Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL337271541M
Compliance #: HL337272442C

Date Concluded: April 14, 2025

Name, Address, and County of Licensee Investigated:
Scandi Haven of Cura
1710 Mckinney Avenue
Benson, MN 56215
Swift County

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

Evaluator's Name: Barbara Axness, 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 alleged perpetrator (AP) emotionally abused the resident when the AP made a social media post which showed the resident sitting on the toilet.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. The AP sent a Snapchat photo to another staff member that showed the resident in the bathroom, and although the actions were disrespectful and unprofessional, there was not a preponderance of evidence it met the definition of abuse. The Snapchat photo was sent to only one person and did not have any additional context or text with it. The AP admitted to sending the picture but stated it was an accident and she didn't realize the resident was in the picture.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident record, the Snapchat photo, facility internal

investigation documentation, personnel files, staff schedules, a law enforcement report, and related facility policy and procedures. Also, the investigator observed the resident's room where the picture was taken.

The resident resided in assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included assistance with all activities of daily living. The resident's assessment indicated the resident was not able to verbalize if she needed help and staff were to anticipate needs. The resident was noted to be forgetful due to her memory loss.

The facility's internal investigation indicated another staff member contacted management after she received a Snapchat photo from the AP that showed a resident's room and in the corner of the photo the resident was sitting on the toilet. Management immediately suspended the employee and assessed the resident. The AP was terminated for violating facility policies. The resident was not aware the picture was taken due to her cognitive status. Other residents were interviewed and denied seeing personal cell phones out while receiving cares.

During an interview, the AP stated she was using her cell phone while the resident was using the bathroom and was contacting another staff member to see if she could work one of her shifts. The AP stated she did not realize the resident was in the top corner of the photo she sent and when she found out that the resident was in the photo, she felt terrible. The AP stated that it wasn't her intention [to send the photo] and she knew she was not supposed to take pictures of residents.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.

(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening

Vulnerable Adult interviewed: Unable due to cognition
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility reported the incident to MAARC. The AP was terminated. Staff were retrained on social media policies.

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
	33727	A. BUILDING: _____ B. WING _____	C 04/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCANDI HAVEN OF CURA	1710 MCKINNEY AVENUE BENSON, MN 56215

(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 April 7, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL337271541M/ #HL337272442C. No correction orders are issued.	0 000		