Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL346006623M
Compliance #: HL346005847C

Date Concluded: April 14, 2026

Name, Address, and County of Licensee Investigated:
Golden Touch Health Care LLC
6800 Scott Avenue North
Brooklyn Center, MN 55429
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Holly German, 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(s):
The facility neglected resident-1 when they failed to prevent and protect resident-1 from repeated unwanted sexual contact from resident-2.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the investigation could not determine if the sexual incident that occurred between resident-1 and resident-2 was a consensual act or not, the facility did not neglect to supervise the residents. The facility provided safety checks, resident call buttons for assistance, redirection and behavior management for known resident behaviors of both residents.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement, both residents' case managers, and resident-1's mental health provider. The investigation included review of the residents' records, the facility internal investigation, facility incident reports, personnel files,

staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed resident-1's interactions with another resident and staff while on site.

Resident-1 resided in an assisted living facility. Resident-1's diagnoses included major depressive disorder and borderline personality disorder. Resident-1's service plan included assistance with medication administration, safety checks, and behavior management. Resident-1's assessment identified resident-1 as independent with walking, at risk to be abused by others, and at risk to abuse others. The assessment indicated resident-1 exhibited behavior concerns such as disrobing her clothing, sexual inappropriateness, and verbal and physical aggression.

Resident-1's individual abuse prevention plan (IAPP) indicated resident-1 was at risk to be abused by others and staff monitored for signs or symptoms of abuse to report promptly. The IAPP indicated resident-1 was at risk for abusing others as resident-1 tended to cross boundaries with others by invading their spaces and asking other residents questions that would irritate them. Resident-1 tended to expose her body to men and then blamed them for bothering her. The IAPP indicated staff redirected resident-1, removed other residents as needed, encouraged resident-1 to stay in her room when needed, and reported any abusive behavior to management.

Resident-2 resided in an assisted living facility. Resident-2's diagnoses included major depressive disorder, anxiety, schizophrenia, and mild intellectual disability. Resident-2's service plan included assistance with behavior management, medication administration, and safety checks. Resident-2's assessment identified resident-2 as independent with walking, at risk to be abused by others, and at risk to abuse others due to Resident-2's lack of insight and mental disabilities. Resident-2's assessment identified resident-2 to have verbally aggressive and physically aggressive behaviors.

Resident-2's IAPP indicated resident-2 was at risk to be abused by others and to be at risk to abuse others due to his mental illness and lack of insight. The IAPP indicated staff aided and redirected resident-2 as needed to prevent a compromise of resident-2's and others safety. The IAPP indicated resident-2 exhibited impaired judgement, agitation, physical aggression, verbal aggression, anxiety, and self-harm behaviors. The IAPP did not indicate resident-2 had history of inappropriate sexual behaviors.

A facility incident report indicated resident-1 stated an inappropriate sexual incident happened between her and resident-2 about two weeks prior to when she notified staff. The report indicated resident-1 stated resident-2 went into her room, exposed his private parts to her, and asked resident-1 to perform oral sex on him. The report indicated resident-2 made resident-1 perform oral sex on him, and she felt ashamed to report it. Staff initiated the facility emergency safety protocol to ensure resident-1 and resident-2 had no further contact, and resident-2 was moved to another facility owned by the same provider. The report indicated resident-1 had made a previous allegation in the past of inappropriate sexual conversation between her and

resident-2, then later recounted it. The report indicated resident-1 stated the incident was a forced act by resident-2, and resident-2 stated it was a consensual act.

