Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL356214722M
Compliance #: HL356219910C

Date Concluded: November 3, 2025

Name, Address, and County of Licensee Investigated:
Global Pointe Senior Living
5200 Wayzata Blvd 120
Golden Valley, MN 55416
Hennepin County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: James Larson, 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), a facility staff member, abused resident #1 when the AP grabbed and attempted to restrain resident #1 during a physical altercation while in resident #2's apartment.

The facility neglected resident #1 when resident #1 was found with bruising on his lower arms and untreated skin tears on his hand.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse and neglect were not substantiated. Although an altercation occurred the incident did not rise to the level of abuse. When resident #1's entered resident #2's apartment the AP grabbed resident #1's arm to keep resident #2 safe. The next day when resident #1's wounds were observed, facility staff cleansed and applied a dressing. The facility nurse assessed and updated the medical provider.

The investigator conducted interviews with facility staff members, nursing staff and a family member of resident #1. The investigation included review of resident #1's records, facility internal investigation documentation, as well as related facility policies and procedures. The investigator toured the facility, observed staff interacting with residents and completing scheduled care activities at the time of the onsite visit.

Resident #1 resided in an assisted living facility memory care unit. Resident #1's diagnoses included dementia, major depressive disorder and a history of skin cancer. Resident #1's service plan included assistance safety checks and medication administration. Resident #1's assessment indicated that resident #1 had a history of behavior issues previously controlled with medication regimen. Resident #1 had fragile skin was not cognitively intact and needed redirection from staff. The resident was able to ambulate independently without the use of assistive devices, although in the past physical therapy has recommended the use of walking poles/sticks to aid in falls prevention. A nursing assessment of body systems completed prior to the alleged incident indicated the resident's skin was classified by nursing staff as fragile, although at that time no wounds were on his skin.

Documents reviewed indicate that while visiting the resident at the facility over a holiday weekend, a family member reported to facility staff that they could see bruising on both forearms and wounds on the hand of the resident. They had not been previously informed of these injuries and wanted staff to report these concerns to the nursing staff.

Facility documents indicated the AP was assisting resident #2 with a shower. Resident #1 entered the apartment seemingly upset and attempted to hit the AP multiple times while also trying to remove resident #2 from the shower. The AP attempted to redirect resident #1 and protect himself while another facility staff was able to remove resident #1 from the bathroom. A facility document indicated the resident did not have injuries after the incident.

Facility documents reviewed also indicated the following afternoon the AP found resident #1 cleaning his hands in his apartment with a wet towel. The AP observed what was described as skin tears on the back of resident #1 hand, he cleansed the wounds and applied a bandage. When asked Resident #1 was not able to recall how they had occurred.

The medical record indicated the facility nurse assessed the wound and updated the medical provider. Resident #1 was treated with antibiotics and the wounds healed.

During an interview, the AP stated that while assisting resident #2 with bathing cares, resident #1 entered resident #2's apartment and was upset and began yelling at the AP. During the encounter, resident #1 attempted to pull resident #2 out of the shower and away from the AP. The AP repeatedly asked resident #1 to leave, and eventually a physical altercation ensued with resident #1 repeatedly striking at the AP. The AP called out for assistance as he positioned himself between resident #1 and resident #2 who continued to aggressively confront the facility staff members. Resident #1 was removed from the apartment by another staff person. The AP

stated that after the altercation he did not observe any physical injuries on resident #1. The AP went on to state that the next afternoon when he entered resident #1's room to administer medication as scheduled, he observed resident #1 at the sink. The AP stated he saw wounds on the back of resident #1's hands at that time.

During an interview, a facility staff person stated the night of the incident she heard yelling coming from the resident #2's room. Upon entering the room, she observed resident #1 in the bathroom yelling at the AP and repeatedly attempting to strike the AP with both hands. The facility staff person was able to redirect resident #1 out of the bathroom and out of the apartment into a common area of the memory care unit where she was able to calm resident #1 down. The staff member stated she did not see any visible injuries, bleeding or open wounds on resident #1's arms or hands on the day of the incident.

During an interview, a facility nursing staff member stated that memory care staff were familiar with the resident #1's behaviors and occasional outbursts and had all received training specific to memory care, related diagnosis and appropriate de-escalation techniques. In addition, it was noted that the resident had weeks earlier discontinued an antipsychotic medication, which was restarted days after this episode.

During an interview, a family member stated that he was not aware of any other altercations involving his family member and other residents or staff members at the facility. The resident continued to reside at the facility for months after the reported incident, and once a suitable facility was secured, the family chose to relocate the resident to another facility by their own choosing.

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.

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.

Vulnerable Adult interviewed: No, Unavailable for interview.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
Reeducation was provided to facility staff. The facility contacted the residents primary care provider to re-assess the need for medication changes and updated care orders.

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
	35621	A. BUILDING: _____ B. WING _____	C 10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLOBAL POINTE SENIOR LIVING	5200 WAYZATA BOULEVARD GOLDEN VALLEY, MN 55416

(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 October 16, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL356219910C/ #HL356214722M. No correction orders are issued.	0 000		