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 #: HL274736002M
Compliance #: HL274738682C

Date Concluded: January 23, 2025

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

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Holly German, RN
Special Investigator

Finding: Substantiated, facility responsibility

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 resident fell down the facility stairs and died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to ensure access to a stairwell was secured, creating a safety hazard. The resident was confused, blind and ambulatory when she admitted to the second floor of the facility. Two days after admitting to the facility, the resident walked to the stairwell independently, fell down the stairs, and passed away approximately three hours later at the hospital.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigator contacted the resident's family members. The investigation included review of the resident records, death record, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related

facility policy and procedures. Also, the investigator observed cares provided to residents, and a resident using the stairs independently while at the facility.

Medical records indicated the resident admitted to the facility after a stay at a skilled nursing facility following a stroke. The previous facility discharge assessment, provided to the facility, indicated the resident used a walker and needed standby assistance outside of her home due vision loss. She was independent with bed mobility and sometimes needed assistance in getting up. The emergency response indicated the resident could independently evacuate with the use of an elevator and her walker. The resident had complete loss of eyesight in the left eye and the right eye had worsening blurry vision due to severe glaucoma. The discharge assessment indicated the resident was intellectually intact, could make her needs known and oriented, however the resident's family member reported the resident being confused about discharging to a new facility.

The resident admitted to the assisted living facility, which was a residential split-level home. The resident admitted on a Friday. The facility failed to complete a comprehensive assessment prior to accepting the resident for admission nor at the time of the resident's admission. Therefore, the facility did not assess the resident's functional or cognitive vulnerabilities and safety concerns due to moving to a new environment with impaired vision, including assessing an ability to independently walk up and down stairs.

The facility created the resident's temporary care plan at the time of admission based on receiving the skilled nursing facility discharge assessment and admission orders. The resident's care plan included assistance with toileting and walking with walker. The care plan indicated the resident "always" needed one person assistance with mobility due to vision impairment. The care plan did not include a registered nurse (RN) signature and lacked authentication of who created the care plan.

The facility incident report indicated the resident had resided at the facility for two days when the staff found her at the bottom of the stairs unresponsive. Staff called 911 and the resident transported to the hospital.

The resident's hospital record indicated the resident arrived at the emergency department with blood from the nose which appeared deformed, blood in the ears, intubated, with a neck brace in place after a fall down multiple stairs. The record indicated the resident presented to the emergency room after CPR (cardio pulmonary resuscitation) had been initiated due to cardiac arrest (when the heart stops beating). The record indicated the family decided to not escalate care and the resident passed away approximately three hours after arriving to the hospital.

The resident's death record indicated her cause of death was blunt force trauma to head and neck secondary to a fall.

While at the facility, the investigator observed a metal gate at the top of the stairwell in the entry of the facility. The gate had an unsecured lever that only required to be flipped up to open the gate. The resident's room was located on the second floor of the facility, approximately 20 feet from a set of stairs that led down to the front door of the facility. The gait had been installed after the incident and was not in place prior to the resident's fall.

During an interview, the licensed assisted living director (LALD) stated an assessment of the resident was not completed by the nurse due to the rush of the admission and the nurse not being available. The LALD stated she completed a temporary plan of care for the resident based on information provided from the discharging facility and information from the family. The LALD stated she did not see the resident as having a risk for falls due to her needing assistance from staff to transfer and walk. The LALD stated there was no gate at the stairwell when the resident admitted to the facility. The LALD stated the second floor of the facility housed residents who are ambulatory, some of which use a walker or a cane. The LALD stated the resident's family did not voice any concerns during admission or during the resident's stay at the facility.

During an interview, the RN stated she was not available to assess the resident prior to her admission to the facility on a Friday. The RN stated she was going to assess the resident on Saturday but was unable to return to the facility until Tuesday due to a family emergency, therefore the resident was not assessed by a nurse prior to her death. The RN stated she never saw or met the resident.

During an interview, a family member stated the resident was confused upon admission to the facility. The family member stated the resident could walk on her own. The family member stated she expressed concern of the resident's room being on the second floor because the resident had severe vision impairment, and the stairs had no gate or anything. The family member stated the facility told her they would help the resident go up and down the stairs by using the chair lift located at the back side of the building.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):
(1) The facility did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The facility did not direct an erroneous order, direction, or care plan.

(2) The facility was not in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

(3) The facility failed to follow professional standards and/or exercise professional judgement.

