Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL331692140M
Compliance #: HL331691019C

Date Concluded: July 31, 2024

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

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

Evaluator's Name: Maggie Regnier
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 she took multiple videos of herself taunting and agitating the resident and posted these videos on social media websites.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. The AP recorded herself, which included both video and audio, interacting with the resident while the resident asked to be left alone, but she continued to follow and record him. The AP also posted videos of these interactions on social media.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members, witnesses, and the AP. The investigation included review of medical records, facility records, personnel files, facility education and training records and social media postings. Also, the investigator observed staff interactions with other staff, residents, and visitors.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's dementia with agitation, impulse control disorder, and was hard of hearing. The resident's service plan included assistance with all activities of daily living including dressing, bathing, grooming, meal set up and medication management. The resident's assessment indicated the resident had impulse control problems and with wandering and exit-seeking behaviors.

The facility's internal investigation indicated the facility was informed by an employee the AP, who worked as an unlicensed caregiver, had posted three videos showing interactions between her and the resident on social media. The same document indicated the videos clearly showed both the AP and resident. Furthermore, the AP was agitating the resident while offering assistance and recording him simultaneously.

The facility's internal investigation included still images with the AP's name appearing as the name of the account and the one responsible identified as posting the videos. Still images from another video Another video shows the VA on one side of a locked door, trying to get in, with the AP capturing this on her device, and the caption on this video shows four laughing face emoji and states "dumb f*&^ing b@#ch".

Another video obtained clearly shows the AP approaching the resident from behind and getting his attention while he walked down the hallway. The resident turned around while the camera view backs away from him, and the resident tells the AP to stay away from him. the video included captioning saying, "He's making it a long a** shift". The recording shows the AP continuing to follow the resident even as he walks away.

The facility policies indicated use of personal cell phone to take photos of residents or work-related items or events was not permissible.

During an interview, an acquaintance of the AP's stated she found video posted under the AP's social media accounts featuring the resident and the AP. She stated the video showed the AP following the resident and it seemed like the AP was annoying him.

During an interview, a manager stated that every employee is trained about the cell phone policy and social media policy.

During an interview, a nurse stated they had trained the AP in the facility expectations on providing compassionate care to residents. The nurse stated that this event was a demeaning way to treat the resident.

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;

Vulnerable Adult interviewed: No, advanced dementia
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: No, attempted multiple times with no response

Action taken by facility:
The facility terminated the AP and re-educated all staff of vulnerable adults and cell phone and social media use.

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
Fridley City Police Department
Fridley City Attorney
Anoka County Attorney

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 06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HARBORS SENIOR LIVING OF FRIDLEY	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 ******ATTENTION****** 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: #HL331691019C/#HL331692140M On June 5, 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 43 residents receiving services under the provider' Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL331691019C/#HL331692140M , 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. Please note Correction Order 2360 is used to document the occurrence of maltreatment; please see the public report	

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0 000	Continued From page 1	0 000	for details.	
02360 SS=F	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(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	Please note Correction Order 2360 is used to document the occurrence of maltreatment; please see the public report for details.	