Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL358427142M
Compliance #: HL358426722C

Date Concluded: April 27, 2026

Name, Address, and County of Licensee Investigated:
Golden Touch Health Care
8216 Hampshire Ct N
Brooklyn Park MN 55445
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Maggie Regnier, 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 resident when the staff did not initiate cardiopulmonary resuscitation (CPR) upon finding the resident unresponsive.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility indicated on its Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) indicated staff received CPR training and was available for residents, however the facility had not trained its staff members for CPR. The resident was found unresponsive, and CPR was not initiated until emergency medical services (EMS) arrived.

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

The resident resided in an assisted living facility. The residents' diagnoses included lung disease, chronic obstructive pulmonary disease, bipolar and anxiety. The resident's service plan included assistance with medications, meals, bathing and behavior management. The resident's assessment indicated the resident was on home oxygen use administered through nasal canula.

The residents profile stated the residents code status was CPR, meaning the resident wanted CPR to be initiated in the event it was necessary.

A facility document indicated one morning a staff member checked on the resident and she responded, then got up and went to the bathroom. Twenty minutes later the staff member checked on the resident and found her on the bathroom floor unresponsive. The report indicated the staff member administered the residents' oxygen via nasal canula and called the nurse. The report further indicates 911 was then called and when EMS arrived, CPR was initiated.

The facility UDALSA indicated CPR was marked as "available". The same document indicated staff received CPR training (BLS) [Basic Life Support] from 3rd party providers.

During an interview, a supervisor stated the staff did not initiate CPR but waited until 911 responders arrived.

During an interview, a nurse stated she would not expect staff to perform CPR. The nurse further stated staff are not trained in CPR.

During an interview, the staff member stated he had not been trained in CPR. The staff member further stated he did not perform CPR.

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.

Vulnerable Adult interviewed: Deceased
Family/Responsible Party interviewed: NA
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility: The staff member called 911.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35842	A. BUILDING: _____ B. WING _____	C 03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN TOUCH HEALTH CARE LLC	8216 HAMPSHIRE COURT NORTH BROOKLYN PARK, MN 55445

(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 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: #HL358426722C/#HL358427142M On March 16, 2026, 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 4 residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for #HL358426722C/#HL358427142M, tag identification 2310 and 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.	
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 1 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure care and services were provided according to acceptable health care standards for one-of one resident reviewed (R1) when the facility indicated in its Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) staff received Cardiopulmonary Resuscitation (CPR) training and was available for residents however the facility had not provided this training nor was CPR available from a facility staff member when it was necessary for R1. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). All full code residents resusication were at risk. The findings include: The American Heart Association guidelines for CPR indicated effective resuscitation education for lay rescuers and health care professionals is an essential component of the Basic Life Support (2025). The facility UDALSA dated October 15, 2025	02310		

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02310	Continued From page 2 indicated under section 3 titled Treatments and Therapies, Training of and use of Cardiopulmonary Resuscitation (CPR) was marked available and the comment section indicated staff received CPR Training (BLS) from 3rd party providers. R1's Service Plan dated January 2, 2025, indicated she received services including assistance with medication management, dressing, and bathing. R1's Resident Profile indicated R1 was admitted to the facility April 1, 2025. This form also indicated R1 code status: CPR. R1's progress notes dated October 20, 2025, at 08:53 a.m., indicated R1 was found on the bathroom floor unresponsive and 911 was called. The same document indicated the police came and started CPR right away. The resident was pronounced deceased at the facility. A incident report dated October 19, 2025,[October 20,2025] indicated a staff member checked on the resident and she responded, then got up and went to the bathroom. Twenty minutes later the staff member checked on the resident and found her on the bathroom floor unresponsive. The report indicated the staff member administered the residents' oxygen via nasal canula and called the nurse. The report further indicates 911 was then called and when EMS arrived, CPR was initiated. A document titled Hennepin County Medical Examiner, dated March 17, 2026 indicated R1 died of natural causes on October 20, 2025. On April 7, 2026 director of nursing (DON)-B stated the unlicensed care giver (ULP)-D saw the	02310		

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02310	Continued From page 3 resident go into the bathroom. DON-B further stated that after a few minutes, ULP-D discovered R1 on the floor unresponsive. DON-B stated the facility incident report indicated the police came and started CPR. On April 9, 2026 ULP-D stated R1 went to the bathroom and after 15-20 minutes ULP-D went to check on R1. ULP-D stated R1 was on the floor, unresponsive. ULP-D further stated he called the RN and called 911 but did not start CPR. ULP-D stated he had not been training in CPR. On April 16, 2026 director of clinical services (DON)-C stated first responders started CPR, not staff. DON-C further stated the staff would not be expected to start CPR. DON-C further stated that some staff are not trained in CPR and other staff know CPR because they had learned before being hired at this facility. TIME PERIOD FOR CORRECTION: Immediate	02310		
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:	02360		

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02360	Continued From page 4 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		