243 MORGAN AVENUE NORTH BROOKLYN CENTER, MN 55430

(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 On October 7, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL343078545C/#HL343075942M and HL343079464C/HL343076283M. No correction orders are issued.	0 000		