Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H81541981M
Compliance #: H81543173C

Date Concluded: April 27, 2023

Name, Address, and County of Licensee Investigated:
Olidia Care Inc.
7530 Market Place Drive
Eden Prairie, MN 55344
Hennepin County

Facility Type: Home Health Agency (HHA)

Evaluator's Name: Willette Shafer, 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) abused a client when the AP rolled the client while in bed and the client fell on the floor.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The AP was not responsible for the maltreatment. During incontinence cares, the AP rolled the client to his side when the client's weight shifted and caused the client to fall from his bed to the floor. The AP immediately called for help and emergency medical assistance. The client was brought to the hospital and died a few days later. The incident was a sudden and unforeseen event.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigator contacted a family member. The investigation included review of the resident's medical record, personnel files, incident report, schedules, hospital record, and police report.

The client resided in his home and received services from a home care agency. The client's diagnoses included quadriplegia and acute and chronic respiratory failure. The client's service plan included assistance with incontinence cares, repositioning, medication administration, suctioning, cough assist, oxygen, tracheostomy care, and transferring.

The police report indicated nothing was out of the ordinary or suspicious. The police report indicated emergency medical assistance and the fire department assisted the client and the client was transported to the hospital.

The client's hospital record indicated; emergency medical services were called after the client rolled out of bed. The client had a laceration on his head. The client was on a medication to thin his blood which caused an internal bleed in his head.

During an interview, the nurse stated the AP was following the client's care plan at the time of the incident. The nurse said the AP reported the client rolled out of bed when the AP was turning the resident during cares. The nurse said the AP had no similar incidents or complaints against her. The nurse said the family member reported the same information about the incident as the AP. The nurse said the client cares were provided by one staff and the AP was following the client's care plan at the time of the incident.

During an interview, the family member stated the AP woke her mid night requesting help. The family member said the AP was providing incontinence care to the client and when the AP rolled the client to his side, his weight shifted too much and the client fell from his bed. The family member said the AP had worked with the client for years before the incident and there were no concerns with the care provided by the AP. The family member said the AP followed the client's treatment plan. The family member described the client as a large man with a big belly, who was unstable in a side lying position. The family member said the resident declined grab bars on his bed.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;

(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No, failed to respond to subpoena.

Action taken by facility:
The facility completed re-education with staff.

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: 248154	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLIDIA CARE INC	7530 MARKET PLACE DRIVE , EDEN PRAIRIE, Minnesota, 55344

(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 The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H81541981M, 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