DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL343079425M
Compliance #: HL343073506C

Date Concluded: February 12, 2026

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: Deb Schillinger RN BSN
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 the resident when the facility did not provide assistance to get out of bed.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was not substantiated. The resident's wheelchair had fallen over while the resident was using it outside of the facility after hitting a curb and sustained damage, the extent to which was unknown. The facility requested the resident have the durable medical equipment provider examine it for any potential repairs, however the resident did not agree to do so. The resident made his own decisions and did not delegate this to the facility.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the home health provider. The investigation included review of the resident record, hospital records, facility internal investigation, facility incident reports, staff schedules, and related facility policy and

procedures. Also, the investigator observed resident and staff interactions and facility processes during onsite visits.

The resident resided in an assisted living facility. The resident's diagnoses included quadriplegia (loss of sensation and/or ability to move both arms and both legs), and stage 4 pressure ulcer. The resident's service plan indicated the resident required the assistance of two staff for transferring and repositioning every two hours using a mechanical ceiling lift. The care plan indicated the resident was able to operate his power-wheelchair. The resident's assessment indicated the resident needed assistance of two caregivers to transfer with a mechanical ceiling lift and was alert and able to make his own decisions.

A concern arose when a report was received the facility had not assisted the resident out of bed for the last six months.

The resident's progress notes indicated the resident fell out of his power wheelchair six months prior while out in the community. After the fall, the fire department was called to lift him back into his chair and emergency medical services (EMS) assessed the resident for injury before he returned to the facility in the power wheelchair.

A progress note later indicated that the resident was notified by a caregiver the caregivers could not assist him to get into his wheelchair until the chair was evaluated and repaired by the durable medical equipment provider if needed due to damage after the fall. The resident refused to do so.

The investigator did view the power-wheelchair during an onsite visit and observed the back of the wheelchair was tilted slightly, and not in an upright position indicative of damage.

During an interview, an unlicensed caregiver stated the last time the resident was assisted out of bed was about six months prior. She stated the caregivers were told the resident's wheelchair was damaged after the fall six months ago, and it needed to be evaluated and repaired, if necessary, to protect the resident's safety. She stated the resident refused to allow the facility to arrange for the wheelchair evaluation and the resident chose not to call for the repairs himself, as he did not believe the wheelchair was damaged or needed repair.

During an interview, the resident stated after he tipped over in his wheelchair the staff said it was not safe for him to get back in the wheelchair until it was repaired. The resident stated he did notice some things were "a little off" in regard to the wheelchair but felt it was mechanically fine, and the resident chose not to call to have the wheelchair evaluated. The resident stated he is in control of calling for the wheelchair to be evaluated and relayed that decision to the facility.

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: Not Applicable
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility: No action taken

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

Minnesota Department of Health

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 01/20/2026

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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, 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: #HL343073506C/#HL343079425M On January 20, 2026, the Minnesota Department of Health initiated a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 3 residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for #HL343073506C/#HL343079425M, tag identification 0470.	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 Assisted Living Facilities. 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 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview, document and record review, the licensee failed to ensure two caregivers were available on each shift to meet the scheduled and reasonably foreseeable unscheduled needs and ability to provide effective response to unforeseen emergencies of each resident as required by the resident's assessments and service plan for one of one resident (R1) who was assessed to require the assistance of two caregivers to provide turning and repositioning care.	0 470		

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0 470	Continued From page 2 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident'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 of the residents). The findings include: Minnesota Administrative Rule 4659.0180, Subpart 5, indicated "A minimum of two direct-care staff must be scheduled and available to assist at all times whenever a resident requires the assistance of two direct-care staff for scheduled reasonably foreseeable and unscheduled needs, as reflected in the resident's assessments and service plan." R1 resided in the facility since June 8, 2022. R1's diagnoses included quadriplegia (paralysis that affects both arms and both legs), stage 4 ulcer pressure, and hypertension. R1's service plan dated January 13, 2026, indicated R1 required the assistance of two staff for mobility, dressing, grooming, toileting, and every two-hour repositioning using Hoyer lift. R1's assessment dated November 29, 2025, indicated R1 was able to make his own decisions, needed assistance of two caregivers to transfer by mechanical (ceiling) lift for repositioning, transfers, as he was not able to move independently. R1's assessment dated November 29, 2025,	0 470		

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0 470	Continued From page 3 indicated R1 is completely dependent and would require assistance of two staff for evacuation in the case of an emergency. During an onsite visit on January 20, 2026, at 10:30 a.m. the investigator observed one unlicensed personnel (ULP) was present at the facility. When asked if any other caregivers were present, ULP #1 said normally there were two people on but one went home sick earlier that day. On January 20, 2026, at 12:16 p.m., the investigator observed and created a photo image of a posting titled "Olydia Home Care INC Staffing Plan" dated December 5, 2025, indicated two caregivers would be present Monday - Sunday for all three shifts. During an onsite visit February 3, 2026, between the times of 4:30 -5:00 a.m., two investigators observed the exterior of the facility, and could view the main entrance and garage entry of the facility. There were no vehicles near the facility. No one entered or left the facility. On February 3, 2026, between 5:00 - 5:06 a.m. two investigators knocked on main door with no answer. No one could be seen through window on front door. On February 3, 2026, between 5:07-5:52 a.m. two investigators continued to observe the facility, with the ability to see the main entry and the garage door, no one entered or left the facility. On February 3, 2026, at 5:53 a.m. a person arrived (later identified as ULP #1) in a black sedan and entered the facility through the main door.	0 470		

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0 470	Continued From page 4 On February 3, 2026, at 5:58 a.m. two investigators knocked on front door, door was answered by ULP #1. A second caregiver, ULP #2, was present in the living room area as the investigators entered. During an interview ULP#2 stated she started her shift at 10 p.m. (February 2, 2026) and she was the only ULP working through the shift. During an interview, ULP#1 stated the other scheduled ULP for the dayshift had not arrived yet. The two investigators exited the facility, however continued the observation of the exterior of the facility from 6:05 a.m. to 7:00 a.m. At 6:11 a.m. ULP#2 left the facility through the main entrance. No one else entered or left the facility from then until the end of the observation at 7:00 a.m. The licensee's policy titled "Staffing & Scheduling" dated April 29, 2024, indicated the facility clinical nurse supervisor must ensure the staffing levels meet each resident's needs, scheduled, reasonably foreseeable and unscheduled needs, as reflected in the resident's assessments and service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 470		