Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL346001340M
Compliance #: HL346005700C

Date Concluded: April 13, 2026

Name, Address, and County of Licensee Investigated:
Golden Touch Health Care LLC
6800 Scott Avenue North
Brooklyn Center, MN 55429
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Holly German, 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 the resident when he held the resident's wrist and twisted the resident's arm.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Although there was conflicting reports of the incident between the resident and the AP, there was not evidence of injury. Both law enforcement and a nurse determined there was no sign of injury to the resident, who declined medical attention when offered.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's psychiatrist and law enforcement. The investigation included review of the resident records, internal facility investigation, facility incident reports, personnel files, staff schedules, law enforcement report,

and related facility policy and procedures. Also, the investigator observed resident and staff interactions while on site.

The resident resided in an assisted living facility. The residents' diagnoses included depression and borderline personality disorder. The resident's service plan included assistance with medication administration, hygiene, and mental health management. The resident's assessment indicated the resident was independent with walking, had history of chronic daily pain, was at risk of abusing others, and being abused by others. The assessment indicated the resident had impaired judgement, agitation, and exhibited behaviors of disrobing her clothes, being sexually inappropriate, socially inappropriate, had persistent and irrational suspicions and mistrust of others, and physical aggression.

A facility incident report indicated the resident stated the AP had emotionally and physically hurt her when the AP grabbed her wrist and twisted both her wrist and arm. The report indicated law enforcement arrived and spoke to the resident and the AP. The AP denied the stated allegation, and the resident declined medical attention. The report indicated a nurse completed an assessment on the resident, no physical injury was noted, and the resident declined medical attention the second time.

A facility internal investigation interviews document indicated the AP stated he did not twist the resident's arm or wrist. The AP stated the resident inquired about the space heater in the kitchen, and the AP told her it was brought downstairs. The AP stated he spilled some food on the floor, and when he wiped it up, the resident accused him of trying to hide evidence of burn marks from the heater. The AP stated he placed the debris from wiping up the spilled food in the trash. The resident attempted to take it out of the trash, and it fell on the floor, so the AP attempted to pick it up from the floor. The resident began yelling when the AP refused to give the trash back to her. The AP stated he placed the debris back in the trashcan and the resident continued to yell the AP was squeezing her wrist and twisting her arm. The resident stated she would call the police because the AP had taken her scotch tape earlier, and she would ensure he would go to jail. The resident declined to be interviewed about the incident during the facility's internal investigation.

A law enforcement report indicated police arrived at the facility and the resident reported the AP put his hands on her after she dug in the trash to retrieve a rag the staff used to clean up the damage caused by an overheated space heater. The report indicated the officer advised the resident to take the issue up with management in the morning, and the call was closed.

Resident progress notes indicated the nurse arrived at the facility after the alleged incident and assessed the resident. The notes indicated there was no injury noted to the resident. The notes indicated the resident stated she did not want the AP in the house and threatened the AP that he would lose his job. Subsequent resident progress notes did not indicate any complaints of pain or injury by the resident.

During an interview, unlicensed personnel (ULP)-1 stated the resident had behavior issues such as interfering in other people's business and making up lies about staff. ULP-1 stated the resident had told her the AP was her favorite caregiver, but the AP was moved to another facility to work after the resident stated she no longer wanted him to work at the facility.

During an interview, ULP-2 stated the resident was known to interject herself into other people's conversations, did things to make others mad and then reported the person when they got mad. ULP-2 stated she did not have concerns about the AP's quality of work and never saw any injury to the resident's hand or wrist.

During an interview, a nurse stated all staff were trained on abuse and neglect, and the staff were directed on how to handle each resident's behaviors based on directive in the resident care plan. The nurse stated there was no evidence revealed in the facility investigation that a physical incident occurred between the resident and AP. The AP was no longer scheduled to work at the facility for his own protection.

During an interview, the AP stated he received training on abuse and neglect. The AP stated the resident had history of making false claims and denied he grabbed or twisted the resident's wrist. The AP stated the resident had come out of her room demanding to see the space heater and claimed she could fix it. The AP stated the resident demanded to see the wipe he used to clean up food he had spilled on the floor, because she believed it was used to clean up a burn mark from the space heater. The AP stated he told the resident not to go in the trash, but the resident took the wipe out of the trash and the wipe fell from her hand to the floor. The AP stated he picked it up from the floor and the resident attempted to take the wipe from him and started to yell help, help, leave me alone. The AP stated he called his supervisor at that time and was advised to give the resident space. The AP stated his hands were not on the resident. The AP stated he called law enforcement. When they arrived, they took a report from the resident and told him to just stay away from the resident before they left.

During an interview, the resident's case manager stated she did not believe the resident intended to tell lies, but the resident was not an accurate reporter. The case manager stated the resident thought people said things, and the resident interpreted it in her way, even though it was not what was said. The case manager stated the resident's physical care needs were met at the facility, and the resident went back and forth on stating whether she felt safe at the facility. The case manager stated she believed the resident's back and forth stance on her safety at the facility had to do with the resident's mental health issues.

During an interview, the resident's psychiatric medical provider stated she could not say with a degree of certainty if the resident was a reliable reporter or not. The provider indicated the resident had reported to her multiple residential moves due to the resident being evicted for her behaviors. The provider stated the resident was not compliant with her mental health plan of care and did not follow through with the recommended consultations and assessments she had ordered. The provider stated the resident told her she was safe at the facility.

During an interview, the resident stated she saw a flash and smelled something burning. The resident stated she saw the AP take the space heater from the kitchen and a burn mark on the floor. The resident stated she asked the AP what happened, and he told her not to mind. The resident stated she wanted to know so she could tell the other residents about the fire hazard. The resident stated the AP took a wet wipe to clean the burn mark on the floor and tried to hide the fact there was a burn mark. The resident stated she took the wipe out of the trash to show another resident as proof of a burn, when the AP came behind her, grabbed her left arm and hand in which the wipe was in, and twisted her arm for about a minute. The resident stated she yelled stop, don't touch me, let me go, and help. The resident stated another resident came out of her room and the AP let go of her.

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.

Vulnerable Adult interviewed: Yes.

Family/Responsible Party interviewed: No, resident was own responsible person.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility no longer scheduled the AP to work at the same facility as the resident.

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
	34600	A. BUILDING: _____ B. WING _____	C 03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN TOUCH HEALTH CARE LLC	6800 SCOTT AVENUE NORTH BROOKLYN CENTER, MN 55429

(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 March 16, 2026, the Minnesota Department of Health initiated an investigation of complaint HL346005700C/HL346001340M and HL346005847C/HL346006623M. No correction orders are issued.	0 000		