Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL21355001M
Compliance #: HL21355002C

Date Concluded: June 9, 2021

Name, Address, and County of Licensee Investigated:
Ridgeway Senior Living
6421 5th Avenue South
Richfield, MN 55426
Hennepin County

Name, Address, and County of Housing with Services location:
Ridgeway Senior Living
720 23rd Street North
New Ulm, MN 56073
Brown County

Facility Type: Home Care Provider

Investigator's Name:
Julie Serbus, RN, Special Investigator

Finding: Substantiated, individual responsibility

Nature of Visit:
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.

Allegation(s):
It is alleged: The alleged perpetrator (AP) abused the client after the client threatened to throw hot coffee on the AP. The AP, while working as unlicensed personnel (ULP) for the home care provider, grabbed the client's right arm/wrist, turned her around, and removed the client from area by pushing her from behind down the hallway. The client had a skin tear and bruise from the incident.

Investigative Findings and Conclusion:
Abuse was substantiated against the AP. The totality of the AP's conduct with the client met the definition of abuse; however, it could not be determined whether the AP caused actual injury to the client.

The investigation included interviews with facility staff members, directors, and client family members. The investigator contacted law enforcement to obtain the police report. The

investigation included a review of the client's medical record, video camera footage, facility policies and procedures, and the AP's employment and training records.

The client lived in the memory care unit. Her diagnoses included dementia, anxiety, depression, and osteoporosis. The client received assistance with activities of daily living (ADLs), medication management, and safety checks. The client could walk independently, had impaired judgment, and was at risk for abuse. At times, the client refused assistance with shower or her ADLs, and staff were instructed to re-approach her at a later time.

Review of the facility's investigation notes, and video camera footage identified one day when the AP approached the client at the dining room kitchenette, the AP pointed to the living room area and asked the client to go there. At the time, the client had a cup in each hand, and the AP and client were standing 1-2 feet apart. The AP touched the client's right arm to direct her to the living room area. The client then said she was going to throw her hot coffee in the AP's face. The AP then grasped the client's right wrist, turned the wrist, and poured the coffee onto the floor to stop the client from throwing the hot liquid. The client then waved her hand in front of the AP's face. The AP told the client "Stop," "Enough" and "Quit!" As the AP again tried to turn the client to get her to leave the area, the client threw a cup of water with her left hand at the AP's face. The AP then pushed the client's right wrist up to the client's chest and turned her around to face away from the AP while the AP continued to hold the client's right wrist to her chest. The AP then walked a few paces behind the client pushing the client forward while holding the client's right wrist. The AP then released the client's right wrist and continued to push her out of the dining room area. The AP's hands appear to be on the client's back. As the AP and client leave the dining room, the AP can be heard saying to someone off camera the client threw water on her. The client hurriedly walked in front of the AP but by her gait, the client appeared to be resistant to walking. Video camera footage showed the AP push the client on her back down two separate hallways with the client in front of the AP walking with a hurried, staggered, resistant gait until it appears the AP puts the client in an apartment. The AP leaves the apartment approximately 22 seconds after she and the client go into the apartment, and the client is not seen again on the footage. No injuries to the client were visibly on the video.

Review of the facility's internal investigation indicated the facility received an electronic message from a staff person about the incident between the AP and client and believed the video camera footage from the day of the incident should be reviewed. The staff person indicated the client had a skin tear on her left hand from the incident and that the client indicated the AP caused the skin tear. The staff person who discovered the skin tear treated the wound with ointment and a dressing. There was no documentation of any injury to the client. Facility management contacted the AP and removed her from the work schedule. Facility management reviewed the video camera footage and conducted staff interviews. The client was assessed by nursing staff. The facility internal investigation determined the incident was not documented nor reported by the AP or the other unlicensed personnel who worked at the time of the incident between the client and the AP. The registered nurse was not informed of the incident until 24 hours after the

incident. The facility conducted an internal investigation two days after the incident and contacted law enforcement and the client's family.

Review of the AP's employment and training records showed the AP received vulnerable adult and abuse training. The AP had no concerns on file prior to the incident with the AP.

Review of police report identified an officer received the information regarding the incident, but no further action was taken by law enforcement.