A law enforcement report indicated resident-1 stated resident-2 coerced her in to performing oral sex on him. The report indicated resident-1 stated resident-2 had performed sex acts in front of her three times previously. Resident-1 stated she and resident-2 were talking in the hallway when resident-2 followed her into her room to look for candy, which he had done often. Resident-1 stated she told resident-2 to leave her room, but he would not leave, and facility staff were assisting another resident at the time. Resident-1 stated after she scratched resident-2's back he stood up in front of her, exposed his penis, and placed her hand on it. Resident-1 stated she performed oral sex on resident-2 even though she did not want to, but felt coerced as she believed resident-2 may become agitated with her if she did not complete the act. Resident-1 stated she spoke to resident-2 after the incident and told him she did not want to do that, in which resident-2 responded by saying she did want to do it. A law enforcement detective spoke to resident-1 four days later and resident-1 told the detective the same story as reported four days earlier during the initial report. Resident-1 stated resident-2 did not use physical force on resident-1 when resident-1 performed oral sex to resident-2. The report indicated the detective subsequently spoke to resident-2. Resident-2 stated he had resided in the facility where the incident occurred for eight years prior to resident-1 moving in. Resident-2 stated resident-1 liked him and harassed him constantly, almost every day since resident-1 had moved in. Resident-2 stated he was in his room when resident-1 came into his room and asked if he wanted to go to her room to get some candy. Resident-2 stated it was normal for him to do that, so he went to resident-1's room. Resident-2 stated once he was in resident-1's room, resident-1 stated she wanted to give resident-2 a "blowjob." Resident-2 stated resident-1 started to touch his genitals through his pants and performed oral sex. Resident-2 stated he was in shock and did not know what to do. When resident-1 stopped, he said sorry and walked to his room. Resident-2 denied he forced resident-1 to perform oral sex. Resident-2 had received a text message from resident-1 shortly after he was moved to another facility after the incident had been reported and instructed resident-2 to reach out to resident-1 if he needed any help. The report indicated the detective noted resident-2 to have a disability present that required the detective to speak very slowly to resident-2 for resident-2 to understand what the detective was saying. The report indicated the status of the case was closed and cleared.

A facility grievance follow-up form indicated staff were interviewed and reported they had not seen any inappropriate physical contact or sexual interaction between resident-1 and resident-2. The report indicated resident-1 had previously been noted to have disrobed in common areas in front of other residents, including resident-2, and the staff redirected and provided privacy for resident-1 during those instances. The facility follow-up actions included continued monitoring of the residents, increased supervision of the residents in common areas, reminders and redirection provided to resident-1 on maintaining appropriate clothing and privacy, and review of resident-1's plan of care.

During an interview, resident-1 stated there had been three instances of inappropriate sexual behaviors displayed in front of her by resident-2 since she had moved to the facility. Resident-1 stated resident-2 came to her room to look for candy. While resident-1 laid in her bed, resident-2 stood in front of her and placed her hand on his penis. Resident-1 stated she did not call staff at that time due to being in shock. Resident-1 stated she did not recall if she told resident-2 to stop because she was scared and resident-2 told her not to say anything. Resident-1 stated she reported the incident to staff a couple weeks later, law enforcement was called, an investigation was started, and resident-2 was moved out of the facility.

During an interview, unlicensed personnel (ULP)-1 stated she had never noticed resident-1 or resident-2 to exhibit inappropriate sexual behaviors. ULP-1 stated resident-1 and resident-2 sometimes got into each other's business that resulted in them yelling at each other. ULP-1 stated resident-1 and resident-2 did not go into each other's rooms. ULP-1 stated she was not aware resident-1 had any concerns about resident-2 prior to the alleged sexual incident between resident- 1 and resident-2.

During an interview, ULP-2 stated resident-1 could not mind her own business, did things to make others mad, then reported them when they reacted. ULP-2 stated she was not aware of resident-1 having any inappropriate sexual behaviors. ULP-2 stated she had not come across any inappropriate behaviors from resident-2. ULP-2 stated resident-1 and resident-2 got along with each other and would sometimes be in resident-2's room making meowing sounds to act like cats for fun.

During an interview, ULP-3 stated he could not tell if resident-1 was a reliable reporter, and she had not exhibited any inappropriate sexual behaviors. ULP-3 stated resident-2 was not a reliable reporter because resident-2 often forgot things he talked about. ULP-3 stated resident-2 told him resident-1 lied on him, and he did not feel safe around resident-1, regarding the alleged sexual incident between resident-1 and resident-2. ULP-3 stated resident-1 and resident-2 had been friends, but it went back and forth with them getting along with each other. ULP-3 stated he did not see resident-2 go into resident-1's room, but he did see resident-1 got into resident-2's room, and resident-2 would sometimes tell resident-1 to get out and other times resident-2 did not care if resident-1 was in his room. ULP-3 stated he did not see any inappropriate interactions between resident-1 and resident-2.

