Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL331696382M
Compliance #: HL331695124C

Date Concluded: February 13, 2026

Name, Address, and County of Licensee Investigated:
The Harbors Senior Living
5300 4th St NE
Fridley, MN 55421
Anoka County

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

Evaluator's Name: Lori Pokela R.N.
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 the resident when staff did not follow the resident's plan of care and the resident's skin condition and wounds worsened.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. There was not a preponderance of evidence to attribute the resident's worsening wounds to staff not following the resident's care plan. In addition, the resident's wounds improved after the incident and other concerns related to services received, failed to rise to the level of neglect.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigator contacted the resident's hospice agency staff. The investigation included review of the resident record(s), facility internal investigation, facility incident reports, personnel files, staff schedules and related facility policy and procedures. Also,

the investigator observed the facility environment, medication and treatment administration, cares and staff interactions with the resident.

The resident resided in an assisted living memory care unit. The resident's diagnoses included senile degeneration, rhabdomyolysis (a serious condition where damaged skeletal muscle tissue breaks down, releasing harmful substances into the bloodstream which can lead to kidney failure), and hydrocephalus (excess cerebral spinal fluid in the brain leading to problems with cognition and mobility). The resident's service plan included weekly bathing, linen changes, laundry, medication management, dressing, grooming, mobility, transfers, toileting, skin treatments, catheter care and repositioning. The resident's wound dressings were monitored, and wound care was provided as needed. Additionally, the resident received hospice services for bathing, wound care, and catheter care.

The resident's assessment indicated the resident was oriented to self, had a Foley catheter (a flexible tube inserted through the urethra into the bladder to drain urine continuously), used a mechanical lift with assistance of two staff, had a history of falls, used positioning pillows, an air mattress, heel protectors, and a reclining chair for skin pressure reduction and edema.

A complaint report indicated the resident was found lying on his catheter with feces on his catheter tubing and heel protectors. The complaint report also indicated the resident was not bathed, had socks that were hard and stuck to the resident's feet and when staff attempted to remove the socks, dry skin was ripped off. Additionally, the complaint report indicated staff were not cleaning the resident's perineal area properly, and staff had not repositioned the resident properly which caused the resident's leg wounds.

Although care was not fully documented on the date of the incident, documentation available indicated that the following cares on the date of the incident were provided: dressing, repositioning, catheter care, incontinent care, safety checks, skin treatment and wound care.

The resident's medical records indicated the resident had a history of skin and wound issues that affected the resident's buttocks and lower extremities. The resident's medical records indicated the resident was admitted with lower extremity edema and later developed lower extremity blisters that would open, heal and reappear on various areas of the lower extremities. The resident also had a history of refusing cares such as baths, transfers out of bed and wearing heel protectors. Facility staff monitored the resident's skin and wounds, reported changes in condition, assessed skin and wound concerns and provided treatment as ordered.

The resident's medical records indicated staff monitored the resident for changes in condition, reported the changes, assessed the resident, treated and/or transported the resident to the hospital for evaluation.

Facility records indicated facility administrative nursing staff provided re-education to nursing staff that included the documentation process, provision of wound care and repositioning.

During an interview, a facility administrative nurse stated that although there were challenges regarding staff documentation, the facility worked on interventions that included: on-the-spot audits, education, change in processes and exploration of new devices that would make real time documentation more convenient for staff. The facility administrative nurse stated hospice monitored and assessed the resident's wounds and provided catheter care. Hospice also changed the resident's wound dressings at least twice per week and facility staff completed cares as needed. The facility administrative nurse stated the facility monitored the resident's skin and catheter care daily, reported any changes in condition and continued to collaborate with the resident's hospice agency and followed recommendations regarding the resident's care.

During an interview, facility administrative staff stated the facility met with staff to educate on documentation of catheter output collection. Facility administrative staff stated that staff were instructed to always put a measurement of output in documentation even if the measurement equals zero. In addition, facility administration staff stated staff re-education was on-going in the facility.

During interview, hospice administrative staff stated although there were concerns with the facility staff delivering proper care to the resident, care had improved and there was improved collaboration with facility staff and the hospice agency. The hospice administrative staff stated the resident's wounds improved, facility staff were now providing cares that kept the resident clean and following hospice recommendations. The hospice administrative staff stated facility staff were very professional and prepared with a developed plan of care at the resident's most recent care conference.

During an interview, the resident's family member stated the resident had skin concerns regarding the buttocks and lower extremity edema upon admission as this was one of the reasons for admitting to the facility. The family member stated the resident had a history of refusals for care and refused to wear heel protectors. The family member stated the resident's wounds had improved and felt the services in place are aiding in the improvements. The family member recalled the resident's right ankle wound getting infected but stated the wound improved with the collaboration of facility and hospice staff. The resident's family stated, although there was always room for improvement, she had no concerns regarding any of the care the resident had received throughout his stay at the facility. The family member stated the facility overall did a good job.

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.

Vulnerable Adult interviewed: Yes or explanatory comment
Family/Responsible Party interviewed: Yes or explanatory comment
Alleged Perpetrator interviewed: Yes, Not Applicable, or explanatory comment

Action taken by facility:
The facility developed and implemented turning and repositioning documentation. Documentation, wound care and repositioning re-education and training was provided after the incident. The facility hired additional staff to facilitate with audits, and to identify and correct concerns regarding care.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

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
	33169	A. BUILDING: _____ B. WING _____	C 01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HARBORS SENIOR LIVING FRID	5300 4TH STREET NE FRIDLEY, MN 55421

(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 January 7, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL331695124C/#HL331696382M. No correction orders are issued.	0 000		