Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL376778402M
Compliance #: HL376775163C

Date Concluded: May 14, 2025

Name, Address, and County of Licensee Investigated:
Golden Oaks Home Care
8481 134th Street Court
Apple Valley, MN 55124
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Rhylee Gilb, 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 neglected the resident when they gave the resident a drink while laying down. The resident aspirated and died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although there was conflicting report family viewed on camera the AP provide water to the resident while laying down and the AP said she offered the resident a drink, however the resident declined, the resident had multiple comorbidities that contributed to her death. The resident had a decline in health status over a period time and more prominently six weeks prior to her death. The facility consulted with the resident's psychiatrist and primary care provider on her change in condition. The facility provided care and services, including total assistance with activities of daily living, which included eating and drinking. The resident had no diet change orders. The resident's autopsy report concluded the resident's primary cause of death was related to heart failure causing hypoxia (lack of oxygen).

The investigator conducted interviews with facility staff members, including nursing staff and unlicensed staff. The investigator contacted the resident's family. The investigation included review of the resident record, death record, hospital records, autopsy report, incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff interactions with residents. There was no video of the incident available.

The resident resided in an assisted living facility. The resident's diagnoses included chronic obstructive pulmonary disease (COPD), type 2 diabetes, and schizophrenia. The resident's service plan included assistance with setting up and reminders for dressing, grooming, and bathing. She received assistance with medication administration.

The resident's progress notes indicated approximately one month prior to the resident's death, she had a change in health condition. The resident experience increased hallucinations and the facility nurse updated her psychiatrist. A week later, the resident presented weak and confused. She had diarrhea episodes and incontinence. The facility nurse sent the resident to the emergency room (ER) for evaluation.

ER records indicated the resident was evaluated for diarrhea and generalized weakness. She had lab work completed and given intravenous fluids. The ER sent her back to the facility to follow up with her primary care provider and instruction to drink plenty of fluids.

Two days later, the resident went to the clinic for evaluation by her primary care provider. The clinic records indicated the resident was seen to address her congestive heart failure and a tooth abscess. The resident was prescribed an antibiotic for 10 days (for tooth abscess) and daily schedule furosemide (a water pill). The provider directed to follow up with the resident's dentist.

The resident's medication administration record (MAR) indicated the facility administered the furosemide daily as ordered. The antibiotic was administered for 10 days as ordered.

The facility nurse completed a change in condition assessment. The resident's change in needs included assistance of one person for all activities of daily living (ADL), assistance with eating, assistance with getting in and out of bed, and stand by assistance when walking.

Approximately two weeks later, the resident had additional changes of behavior of crawling out of bed. The facility nurse assessed the resident and continued all ADLs with assistance of one staff, but additionally assessed the resident as not being able to hold a fork or glass without assistance. An incident report indicated the resident was crawling out of bed and had rug burns to her knees. Progress notes indicated the resident had incoherent speech but was able to follow direction. The resident was not able to hold herself up or walk. The resident's mattress was moved to the floor to prevent injury and safety checks every two hours were added. The nurse updated the resident's family and primary care provider.

Progress notes a week later indicated the resident continued a declined in function, including weakness, incontinence, and confusion.

The day prior to hospitalization, an overnight progress note, written by the AP, indicated the resident had bowel incontinence, was eating it, and required a shower. The resident was crawling on the floor and her mattress placed on the floor to prevent injury. The AP wrote she called the nurse. The next progress note by the nurse indicated the resident was lethargic, denied pain and had swelling to her right foot. The resident's knees buckled when standing. The nurse indicated the resident continued to require assistance of one staff. The nurse documented vitals, which were in normal limits, including oxygen saturation and temperature. The nurse placed a call to the primary care provider. Progress notes during the day indicated the resident ate breakfast and lunch with assistance. By evening, the resident was not able to stay awake during dinner and not able to walk well. Staff moved the resident to bed and provided a nebulizer. Unlicensed personnel (ULP) updated the nurse. The nurse came in the evening to assess the resident, who was confused. The nurse indicated to continue to monitor and update the provider with any other changes.

The overnight progress note, written by the AP, indicated safety checks every hour were done and peri-care for incontinence. At 5:00 a.m., the AP attempted to give the resident a drink of juice, but the resident did not drink and slept. Around 6:00 a.m., the resident's breathing changed with a "whizzing" sound. The AP notified the nurse. The next progress note, documented by the nurse, indicated she came to the facility to assess the resident. The resident had gurgled breathing and was unresponsive to stimuli. The resident's vitals indicated a change from the resident oxygen saturation from the day prior from 96% to 86%. The nurse called 911 and paramedics transported the resident to the hospital.

