Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL274735442M
Compliance #: HL274732802C

Date Concluded: November 18, 2025

Name, Address, and County of Licensee Investigated:
Golden Nest
1918 19th Avenue Northeast
Minneapolis, MN 55418
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brandon Martfeld, 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 alleged perpetrator (AP) abused the resident when a harness belt was placed over the resident's head and a lap/seat belt was used to secure the resident into the wheelchair.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The resident required a medical device that included a harness and lap seatbelt when up in her wheelchair. The facility initially failed to have the medical device assessed and care planned, however the use of the medical device was utilized in a therapeutic manner to support the resident's upper body. No AP was identified for being responsible in the investigation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, facility incident reports, staff schedules, and related facility policy and procedures. Also, the

investigator observed the resident's medical device in place while the resident in her wheelchair.

The resident resided in an assisted living facility. The resident's diagnoses included stroke affecting left side of the body, mild cognitive impairment and dementia. The resident's service plan included assistance with transfers that required two staff and a mechanical lift, and the resident's left arm needed to be supported. The resident's assessment indicated the resident was dependent on staff for activities of daily living and was cognitively impaired. The resident's assessment failed to identify the resident's medical device on her wheelchair.

Review of the resident's medical records indicated the facility staff had not assessed the resident for the use of the medical device and the care plan was not developed at the time of the allegation. At the time of the investigation, the facility had completed an assessment, and the care plan indicated the resident had poor upper body control and required the medical device when up in her wheelchair.

A physician order for the medical device indicated the resident had impaired upper body control and upper limp weakness. The resident had impaired upper body stability which increased the risk for the resident to fall when the wheelchair was being used. The medical device was used to provide upper body control and promote appropriate seated posture.

During an onsite visit, the investigator observed the resident in her wheelchair with a medical device and lap seatbelt positioned around the resident's body. The harness was made of velvet material, and the medical device was loose enough to not put any pressure on the resident's skin. Additionally, the left arm rest had substantially loose Velcro straps where they were not holding the resident's arm down. If the resident had any mobility of her left arm, she would have been able to pull her arm out.

Review of the resident's record indicated there was not any skin concerns related to the use of the medical device. The resident's record lacked written direction to unlicensed personnel (ULP) for the application and monitoring of the harness, lap seatbelt, and arm rest straps when in use. Although the medical device was used properly, lack of written directions had the potential to lead to an unsafe use of the device and a licensing order was issued.

During an interview, an ULP stated the medical device was applied to the resident when the resident was up in her wheelchair for meals. The medical device prevented the resident from sliding out of the wheelchair. The resident was up for approximately 30 minutes to an hour and laid back down in bed.

During an interview, leadership staff stated the resident had been hospitalized and when she returned a new wheelchair was delivered to the facility. When the wheelchair was delivered the medical device was in place and mounted on the wheelchair. The medical device was not assessed, and a plan of care was not developed for the resident initially. Leadership stated they

verbally directed facility staff to apply the medical device around the resident when the resident was up in her wheelchair. The medical device was used to prevent the resident from leaning forward and falling out of the wheelchair because the resident had poor upper body control. Leadership stated approximately four months after the resident's wheelchair was delivered to the facility, the medical device was assessed, added to the resident's plan of care and an order from the resident's primary care provide was obtained.

During an interview, the resident stated she preferred to wear the medical device.

During an interview, a family member stated she worried about the resident falling out of the wheelchair, and the medical device helped prevent the resident from falling.

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; or
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.

(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility assessed the resident with the medical device, added the device to the care plan and obtained a physician order for the therapeutic use of the medical device.

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
	27473	A. BUILDING: _____ B. WING _____	C 11/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN NEST LLC	1918 19TH AVENUE NE MINNEAPOLIS, MN 55418

(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: HL274735442M/HL274732802C On November 3, 2025, 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 19 residents receiving services under the provider's Assisted Living license. The following correction order is issued for HL274735442M/HL274732802C, tag identification 450.	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.	
0 450 SS=D	144G.41 Subdivision 1 Minimum requirements	0 450		

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0 450	Continued From page 1 All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on observation, interview and documentation, the licensee failed to have a person-centered plan of care in place for frequency of monitoring and directions to unlicensed personnel for use of a medical device for one of one resident (R1). 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During an observation on November 3, 2025, at 9:19 a.m., R1 was observed in her wheelchair with a chest harness and lap/seat belt in place. In	0 450		

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0 450	Continued From page 2 addition, R1's left arm was positioned on a black support cushion that was built into the arm rest of the wheelchair and had two straps applied around her left arm. R1's diagnoses included stroke affecting left side of her body, mild cognitive impairment, and dementia. R1's service plan dated April 25, 2025, indicated R1 required two staff and a mechanical lift for transfers. R1's service plan indicated R1 required support of her left arm. R1's assessment dated June 19, 2025, indicated R1 had left sided impairment due to a stroke and required staff assistance for wheelchair mobility. A physician order dated August 28, 2025, indicated R1 had impaired upper body control and upper arm weakness. The resident had impaired upper body stability which increased the risk for the resident to fall when the wheelchair was being used. The medical device was used to provide upper body control and promote appropriate seated posture. R1's medical record lacked evidence about the use of the two black straps around her left arm. In addition, R1's medical record lacked evidence of directions to unlicensed personnel (ULP) for the application and monitoring for the use of the medical device and two black straps that included effectiveness, R1's skin integrity, safety, R1's physical and emotional status, and how frequent the medical device should be checked. During an interview on November 3, 2025, at 9:34 a.m., ULP-F stated the anterior harness and	0 450		

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0 450	Continued From page 3 lap/seat belt were to prevent the resident from sliding out of the wheelchair. ULP-F stated the two black straps around R1's left arm was to ensure her arm did not fall off the support cushion. ULP-F stated R1 used the anterior harness, lap/seat belt and two straps around her left arm when R1 gets up for meals. ULP-F stated R1 will get up in her wheelchair for meals and be up for 30 minutes to one hour and is laid back down in bed afterwards. During an interview on November 3, 2025, at 12:40 p.m., registered nurse (RN)-A, licensed assisted living director (LALD)-B and RN-C stated R1 had been hospitalized and when she returned, a new wheelchair was delivered to the facility. RN-A stated when R1's new wheelchair was delivered the medical devices that included the anterior harness, lap/seat belt and the two black straps were in place. RN-A stated the licensee staff were to apply the medical devices when R1 was up in her wheelchair. RN-A stated the medical device was to prevent R1 from leaning forward and falling out of the wheelchair because R1 had poor upper body control. During an interview on November 3, 2025, at 1:17 p.m., R1 stated the medical device and two black straps did not bother her. During an interview on November 4, 2025, at 9:48 a.m., family member (FM)-E stated she preferred R1 used the medical device because of the risk of R1 falling out of her wheelchair. The licensee's Restraint policy dated August 1, 2021, indicated the licensee was not to use manual restraints under any circumstances.	0 450		

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0 450	Continued From page 4 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		