The facility failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility created a temporary plan of care and educated staff of the care needs of the resident.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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

Hennepin County Attorney
Minneapolis City Attorney
Minneapolis Police Department
Minnesota Board of Executives for Long Term Services and Supports

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 12/11/2024

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: HL274738682C/HL274736002M On December 11, 2024, 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 22 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for HL274738682C/HL274736002M, tag identification 1610, 2310, 2360.	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.	
01610 SS=J	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring	01610		

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01610	Continued From page 1 (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to complete a comprehensive assessment for a new admission for 1 of 1 residents (R1) reviewed. The registered nurse (RN) failed to complete an assessment of R1 prior to admission nor an initial assessment when R1 began services. R1's safety risks were not identified and no interventions implemented when R1 had visual impairments in a new environment. R1 fell down the stairs and died. This practice resulted in a level four violation (a violation that results in 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).	01610		

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01610	Continued From page 2 The findings include: R1's previous facility discharge care plan dated August 29.2024 was printed and provided to the licensee on September 13, 2024, indicated indicated the resident used a walker and needed standby assistance outside of her home due vision loss. She was independent with bed mobility and sometimes needed assistance in getting up. The emergency response indicated the resident could independently evacuate with the use of an elevator and her walker. The resident had complete loss of eyesight in the left eye and the right eye had worsening blurry vision due to severe glaucoma. The discharge assessment indicated the resident was intellectually intact, could make her needs known and oriented, however the resident ' s family member reported the resident being confused about discharging to a new facility. R1's medical records lacked any assessment completed by the RN, including a preadmission nor admission comprehensive assessment. R1's service delivery record dated September 2024, indicated R1 first received services on September 13, 2024. R1 received assistance with toileting and transfers. R1's temporary care plan, not dated, indicated R1 required assistance with toileting and walking with walker. The care plan indicated R1 "always" needed one person assistance with mobility due to vision impairment. The care plan did not include a registered nurse (RN) signature and lacked authentication of who created the care plan. An incident report dated September 15, 2024, at	01610		

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01610	Continued From page 3	01610		

2:20 p.m., indicated R1 was found at the landing of the stairs by the front door after falling down the stairs. Staff called 911 and R1 was transported to the hospital.

R1's hospital record dated September 15, 2024, indicated R1 arrived at the emergency department with blood from the nose which appeared deformed, blood in the ears, intubated, with a neck brace in place after a fall down multiple stairs. The record indicated R1 presented to the emergency room after CPR (cardio pulmonary resuscitation) had been initiated due to cardiac arrest. The record indicated R1 passed away approximately three hours after arriving to the hospital.

R1's death record indicated R1 died September 15, 2024, at 5:34 p.m. The record indicated R1's cause of death was blunt head and neck trauma due to fall.

During an onsite visit on December 11, 2024, at 8:25 a.m., the surveyor observed the licensee was a split-level family home. R1 resided on the upper-level floor. The room R1 had resided in was located approximately 20 feet from the stairs. The surveyor observed an unsecured gate at the top of the stairs, with a lift handle to open the gate.

During an interview on December 11, 2024, at 10:30 a.m., RN-E stated she did not perform an assessment on R1. RN-E stated R1 admitted on a Friday and RN-E was not at the facility. She was going to do an assessment the next day (Saturday) but had a family emergency and was not back to the facility until the following Tuesday. RN-E stated she did not meet R1.

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01610	Continued From page 4	01610		

During an interview on December 23, 2024, at 1:00 p.m., licensed assisted living director (LALD)-B stated prior to the admission of R1, she met R1 in person on Thursday at the care facility she was at. LALD-B stated she preferred to have R1 admit to the facility on Tuesday instead of in a rush on Friday due to the nurse not being available to see R1. LALD-B stated she felt pressure from the family to admit R1 right away. LALD-B stated she created a temporary care plan for the resident and held a meeting with the staff on the care R1 needed.

During an interview on December 23, 2024, at 2:00 p.m., family member (FM)-C stated R1 was able to get up on her own when she admitted to the facility. FM-C stated R1 was legally blind in one eye and could only see brightness, darkness, or a fuzzy figures in the other eye. FM-C stated FM-D explained to the facility staff about R1's vision disabilities. FM-C stated she spoke to R1 about using the call light because she and the staff knew R1 could get up on her own. FM-C stated she was not aware if R1 had been assessed for a fall risk.

