Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL349196222M
Compliance #: HL349194840C

Date Concluded: December 23, 2025

Name, Address, and County of Licensee Investigated:
Global Case Management East St. Paul
217 Winifred Street East
St Paul MN, 55107
Ramsey County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Kris Detsch, RN
Special Investigator

Finding: Substantiated, individual 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 a resident when they left him unattended in the community. While he was unattended, community members assaulted him prompting someone to call law enforcement who then sent the resident to the hospital. Upon hospitalization, the resident had seizures and became critically ill (life-threating). The resident required treatment in the intensive care unit (ICU).

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The alleged perpetrator (AP) was responsible for maltreatment. The AP, who was an unlicensed personnel (ULP), failed to follow the resident's care plan and left him unattended at a park in the community. The AP also failed to ensure the resident had his Angel Alert device (GPS tracking system). While the resident was unattended, community members kicked and threw rocks at him. Emergency responders (EMS) took the resident to the hospital where he had multiple seizures which became life threatening.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigator contacted case workers. The investigation included review of the resident records, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator toured the facility and observed their staffing structure, resident population, and medication administration systems.

The resident resided in an assisted living facility. The resident's diagnoses included a seizure disorder, aphasia (difficulty talking), and diabetes (disease effecting blood sugar levels). The resident's service plan included assistance with behavior and medication management. The service plan indicated the resident required staff to supervise him while he completed his own daily cares. The resident's nursing assessment indicated he walked independently and had a history of wandering.

The resident's individual abuse prevention plan (IAPP) indicated he had a history of altercations when he was out in the community. The IAPP indicated he was physically and verbally abusive to others. The IAPP required staff to be within visual range of him when he was in the community.

Medication administration records indicated the resident did not receive his medications the evening prior to the incident nor the morning of the incident. This included his seizure medications.

A facility incident report indicated the resident and the AP went to the community park. The AP left the resident at the park unattended when the AP went back to the facility to complete other tasks. When the resident did not return, the AP searched the park and surrounding area. The AP notified the manager who then contacted local hospitals in search of the resident. The resident went to the hospital after law enforcement were called to the park and was receiving care at the hospital for seizures. Due the resident lacking proper identification, it took a day for the facility to identify the resident's hospital admission.

Hospital records indicated the resident arrived at the emergency room (ER) early in the afternoon because someone assaulted him in the community. The records indicated he had seizures and required intravenous (IV) medications. The resident's physical health continued to decline, and he required treatment in the ICU. Hospital records indicated the resident's identity was unknown, so physicians were unaware of his medical history or medications. The records indicated acute (sudden) stress, low blood sugar levels, and/or non-compliance with medication management could have caused the resident's seizures. Hospital records indicated after they discovered the resident's identity, they were able to get his medical history which included a diagnosis of a seizure disorder. They were then able to find out what medications he required to manage it. Hospital records indicated the resident remined hospitalized for 18 days then discharged to a different location and did not return to the facility.

During an interview, a manager said the resident was only able to answer simple questions and say short phrases. The manager said the resident liked sports and physical activities; he went to the park or gym frequently during the week. The manger said the AP took the resident to the park after lunch, then left him there and returned to the facility. The manager said the AP got "caught up" at the facility doing various tasks and thought the resident would walk back home, but he did not. The manager said the AP went back to the park after his shift ended to look for the resident but could not locate him. The manger said the AP called him, so he came into the facility approximately two hours later. The manager said he went to two different hospitals and asked if the resident was there. The manager said he called law enforcement to see if they received any calls or had records about his whereabouts. The manager said he even called the local jail. The manager said the hospital contacted him the following day. The manager said the AP "knew better" then to leave the resident unattended and made a poor decision. The manager said this was an isolated incident. The manger said the resident was also supposed to have his Angle Alert device with him, but the battery was charging at the time of the incident. The manager said it was the AP's responsibility to ensure the resident had this device with him when he was out in the community.

During an interview, a hospital case worker said she saw the resident the day after he arrived in the ER and she worked with law enforcement to help identify him. Law enforcement told her the resident arrived at the hospital because they received two calls from community members. One caller indicated the resident was walking down the street yelling, the other caller said children in the community were kicking and throwing rocks at him. The case worker said law enforcement arrived at the hospital and took the resident's fingerprints; however, they were still unable to determine who he was. The case worker said law enforcement went to the community center (location close to the park) and asked people there about the resident and a janitor identified him. The case worker said once she had the resident's name, she was able to obtain information about him. The case worker said she contacted the facility manager then he went to the hospital and visually identified the resident. The case worker said the resident did not have his Angel Alert device with him when he arrived at the hospital.

During an interview, the AP said he was the only worker at the facility at the time of the incident. The AP said the resident took his medications in the morning and he was in a good mood. The AP said the other two residents left the facility for various reasons, so he took the resident to the park. The AP said the resident required staff to watch him, even at a distance. The AP said he left the resident and returned to the facility to use the restroom. The AP said he then completed household tasks and became distracted. The AP said the resident did not return home, so he went back to the park to look for him, but did not find him. The AP said the resident was unattended for about a couple of hours. The AP said he did not give the resident his Angel Alert system because he had to charge the battery. The AP said there were no other people around the resident when he left him at the park. The AP said the resident could not communicate with others. The AP said the resident's care plan indicated staff were to always supervise him. The AP said he got too comfortable and walked away from the resident. The AP

said this was an isolated incident. The AP said after the incident the facility provided re-education regarding missing residents, and their policy.

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 AP 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 in compliance with regulatory standards.

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

The facility provided adequate staffing levels.

The AP failed to follow the facility directive and/or policies and procedures.

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

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

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: No. Unable.
Family/Responsible Party interviewed: No. Attempted, did not respond.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility provided re-education to their staff regarding missing residents.

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
Ramsey County Attorney
St Paul City Attorney
St Paul Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34919	A. BUILDING: _____ B. WING _____	C 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLOBAL CASE MGMT-EAST ST PAUL	217 WINIFRED STREET EAST SAINT PAUL, MN 55107

(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: HL349194840C/HL349196222M On December 9, 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 two residents receiving services under the provider's Assisted Living license. The following correction order is issued issued for HL349194840C/HL349196222M, tag identification 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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 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 an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		