Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL356213307M
Compliance #: HL356212639C

Date Concluded: July 28, 2026

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

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

Evaluator's Name:
Lacey Eggersdorfer, 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 alleged perpetrator (AP), an unlicensed staff member, neglected the resident when he failed to provide safety checks to the resident during his overnight shift. The resident sustained an injury during the night that wasn't discovered until the next morning.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP failed to complete the resident's scheduled overnight safety checks. The resident allegedly fell and was found by staff the following morning. The resident was transported to the hospital for evaluation. During the investigation it was found the AP had a pattern of not completing services for residents and documenting that the services were completed.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, hospital records, pharmacy records, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures.

The resident resided in an assisted living memory care unit. The resident's diagnoses included a history of severe dementia. The resident's service plan included assistance with safety checks three times overnight. The resident's assessment indicated she was disoriented at baseline.

The facility's internal investigation indicated an unlicensed staff entered the resident's room at the start of the morning shift and noticed the resident had a large cut on the top of her head and a dent in the resident's bathroom wall. The unlicensed staff contacted the nurse and emergency services were called. The resident was transported to the hospital and received staples to close the head wound. The internal investigation also indicated the resident did not have a head wound when she was assisted to bed the night before by the evening shift.

A photo of the wall dent in the resident's room indicated a corner sticking out of the wall sustained significant damage characterized by a large indentation that fractured the drywall. The photo indicated the damage was consistent with a forceful impact.

Hospital records indicated the resident was diagnosed with a bladder infection in addition to the cut on her head. The hospital record indicated the physician suspected the resident suffered a fall overnight when she was walking to the bathroom.

Service delivery records indicated the AP documented three safety checks completed. Each safety check took approximately two minutes.

Review of facility documents indicated the AP documented in the resident's chart that three safety checks were completed at 11:15 p.m., 1:00 a.m. and 4:30 a.m. The AP reported he went and checked on the resident at 11:00 p.m. and 2:00 a.m. however review of camera footage showed the AP did not enter the resident's room the whole night shift. Further review of facility documents indicated the AP had a history and pattern of not completing services that were on resident service plans.

During an interview, the AP stated he was trained to visually observe residents and confirm they are breathing when completing safety checks. He stated he completed the first two safety checks on the resident and that he had seen her in bed. He admitted he did not complete the third safety check for the resident but he believed he accidentally checked the service complete, and clicked "submit" on the safety check.

During an interview, the manager stated she reviewed video footage from the night of the incident and did not see the AP enter the resident's room at all during his shift. She stated the AP could not have performed any of the three safety checks. The manager stated she asked the

AP how he could have completed the first two safety checks when he failed to enter the resident's room, and the manager stated the AP had no response.

Video footage was requested for review but was no longer available.

In an interview, a family member of the resident stated he chose the facility so the resident would stay safe and was concerned that the resident wasn't being provided services that kept her free of injury.

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: Yes, unable to recall events
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility had the resident transported to the hospital and terminated the employee.

Action taken by the Minnesota Department of Health:
Insert appropriate action from standard language document

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Golden Valley City Attorney
Golden Valley Police Department

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 07/08/2026

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 ******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: #HL356212639C/#HL356213307M On July 8, 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 65 residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL356212639C/#HL356213307M, 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	

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0 000	Continued From page 1	0 000	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, 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, 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		