During an interview on December 24, 2024, at 2:00 p.m., FM-D stated R1 had become very confused prior to admitting to the facility from a nursing home which was not R1's baseline. FM-D stated the facility knew R1 had trouble walking, falling, could not see, and accepted R1 for placement. FM-D stated when she arrived with R1 to the facility the day of admission, she noted staff using a chair lift to bring R1 to the second floor. FM-D stated she told staff she did not like the idea of needing to use a chair lift and staff stated the only available room was on the second floor. FM-D stated she noticed the stairwell near R1's room and told staff she was concerned

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01610	Continued From page 5 about the steps since there was no gate or anything at the stairs, voicing the danger for R1 to be on the second floor. FM-D stated staff told her there was a room on the main floor that R1 could move to after the resident who was currently in it completed a covid isolation. FM-D stated R1 could not see well, and at her previous apartment she could touch items to know where she was and to manage moving around, but at the facility everything was new and R1 was not used to it. FM-D stated the facility should not have accepted R1 for admission if they were not ready for her. The licensee-provided policy titled "Acceptance of Resident" dated August 1, 2021, indicated the clinical nurse supervisor will evaluate the agency's ability to meet the clinical need of a resident, and the RN conducts and initial assessment. The licensee-provided policy titled "Assessment and Reassessment" dated August 1, 2021, indicated the initial RN assessment will be completed prior to the date on which the prospective resident executes a contract or on the date on which the prospective resident moves in, and if necessary, the assessment may be conducted via telecommunications. Additionally, the policy indicated if services are provided to a resident before the assessment, the RN will complete a temporary plan with the resident and orient staff to services. TIME PERIOD FOR CORRECTION: Seven (7) days	01610		
01620 SS=H	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 6	01620		

(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.
(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.
(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on interview and document review the licensee failed to assess mobility status in relation to physical environment risk factors for falls on ongoing assessments for 2 of 3 residents (R2, R3) reviewed. The licensee installed a gate at the top of the stairs after an incident of a resident falling down the stairs. The licensee failed to assess R2 and R3 for capability and safe use of the stairs.

This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death,

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01620	Continued From page 7 or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During an onsite visit on December 11, 2024, at 8:25 a.m., the investigator observed the facility as a residential split-level home. Resident rooms were located on both the upper level and lower level of the home. At the top of the upper level stairs was an unsecured gate, with a lift handle to open the gate. At approximately 9:25 a.m., the investigator observed a resident (R3) walk down the stairs to the basement where R3 sat at a table and had a meal. When R3 completed the meal, R3 stood up and walked back up the stairs. There was no staff member observed monitoring or stand by assisting R3 down or up the stairs. An incident report dated September 15, 2024, at 2:20 p.m., indicated R1 was found at the landing of the stairs by the front door after falling down the stairs. Staff called 911 and R1 was transported to the hospital. R1's death record dated September 15, 2024, indicated R1 died due to head and neck injury due to the fall. R2's diagnosis included dementia and forgetfulness. R2's room was located on the second floor. R2's 90 day assessment dated October 08, 2024, indicated R2 was disoriented to situation and place and required assistance of one staff for mobility. The assessment indicated R2 scored a	01620		

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01620	Continued From page 8	01620		

"2" for a gait/balance assessment on a scale of 0-6, but did not indicate what a score of 2 indicated. The assessment indicates no vulnerabilities for safe ambulation. R2's assessment lacked evaluation of R2's ability or inability to safely use the stairs.

R3's diagnosis includes depression and anxiety. R3's room was located on the third floor.

R3's assessment dated November 27, 2024, indicated R3 was alert and oriented and was independent with transfers. The assessment indicated "staff to offer" R3 stand by assistance with stairs, but failed to evaluate R3's ability or inability to safely use the stairs independently.

During an interview on December 23, 2024, at 1:00 p.m., licensed assisted living director (LALD)-B stated they place residents who need assist with walking on the second floor despite not having an elevator in the facility, because when the residents use their call light, they can get to them fast. LALD-B stated prior R1 falling down the stairs, ambulatory residents were not assessed for using the stairs. LALD-B stated the facility installed a gate to the top of the stairs after R1 fell down the stairs. LALD-B stated after the fall incident of R1, they now ensure staff assist any resident up and down the stairs.

The licensee-provided policy titled "Assessment and Reassessment" dated August 1, 2021, indicated the RN will provide the admission visit, conduct and document a comprehensive assessment and prepare a care plan based on the comprehensive evaluation. Ongoing resident assessments will be conducted based on changes in the needs of the resident and not to exceed 90 days.

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01620	Continued From page 9 TIME PERIOD OF CORRECTION: Seven (7) Days	01620		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	