Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL332556386M
Compliance #: HL332552058C

Date Concluded: June 8, 2023

Name, Address, and County of Licensee Investigated:
Golden Touch Health Care
6433 Georgia Avenue North
Brooklyn Park, MN 55428
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brandon Martfeld, 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 residents when they failed to have staff scheduled on-site at the facility to provide supervision for the residents.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The alleged perpetrator (AP) was responsible for the maltreatment. The AP was scheduled for a night shift but left the facility when a resident was displaying behaviors, leaving five vulnerable residents that required staff supervision, unsupervised at the facility.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the county case manager. The investigation included a review of residents' medical records, facility incident report, facility policy and procedures, and law enforcement report.

The resident list provided by the facility indicated the day of the incident a total of five residents resided in the assisted living facility. All five residents required 24/7 staff supervision for various mental health issues and medication management.

The law enforcement report indicated a resident of the facility called 911 and reported another resident had punched a hole in an interior door, broke a bathroom mirror, and pulled an outlet out of the wall. Law enforcement responded to the facility and found the resident in the attached garage of the facility, agitated, staring off in the distance with his fist in a ball. Law enforcement attempted and were unable to locate staff responsible for the residents. A third resident told law enforcement the AP left the facility in a vehicle.

The resident with the behavior refused to be evaluated at a hospital and the other four residents did not want to leave the facility. Law enforcement contacted the facility program manager informing management of the unsupervised residents at the facility. The law enforcement report indicated the residents were left unsupervised for at least one hour and 40 minutes.

During an interview, the AP stated a resident attempted to hit the AP in the medication room. The AP stated because of the resident behavior, the AP thought her blood pressure was elevated, left the facility, and went to a house two blocks away to obtain her medications. The AP did not attempt interventions to mitigate the behavior of the resident, protect the resident from self-harm or ensure the safety of the other vulnerable residents, and/or contact the nurse or 911 for assistance with the resident. The AP stated she did not return to the facility but was aware law enforcement had responded to the facility. The AP stated she was aware the residents required constant staff supervision. The AP stated she was no longer employed at the facility.

During an interview, the nurse stated the residents required constant staff presence and supervision. The nurse stated the AP is no longer employed by the facility.

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: No, the five residents were re-located to other facilities at the time of the investigation due to a facility fire.
Family/Responsible Party interviewed: NA
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
After the program manager was notified, the program manager went to the facility. The AP is no longer employed by the facility.

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
Hennepin County Attorney
Brooklyn Park City Attorney
Brooklyn Park Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33255	A. BUILDING: _____ B. WING _____	C 05/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN TOUCH HEALTH CARE LLC	6433 GEORGIA AVENUE NORTH BROOKLYN PARK, MN 55428

(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 LICENSING 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: HL332556504M / HL332552230C HL332556386M / HL332552058C HL332556364M / HL332552105C On May 16, 2023, 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 five total residents receiving services under the provider's Assisted Living license. No correction orders were issued for complaint #HL332556504M/#HL332552230C. The following correction orders are issued for HL332556386M/ HL332552058C and HL332556364M/ HL332552105C, tag identification 2360 and 3000.	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 License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
02360	144G.91 Subd. 8 Freedom from maltreatment	02360		

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02360	Continued From page 1 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 two residents reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	
03000 SS=F	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined	03000		

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03000	Continued From page 2 in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) two incidences of neglect for two of two residents (R1 and R2) reviewed and which had the potential to affect all five residents.	03000		

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03000	Continued From page 3 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), 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). The findings include: Review of R1's medical record indicated R1's diagnoses included depression and schizoaffective disorder. R1's Nursing Care Plan dated April 7, 2023, indicated R1 received assistance with mental health and medication management. Review of a law enforcement report dated April 27, 2023, indicated a resident called 911 and reported R1 had punched a hole in an interior door, broke a bathroom mirror, and pulled an outlet out of the wall. Law enforcement found the resident in the attached garage of the licensee, agitated, staring off in the distance with his fist in a ball. The law enforcement report the officer attempted but was not able to locate staff at the licensee. Another resident told the officer that staff left in a vehicle. R1 refused to be evaluated at a hospital, and the other four residents did not want to leave the licensee. The law enforcement report indicated five resident were left without staff supervision for at least one hour, and 40 minutes. During an interview on June 2, 2023, at 8:48 a.m., registered nurse (RN)-C stated the program manager handled the incident and would know if	03000		

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03000	Continued From page 4 the incident was reported to MAARC. During an interview on June 2, 2023, at 8:50 a.m. program manager (PM)-A stated he did not report the incident to MAARC. PM-A further stated he was not aware that the incident should have been reported. Review of R2's medical record indicated R2's diagnoses included pancreatic cancer, depression, anxiety and attention deficit hyperactivity disorder. R2's Nursing Care Plan dated April 19, 2023, R2 received assistance with mental health and medication management. R2's Individual Abuse Prevention Plan (IAPP) indicated the resident had a history of illegal drug use. The licensee's nursing progress notes dated February 23, 2023, indicated staff found the resident unresponsive in the resident's room. Staff called emergency medical services, and the resident was transported to the hospital. The MAARC report dated April 12, 2023, (48 days following the incident) indicated the resident was found unresponsive. Emergency medical services were called, and the resident was transported to a hospital. During an interview on May 24, 2023, at 8:26 a.m. RN-C stated R2's incident did not happen in April but occurred in February. RN-C stated she did not have an explanation as to why a MAARC report was reported in April for R2, because R2 did not have an episode of being found unresponsive in April. RN-C stated the incident of R2 being found unresponsive should be reported to MAARC right away.	03000		

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03000	Continued From page 5 The licensee's Vulnerable Adult Maltreatment-Prevention and Reporting policy dated August 1, 2021, directed staff who suspect maltreatment of a resident (abuse, financial exploitation, or neglect) will report to MAARC no later than 24 hours. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		