The resident's hospital records indicated the resident arrived to the ER for changes in mental status and shortness of breath. Vital signs taken through out the day at the ER showed critically low blood pressure, but other vitals were stable. The resident's lab value of troponin levels (heart damage indicator) were high and carbon dioxide levels were high in the blood stream (evident of lung failure). The resident's chest x-ray results showed no significant changes from a previous x-ray, which had abnormalities at baseline due to COPD. Heart monitoring showed an unstable heart rhythm which was abnormal compared to the heart monitor test at her last ER visit. Although, imaging of the head had unremarkable results, the resident displayed left sided weakness and the ER physician referred the resident to stroke neurology who recommended an MRI (magnetic resonance imaging) of the brain to rule out a stroke. The resident's family declined further testing and desired for comfort care for the resident. The resident died the next day while in the ER.

The resident's autopsy results indicated there was no evidence of stroke and had no explanation for the left sided weakness. The cause of death was pulmonary edema (abnormal fluid build up in the lungs) due to heart shock because of irregular heart rhythm and congestive

heart failure. The clinical pathology determined the excess fluid was due to backed up blood from the heart. Lung exam showed emphysema (lung disease) changes consistent with COPD. Inflammatory cells were found consistent with congestive heart failure. The extent of pneumonia was “not dramatic enough” to suggest she died of pneumonia alone and although a clinical concern of aspiration was expressed, it was “not appreciated” on the examination of lung tissue at the autopsy. Pulmonary edema resulted from heart failure impaired gas exchange in the lungs leading to life-threatening hypoxia (lack of oxygen). Other organs presented with excessive fluid and elevated troponin levels showed the primary cause of death was related to the heart.

During an interview, the AP stated safety checks were every two hours, however because the resident had been weak and declining, she completed every one-hour safety checks and helped her with the bathroom. The AP said the resident had been able to do a lot of things by herself previously. After she started declining, she also had incontinent bowel episodes, including her messing around with the bowel movement. The AP said during a typical night, the resident usually would drink during the night, but the night before she went to the hospital, she declined when offered and said “later.” The AP said previous nights her mattress was on the floor, but that night her mattress was on her bed. The AP said the resident usually snored really loud and could be heard in another room. The AP said around 6:00 a.m., her snore was not loud and that was unusual for her; her breathing was different. She contacted the nurse who came in right away and assessed her. The nurse sent her to the hospital.

During an interview, the nurse stated the resident was a heavy smoker and refused to decrease the amount she smoked. The resident had a fall and shoulder fracture approximately nine months prior to her death, however was not a candidate for surgery due to her smoking. Therefore, her shoulder healed in a way that impaired her mobility of that arm around six months after the injury. At that point, the resident required more assistance. The nurse stated during the resident’s decline she frequently assessed the resident, reported changes to her psychiatrist and primary care provider. The nurse stated she took the resident to the ER the first time and to her primary care provider appointments. The nurse stated she increased assistance for the resident as she required total assistance with all ADLs. The nurse stated she did not receive any concern about the resident’s ability to eat or drink. The nurse stated she also kept the resident’s family updated on her condition.

During an interview, an ULP stated as the resident declined, they had to provide a lot of assistance with her ADLs including eating and drinking. The ULP stated the resident had physical weakness to hold silverware and a glass, but did not have difficulties eating or drinking.

During an interview, a family member stated she felt the facility provided good care to the resident and the facility nurse kept her updated on the changes. The family member stated the resident had a long history of heart problems and was a chronic smoker. The family member stated the resident moved to the facility because her breathing was bad due to smoking that her previous location was no longer accessible due to stairs. The family member stated the

resident continued to decline in health status and mental status; eventually the resident was no longer able to have conversations with her on the phone. The family member stated she was grateful the nurse encouraged to have a visit with the resident prior to her death because she had not been well for a while.

Another family member declined to interview, but stated she saw on camera the AP provide water to the resident and she choked. The family member stated there was no video available.

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: No, resident is deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility assessed the resident, provided services as the resident required more assistance, updated the physicians and made medication order changes.

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
	37677	A. BUILDING: _____ B. WING _____	C 04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN OAKS HOME CARE LLC	8481 134TH STREET COURT APPLE VALLEY, MN 55124

(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 April 30, 2025, the Minnesota Department of Health conducted a complaint investigation HL376775163C/HL376778402M. No correction orders are issued.	0 000		