During an interview, a nurse stated staff got report on every resident and their plan of care so they could see how they are to respond to any resident concerns. The nurse stated every staff member received training on abuse and neglect. The nurse stated staff were trained to always protect the victim of any abuse incident and then report it. The nurse stated resident-1 had continuous behavior and made accusations consistently as her perceptions tended to be different than what another person's understanding would be, due to her mental health diagnosis. The nurse stated staff were directed to spend one-to-one time with resident-1 as needed to ensure she had an accurate understanding of what was said to resident-1. The nurse stated there had been no noted concerns about any sexual behavior by resident-2, and the

allegation resident-1 made about resident-2 surprised staff. The nurse stated no staff or other residents had reported any concerns about resident-2. The nurse stated resident-1's and resident-2's relationship was like they were nemesis to each other, not like they were friends. The nurse stated resident-1 had to be re-directed out of resident-2's room at times. The nurse stated resident-2 never reported any concerns about resident-1. The nurse stated staff decided to move resident-2 to another facility.

During an interview, resident-2's guardian stated she had never known resident-2 to be sexually inappropriate. The guardian stated resident-2 did not voice any concerns to her about resident-1, and she was not even aware a female lived in the house. The guardian stated resident-2 mentioned the alleged incident to her, but only stated resident-1 was a willing participant and gave the guardian no further details. The guardian stated she believed resident-2's care needs were met at the facility, and resident-2 was safe at the facility. The guardian stated there have been no subsequent reported issues for resident-2 since he moved to the other facility.

During an interview, resident-1's case manager stated she was in contact with resident-1 weekly, and she was not aware resident-1 exhibited any inappropriate behavior towards others. The case manager stated she received an email from resident-1 that contained the allegation of the sexual incident with resident-1. The case manager stated resident-1 had never reported any concerns about resident-2 before. The case manager stated she asked resident-1 about it, and resident-1 did not provide her with any more details on the incident beyond what was in the email. The case manager stated she asked resident-1 if she pressed her call button at the time of the incident, and resident-1 told her she did not because she had frozen and did not think to do that. The case manager stated she recommended to resident-1 for resident-1 to move to an all-female house, but resident-1 declined to move.

During an interview, resident-1's mental health provider stated she could not say with a degree of certainty if resident-1 was a reliable reporter, but resident-1 had told her about conflict she has had with staff and other residents almost every time she had met with resident-1. The provider stated resident-1 told her about many moves resident-1 had to make due to being evicted from facilities related to her behavior. The provider stated resident-1 mentioned a sexual assault with a male housemate but was evasive about the details. The provider stated she asked resident-1 if she was safe at the facility, and resident-1 told her she was. The provider stated she was not aware of any proven false allegations' resident-1 had made.

Resident-2 did not return requests for interview.

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.
(3) the vulnerable adult, who is not impaired in judgment or capacity by mental or emotional dysfunction or undue influence, engages in consensual sexual contact with:
(i) a person including a facility staff person when a consensual sexual personal relationship existed prior to the caregiving relationship; or
(ii) a personal care attendant, regardless of whether the consensual sexual personal relationship existed prior to the caregiving relationship; or
(iv) if in a facility, the error is immediately reported as required under section 626.557, and recorded internally in the facility;
(v) if in a facility, the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and
(vi) if in a facility, the actions required under items (iv) and (v) are sufficiently documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Vulnerable Adult interviewed: Yes, resident-1. No, resident-2 did not return requests for interview.
Family/Responsible Party interviewed: Not applicable, resident-1 was own responsible party. Yes, resident-2.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility moved resident-2 to reside at a new facility.

Action taken by the Minnesota Department of Health:
No further action is required.

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
	34600	A. BUILDING: _____ B. WING _____	C 03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN TOUCH HEALTH CARE LLC	6800 SCOTT AVENUE NORTH BROOKLYN CENTER, MN 55429

(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 March 16, 2026, the Minnesota Department of Health initiated an investigation of complaint HL346005700C/HL346001340M and HL346005847C/HL346006623M. No correction orders are issued.	0 000		