Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL356215821M
Compliance #: HL356218016C

Date Concluded: November 8, 2024

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: Lena Gangestad, 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 the resident by failing to complete the daily wellness check as outlined in the care plan. Later, the resident was found unresponsive in his room only after his family requested someone check on him.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The unlicensed caregiver #1 and #2 failed to perform a wellness check on the resident and falsely documented that they did so on Saturday, Sunday, and Monday. Additionally, an office assistant received a call from the resident's family, who had requested a wellness check after not hearing from the resident for three days. However, the office assistant did not relay the message to an unlicensed caregiver for almost three hours. The resident was later found unresponsive and was sent to the hospital for further evaluation, where he passed away two days later due to a stroke.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of resident's records, incident reports, and the resident's external medical record. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living facility. The resident's diagnoses congestive heart failure, essential hypertension, paroxysmal atrial fibrillation. The resident's service plan included daily wellness check in the morning.

On Monday at noon, a family member called the office assistant to request that someone check on the resident, as they had not heard from him for three days. The office assistant relayed the message to the unlicensed caregiver #3 about three hours later. The unlicensed caregiver #3 found the resident unconscious in his apartment living room. The unlicensed caregiver #3 then called 911, and the resident was transported to the hospital.

The hospital records indicated the resident was unresponsive when he was found with his right arm purple and cold to the touch. It was unclear how long he had been in this condition. He was admitted to the intensive care unit (ICU) with a sudden brain injury caused by a large stroke on the left side of the brain's main blood vessel, but it was too late for intervention. Comfort care was initiated, and the resident passed away two days later in the hospital.

During an interview, unlicensed caregiver #1 stated that the last time she saw the resident was on Friday. She said that she was busy on Saturday and did not check on him. Additionally, she was not assigned to him on Sunday, so she did not check on him that day either. She confirmed that every time the resident was checked, staff were required to document it in the system.

During an interview, unlicensed caregiver #2 stated she worked on Monday morning. She said it was a busy day, and she did not see the resident in the common areas or go to his room to check on him. She also confirmed that staff were required to document each wellness check.

The daily wellness check record indicated unlicensed caregivers #1 and #2 documented that they checked on the resident on Saturday, Sunday, and Monday morning.

During an interview, an office assistant stated she received a call from the resident's family member on Monday with a request she check on the resident since they had not heard from him. She made a note of it but forgot to inform the unlicensed staff to check on him. She notified the staff as soon as she remembered, which was about two or three hours after the family member called.

During an interview, a manager stated the resident had a daily wellness check listed in his care plan. The manager stated wellness checks mean an unlicensed caregiver needed to visually confirm the resident's presence, either by seeing him in the common area or in his room. She

said that, following the incident, the facility initiated retraining for all unlicensed caregivers on the importance of timely and accurately documented wellness and safety checks.

During an interview, a family member stated the last time they spoke with the resident was on Friday afternoon. The family member stated they were unable to reach him on Saturday and Sunday. Finally, on Monday, they contacted the facility around noon to request that staff check on him.

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

Action taken by facility:
The facility provided re-training for all staff on daily wellness and safety checks.

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
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 10/21/2024

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 On October 21, 2024, the Minnesota Department of Health initiated an investigation of complaint HL356215821M/HL356218016C. The following correction order is issued, tag identification 2360.	0 000		
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 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	No plan of correction is required for this tag.	