Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL358427024M
Compliance #: HL358423230C

Date Concluded: July 19, 2023

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

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brandon Martfeld, 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 a resident when the resident was found smoking in her room with supplemental oxygen.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. After staff found the resident asleep in her room with a lit cigarette with burns to the resident's hand and clothes, and with supplemental oxygen, the facility failed to assess, develop, and implement interventions to keep the resident safe while smoking.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident records, facility incident report, and policies and procedures. Also, the investigator observed the facility, the facility's smoking areas and the resident.

The resident resided in an assisted living facility. The resident's diagnoses included post-traumatic stress disorder, attention-deficit/hyperactivity disorder, major depression, and anxiety. The resident was independent with activities of daily living, was alert, oriented and forgetful. The resident used supplemental oxygen and the assessment indicated there were no safety concerns related to smoking. The abuse prevention plan (IAPP) indicated the resident was safe to independently smoke.

An incident report indicated one day staff found the resident asleep in her room with a lit cigarette. The staff found burns on the resident's hands and clothes. Staff took the cigarette away, woke up the resident and explained to the resident that it was unsafe to smoke in her room.

Management arranged a meeting with the resident nine days after the incident to discuss the safety factors of the resident smoking in her room with supplemental oxygen. Management told the resident the facility allowed smoking only in the designated smoking areas including the deck, garage, and yard. Management informed the resident if she continued to smoke in the resident's room, the facility would terminate her assisted living contract.

Following the meeting with management, staff found the resident smoking in her room with the oxygen, on at least five different occasions.

During the on-site visit, the investigator observed the resident sitting on her bed with a night-stand drawer containing loose tobacco and empty cigarette tubes to make cigarettes. The resident's supplemental oxygen was observed next to the resident's bed. Later, the resident was smoking on the deck of the facility, wearing a T-shirt with multiple burn holes.

During interviews, several staff members stated the resident smoked in her room with supplemental oxygen next to the bed multiple times. The staff members stated the resident was smoking in her room after the meeting between the resident and management. The resident would smoke in her room when she was tired and did not feel like coming out of her room. The resident did not like staff coming into her room. The staff members stated they informed management of the resident's continued smoking in her room.

During an interview, management stated the meeting with the resident was to notify the resident if she continued to smoke in her room, services would be terminated. After the first incident, staff were to check on the resident every 30 minutes to ensure she was not smoking in her room. Management stated they had no documentation of staff completing every 30 minutes safety checks for the resident. Management stated the resident was safe to smoke independently, therefore an assessment had not been completed following the resident's unsafe smoking to identity and implement interventions to keep the resident safe.

During an interview, the resident denied smoking in her room.

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.
Family/Responsible Party interviewed: No, resident responsible for self.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Management arranged for one-to-one staffing with the resident. Maintenance checked and ensured the smoke detector in the resident’s room was functioning. Staff completed a smoking assessment and arranged for the resident to wear a smoking apron while smoking. Management requested but the resident refused to have the smoking materials stored in a central location of 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
	35842	A. BUILDING: _____ B. WING _____	C 07/10/2023

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 ******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: #HL358423230C/#HL358427024M On July 10, 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 (5) residents receiving services under the provider's Assisted Living license. The following immediate correction order is issued. Correction orders with a period to correct that are not immediate may be issued at a later date during the investigation. The following immediate correction order is issued for #HL358423230C/#HL358427024M, tag identification 2310. On July 17, 2023, the immediacy of correction order 2310 has been removed, however non-compliance remains at a scope and level of I.	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.	

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0 620	Continued From page 1	0 620		
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) an incident of maltreatment for one of one resident (R1) reviewed. Staff failed to supervise R1 when she lit and smoked a cigarette in bed and fell sleep, when in bed in her room with oxygen. 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Review of R1's medical record indicated R1's diagnoses included post-traumatic stress disorder, attention-deficit/hyperactivity disorder, major depression, and anxiety. R1's assessment dated June 2, 2023, indicated R1 was independent with activities of daily living,	0 620		

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0 620	Continued From page 2 used oxygen at two liters using a nasal cannula, and had no safety concerns related to smoking. R1's individual abuse prevention plan (IAPP) dated June 2, 2023, indicated R1 was capable of safe smoking independently. Review of an incident report dated June 6, 2023, indicated staff found R1 in her room sleeping with a lit cigarette in her hand and burn marks on her clothes. A document titled (R1) Fire Safety Violation dated June 15, 2023, and not signed, indicated management arranged a meeting with R1 to discuss the safety concerns of R1 smoking in her room on June 6, 2023. The document indicated R1 acknowledged smoking was only allowed in the designated smoking areas included the garage, deck, or yard. In addition, R1 was educated on the risk of smoking with oxygen present. R1 was to request staff assistance to the designated smoking areas when needed. The document indicated failure of R1 to follow the smoking rules may result in termination of R1's assisted living contract with the licensee. The meeting occurred nine days following staff identifying the safety concerns with R1 falling asleep in the room, burned clothing, and oxygen in R1's room. Review of not dated shift notes indicated five different incidences where staff members discovered R1 smoking in her room. The Minnesota Department of Health received two MAARC reports, one dated June 19, 2023, and the other dated June 20, 2023, (13 and 14 days following the incident.)	0 620		

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0 620	Continued From page 3 On July 10, 2023, at 10:55 a.m. R1 was observed in her room sitting up in bed. R1 had a night stand drawer on the bed with loose tobacco and empty cigarette tubes to make her cigarettes. R1 got out of bed, stood and held onto the bed. While standing R1's legs were shaky. After standing next to the bed for a couple minutes, R1 crawled back into bed. An oxygen concentrator was observed next to R1's bed. During an interview on July 10, 2023, at 1:20 p.m., housing manager (HM)-B stated the MAARC report was filed right after the incident with the resident. HM-B stated she filed a MAARC report on June 7, 2023, and the licensed assisted living director (LALD) filed a report on June 6, 2023. HM-B stated the LALD forgot he told me to file a report and then filed one himself. There was no documentation to establish the facility reported the incident before June 19, 2023. 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 after the maltreatment was first suspected. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 620		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the	02310		

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02310	Continued From page 4 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 observation, interview, and record review, the licensee failed to ensure appropriate care and services were provided based on the resident's needs and an up-to-date assessment and service plan when safe smoking interventions were not implemented for one of one resident (R1) reviewed. R1 was found by staff sleeping with a lit cigarette in her room, holes in R1's clothing, and an oxygen concentrator next to her bed. This had the potential to affect all five residents at the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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). This resulted in an immediate correction order on July 10, 2023. The findings include: Review of R1's medical record indicated R1's diagnoses included post-traumatic stress disorder, attention-deficit/hyperactivity disorder, major depression, and anxiety. R1's assessment dated June 2, 2023, indicated R1 was independent with activities of daily living,	02310		

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02310	Continued From page 5 used oxygen at two liters using a nasal cannula, and had no safety concerns related to smoking. R1's individual abuse prevention plan (IAPP) dated June 2, 2023, indicated R1 was capable of safe smoking independently. Review of an incident report dated June 6, 2023, indicated staff found R1 in her room sleeping with a lit cigarette in her hand and burn marks on her clothes. A document titled (R1) Fire Safety Violation dated June 15, 2023, and not signed, indicated management arranged a meeting with R1 to discuss the safety concerns of R1 smoking in her room on June 6, 2023. The document indicated R1 acknowledged smoking was only allowed in the designated smoking areas included the garage, deck, or yard. In addition, R1 was educated on the risk of smoking with oxygen present. R1 was to request staff assistance to the designated smoking areas when needed. The document indicated failure of R1 to follow the smoking rules may result in termination of R1's assisted living contract with the licensee. The meeting occurred nine days following staff identifying the safety concerns with R1 falling asleep in the room, burned clothing, and oxygen in R1's room. Review of not dated shift notes indicated five different incidences where staff members discovered R1 smoking in her room. On July 10, 2023, at 10:55 a.m. R1 was observed in her room sitting up in bed. R1 had a night stand drawer on the bed with loose tobacco and empty cigarette tubes to make her cigarettes. R1 got out of bed, stood and held onto the bed.	02310		

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02310	Continued From page 6 While standing R1's legs were shaky. After standing next to the bed for a couple minutes, R1 crawled back into bed. An oxygen concentrator was observed next to R1's bed. On July 10, 2023, at 11:29 a.m., R1 was observed smoking on the deck of the licensee. R1 was observed to put her cigarette out in a pop can in a little metal bucket. R1's white T-shirt was observed to have multiple burn holes. On July 10, 2023, at 1:50 p.m., R1's lit cigarette fell out of her hand onto the garage floor. The lit cigarette continued to smolder on the garage floor. R1 denied smoking in her room. No staff member was present in the garage. During an interview on July 10, 2023, at 10:34 a.m., unlicensed personnel (ULP)-A stated R1 made her own cigarettes. ULP-A stated R1 had oxygen in her room and that R1 was checked on every hour or two. ULP-A stated R1 would smoke in her room when R1 was tired and did not want to come out of her room. No documentation was provided that indicated staff checked on R1 every one to two hours. During an interview on July 10, 2023, at 1:20 p.m., housing manager (HM)-B and RN-C stated after June 6, 2023, incident a meeting was held with R1 on June 15, 2023. HM-B and RN-C stated the meeting was to notify R1 that if she continued to smoke in her room, then services would be terminated. HM-B and RN-C stated from June 6, 2023, until June 15, 2023, staff were to check on R1 every 30 minutes to ensure she was not smoking in her room. RN-C stated R1's IAPP and assessment was not updated following the incident of R1 smoking in her room with oxygen on June 6, 2023. The facility failed to	02310		

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02310	Continued From page 7 provide documentation of staff checking R1 every 30 minutes from June 6, through June 15, 2023. During an interview on July 11, 2023, at 1:32 p.m. ULP-D stated R1 always smoked in her room. ULP-D stated R1 had smoked in her room two weeks ago. ULP-D stated R1 was not safe to smoke and that R1's shirts had burn marks. ULP-D stated progress notes had been made about R1 smoking in her room. During an interview on July 11, 2023, at 2:03 p.m. ULP-E stated R1 smoked in her room on July 4, 2023. ULP-E stated she told R1 it was not safe because R1 had oxygen in her room. ULP-D stated progress notes were made about R1 smoking in her room. The licensee did not have a smoking policy. The licensee failed to provide an assessment policy. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. Immediacy is removed as confirmed by the surveyors on-site observations on July 17, 2023, and review by the rapid response supervisor on July 17, 2023, however, non-compliance remains at a scope and severity of I.	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.	02360		

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02360	Continued From page 8 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: 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		
03000 SS=D	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 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.	03000		

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03000	Continued From page 9 (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 observation, record review, and interview, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) an incident of maltreatment for one of one resident (R1) reviewed. Staff failed to supervise R1 when she lit and smoked a cigarette in bed and fell sleep, when in bed in her room with oxygen. 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	03000		

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03000	Continued From page 10 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Review of R1's medical record indicated R1's diagnoses included post-traumatic stress disorder, attention-deficit/hyperactivity disorder, major depression, and anxiety. R1's assessment dated June 2, 2023, indicated R1 was independent with activities of daily living, used oxygen at two liters using a nasal cannula, and had no safety concerns related to smoking. R1's individual abuse prevention plan (IAPP) dated June 2, 2023, indicated R1 was capable of safe smoking independently. Review of an incident report dated June 6, 2023, indicated staff found R1 in her room sleeping with a lit cigarette in her hand and burn marks on her clothes. A document titled (R1) Fire Safety Violation dated June 15, 2023, and not signed, indicated management arranged a meeting with R1 to discuss the safety concerns of R1 smoking in her room on June 6, 2023. The document indicated R1 acknowledged smoking was only allowed in the designated smoking areas included the garage, deck, or yard. In addition, R1 was educated on the risk of smoking with oxygen present. R1 was to request staff assistance to the designated smoking areas when needed. The document indicated failure of R1 to follow the	03000		

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 07/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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03000	Continued From page 11 smoking rules may result in termination of R1's assisted living contract with the licensee. The meeting occurred nine days following staff identifying the safety concerns with R1 falling asleep in the room, burned clothing, and oxygen in R1's room. Review of not dated shift notes indicated five different incidences where staff members discovered R1 smoking in her room. The Minnesota Department of Health received two MAARC reports, one dated June 19, 2023, and the other dated June 20, 2023, (13 and 14 days following the incident.) On July 10, 2023, at 10:55 a.m. R1 was observed in her room sitting up in bed. R1 had a night stand drawer on the bed with loose tobacco and empty cigarette tubes to make her cigarettes. R1 got out of bed, stood and held onto the bed. While standing R1's legs were shaky. After standing next to the bed for a couple minutes, R1 crawled back into bed. An oxygen concentrator was observed next to R1's bed. During an interview on July 10, 2023, at 1:20 p.m., housing manager (HM)-B stated the MAARC report was filed right after the incident with the resident. HM-B stated she filed a MAARC report on June 7, 2023, and the licensed assisted living director (LALD) filed a report on June 6, 2023. HM-B stated the LALD forgot he told me to file a report and then filed one himself. There was no documentation to establish the facility reported the incident before June 19, 2023. The licensee's Vulnerable Adult Maltreatment-Prevention and Reporting policy dated August 1,	03000		

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03000	Continued From page 12 2021, directed staff who suspect maltreatment of a resident (abuse, financial exploitation, or neglect) will report to MAARC no later than 24 hours after the maltreatment was first suspected. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	03000		