DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL303452903M
Compliance #: HL303454896C

Date Concluded: October 9, 2023

Name, Address, and County of Licensee Investigated:
Golden Horizons Assisted Living
1790 College Way
Worthington, MN, 56187
Nobles County

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

Evaluator's Name: Christine Bluhm, 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:
The facility neglected the resident when the facility did not intervene or report abuse by a family member.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While the resident did have some injuries these were attributed to a fall. The investigation did not find evidence of abusive acts or interactions directed towards the resident.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigator contacted law enforcement for police an investigation report and the hospital for the resident's medical records. The investigation included review of facility policies and facility resident records. Also, the investigator observed visitor and staff interactions with current residents.

The resident resided in a secured assisted living memory care unit. The resident's diagnoses included late onset Alzheimer's disease, cardiac disease, and osteoporosis. The resident's service plan indicated the resident required assistance with all activities of daily living, bathing, dressing, meals, and medication management as well as safety checks and frequent supervision. The resident's cognitive assessment indicated the resident had difficulty expressing thoughts or word finding at times and may not be able to report abuse or neglect secondary to her dementia diagnosis. The resident's individual abuse prevention plan (IAPP) indicated that staff were to watch for signs and symptoms of abuse or neglect and report to administration if abuse was suspected.

The nursing documentation note in the resident's file indicated a police officer made a visit to the facility for a complaint of abuse and met with the resident's family and facility staff regarding the complaint.

The police report indicated the police department received a report that the resident was in the hospital as a result of injuries possibly due to abuse by her husband. Interviews obtained by the officer indicated family and a nurse believed the injuries were from a recent fall. Another staff interviewed by the officer, stated that the husband could be aggressive with the resident at times but had not witnessed abuse or harm. The report summarized there was no evidence that abuse occurred.

The resident's hospitalization record indicated the resident had injuries that included displaced ribs, a displaced pelvic bone and chronic spine compression fractures all believed to be consistent with fall injuries. The records did not mention suspected abuse.

During an interview, a facility staff person stated she never witnessed any abuse toward the resident and only heard the allegations second hand from another facility staff person.

During an interview, a nurse stated it was brought to her attention a vulnerable adult report had been made. She stated she was personally unaware of any suspected abuse and knew of no staff members who knew of such an occurrence. The nurse stated she understood the husband to be caring and helpful when staff members involved him in the resident's cares.

During an interview, a family member stated the resident was in the dementia unit at the time and if anyone touched the resident to do anything, use the restroom or help with a shower for example, the resident would scream out. He stated that the resident's injuries were consistent with a fall and was not aware of any abuse.

In conclusion, the Minnesota Department of Health determined neglect 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.

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, the resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
No action taken.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30345	A. BUILDING: ______ B. WING ______	C 08/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN HORIZONS OF WORTHINGTON	**1790 COLLEGEWAY WORTHINGTON, MN 56187**

(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 August 9, 2023, the Minnesota Department of Health initiated an investigation of complaint HL303452903M and HL303454896C. No correction orders are issued.	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE