Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL346008602M
Compliance #: HL346005824C

Date Concluded: April 11, 2025

Name, Address, and County of Licensee Investigated:
Empire System Home Care/Golden Touch
6324 Scott Ave N
Brooklyn Center MN 55429
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Maggie Regnier
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 by slapping the resident on the buttocks.

Investigative Findings and Conclusion: The Minnesota Department of Health determined abuse was not substantiated. No specific AP could be identified. The resident gave a name, but no one could be found to match it.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted other residents and care managers. The investigation included review of the resident records, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures. Also, the investigator observed staff interactions with other staff, visitors and residents.

The resident resided in an assisted living facility. The resident's diagnoses included personality disorder and paralyzed from the waist down.

A concern arose when the resident reported being inappropriately touched when an employee slapped the resident's buttocks and commented about the size of the resident's "backside". The resident provided a specific name as the person who did this.

A review of documents identified no employee nor visitor nor resident by the name of the AP.

During an interview, a different resident stated she had been at the facility for more than seven years and never knew or heard of the name of the AP. This resident further stated she has always been treated with dignity and respect by staff at the facility.

During an interview, manager #1 stated she had not heard of the name of the AP or anyone at the facility over the last few years she worked there. Manager #1 stated the resident was at the facility for a total of 3 months but was no longer there.

During an interview, manager #2 stated the resident never reported any inappropriate interactions with staff during the three months the resident was at the facility [the concern was reported after the resident was no longer living at the facility]. Manager #2 stated no one among the employees, visitors, nor residents had been identified by the name reported by the resident.

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:
(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: No, attempts to interview were unsuccessful

Family/Responsible Party interviewed: No resident is responsible for himself
Alleged Perpetrator interviewed: No specific AP could be identified with the name provided

Action taken by facility: The facility worked with the investigator during the investigation.

Action taken by the Minnesota Department of Health: No further action 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 03/20/2025

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 20, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL346005824C/#HL346008602M. No correction orders are issued.	0 000		