Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL350177024M
Compliance #: HL350171575C

Date Concluded: December 16, 2024

Name, Address, and County of Licensee Investigated:
Heritage of Edina Inc.
3450 Heritage Drive
Edina, MN 55435
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Willette Shafer, RN
Special Investigator

Finding: Substantiated, individual 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 alleged perpetrator (AP) abused the resident when the AP was observed on video swearing and yelling at the resident and hit the resident with an unknown object.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The video showed the AP hit the resident with a bag of garbage. The audio from the video heard the AP tell the resident he was a "worthless honkey" and told him he could not "even stand" on his own feet to clean his own "nasty ass." The AP called the resident a "mother fucker."

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted a family member. The investigation included review of the resident's records, facility internal investigation, facility incident reports, personnel files, and facility policies. The investigator requested the police

report. Also, the investigator toured the facility and observed facility staff providing hygiene cares to residents.

The resident resided in an assisted living facility. The resident's diagnoses included senile degeneration of brain, multiple sclerosis, depression, and anxiety. The resident's service plan included assistance with dressing, bathing, grooming, incontinence cares, medication administration, mobility, and housekeeping. The resident's assessment indicated he was confused, anxious and easily agitated. Interventions to help the resident remain safe included talking calmly and offer reassurance.

A recording of the incident showed the resident laying on the bed naked, covered only with a brief. The video showed the AP hit the resident with a bag of garbage. The audio from the video heard the AP tell the resident he was a "worthless honkey" and told him he could not "even stand" on his own feet to clean his own "nasty ass." The AP called the resident a "mother fucker."

The internal investigation indicated an email with an attached video was sent to the facility's human resources department. Upon video review, the AP was identified as a staffing agency employee who had not worked at the facility for over one month. The facility spoke to unlicensed personnel (ULP)-1 and ULP-2, who were witness to the incident and the video. The investigation indicated ULP-2 recoded the video while her phone was in her pocket facing outward, so the camera was pointed at the AP. ULP-1 said ULP-2 sent her the video to report the incident as ULP-2 was afraid of the AP. When the facility met with ULP-2, she denied she recorded the video and said she did not know who sent it to her. ULP-2 said she sent it to ULP-1 because she wanted to discuss the video and what to do with it.

During an interview, ULP-1 said a video of the incident was sent to her by ULP-2. She identified the AP in the video and said the AP called the resident names and hit him with a garbage bag filled with a dirty brief. She said she was trained on vulnerable adult maltreatment. She said ULP-2 sent her the video to report as ULP-2 was fearful of the AP. The AP has threatened ULP-2 in the past.

During an interview, a member of management, who is also a nurse, said she conducted the internal investigation. She said ULP-1 reported ULP-2 sent her the video and she sent the video to the facility's human resources department. When management questioned ULP-2, she denied she recorded the incident. After investigating the incident and speaking with all staff members who worked with the AP, management said the only person who could have recorded the incident was ULP-2. She watched the video and described the AP's actions as disgusting and said the AP should not be allowed to work with vulnerable adults. The resident was assessed, and no injuries were noted. She reported the incident to the staffing agency and the AP was removed from the schedule. Facility staff receive training on maltreatment of vulnerable adults from staff development upon hire and annually.

The resident's family member declined interview as they had no further information to add. The family member said the facility reported the incident to them.

The AP declined the interview but provided a written statement via email that indicated the video was edited and falsified.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(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; or
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):

(1) The AP did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The facility did not direct an erroneous order, direction, or care plan.

(2) The facility was in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

The AP failed to follow the facility directive and/or policies and procedures.

(3) The AP failed to follow professional standards and/or exercise professional judgement.

The AP failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: No, due to cognitive deficit.

Family/Responsible Party interviewed: No, family member declined interview.
Alleged Perpetrator interviewed: No, the AP declined.

Action taken by facility:
The facility reported the incident and completed a thorough internal investigation. The facility assessed the resident and spoke to all staff and residents who worked with the AP. The facility recently provided education on vulnerable adult maltreatment to all staff members.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

You may also call 651-201-4200 to receive a copy via mail or email.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Edina City Attorney
Edina Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35017	A. BUILDING: _____ B. WING _____	C 11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE OF EDINA INC	3450 HERITAGE DRIVE EDINA, MN 55435

(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 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: HL350171575C/HL350177024M On November 14, 2024, 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 76 residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL350171575C/ HL350177024M, tag identification 2360.	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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 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(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person 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.	