During an interview, the AP stated, at the time of the incident with the client, she was trying to get the clients into the living room for activities. She said the client did not want to leave and threatened to throw hot coffee in her face. The AP said she grabbed the client's wrist to prevent her from throwing the hot coffee. She stated it was such a quick reaction, but then the client threw a cup of water at her. The AP then said she removed the client from the dining room and walked her down to her apartment. She did not recall the client being resistant when she walked with her. She said she did not put her hands on the client but just guided her to her apartment. The AP said it all happened so quickly, and "I was just defending myself." The AP said the next day at work she found out there was a bruise on the client's wrist and identified she had grasped the client's right wrist to stop her from throwing the coffee. The AP admitted to bruising the right wrist but did not know anything about a skin tear on the left hand. The client had not bumped the hand that she was aware of. The AP stated this had never happened before. The AP said, "I should have stepped away and let someone else take over."

During an interview, a staff member said she heard a commotion and turned to see some scuffling between the AP and the client. The staff member said the AP said to the other staff member that the client had thrown water at her. The staff member also said she witnessed the AP behind the client pushing her down the hall. The staff member stated she did not approach the AP about the incident but had overheard the AP telling the client to go to her room. The staff member said she did not report the incident until a day and half day later when nursing staff was on duty.

During an interview, the client's family members said they received a call from the facility that an incident had happened with the client over the weekend. At the time, they said they were told the facility was investigating the incident, and the AP was not currently working. The family stated the facility staff told them there was video camera footage of the incident between the AP and the client in the dining room and of the AP talking the client back to her apartment. The facility arranged for a family member to have an outdoor visit with the client that afternoon. The family member said the client told her there were mean people and showed her hand with the skin tear to her family member.

During an interview, facility administration said the when the incident with the AP and the client was brought to their attention it was reported to the Minnesota Adult Abuse Reporting Center. They said they were told by staff the client's skin tear was from the altercation with the AP. They

stated there was no client care documentation about the incident or when or what time skin tear was discovered. The director of health services/registered nurse worked on the investigation process when she returned to work after the weekend. Facility administration stated the client was assessed, video camera footage reviewed, the staff who reported the incident and staff who also worked the same shift as the AP were interviewed, and the AP gave a statement.

In conclusion, abuse was substantiated against the AP.

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;
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: No, due to the client's dementia diagnosis.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility conducted an internal investigation. The AP is no longer employed at the facility.

Action taken by the Minnesota Department of Health:
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, or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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
Minnesota Department of Human Services - Licensing
Brown County Attorney
New Ulm City Attorney
New Ulm Policy Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H21355	A. BUILDING: _____ B. WING _____	C 05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWAY SENIOR LIVING	715 SOUTH GERMAN STREET #100 NEW ULM, MN 56073

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0 000	Initial Comments ******ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to a 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: On May 17, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL21355002C/#H21355001M. At the time of the investigation, there were 90 clients receiving services under the comprehensive license. The following correction orders were issued for #HL21355002C/#HL21355001M, identification tags 0325, 0805, and 2015.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. 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 surveyors ' 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 144A.474 SUBDIVISION 11 (b)(1)(2)	
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or	0 325		

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0 325	Continued From page 1 in an assisted living facility licensed under chapter 144G has these rights: (14) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure one of one client (C1) reviewed was free from maltreatment. C1 was abused. Findings include: On June 9, 2021, the Minnesota Department of Health (MDH) issued a determination that there was a preponderance of evidence that maltreatment occurred, and that an individual staff person was responsible for the maltreatment.	0 325	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of tag 0325.	
0 805 SS=D	144A.479, Subd. 6(a) Reporting Maltrx of Vulnerable Adults/Minors Subd. 6.Reporting maltreatment of vulnerable adults and minors. (a) All home care providers must comply with requirements for the reporting of maltreatment of minors in section 626.556 and the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. Each home care provider must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported.	0 805		

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0 805	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately (within 24 hours) report suspected abuse for one of one client (C1) reviewed. Unlicensed personnel (ULP)- I reported suspected abuse to the registered nurse (RN)-A both electronically and by phone the day after ULP-D allegedly abused C1. RN-A reported the suspected abuse to the Minnesota Adult Abuse Reporting Center (MAARC) two days after the incident between ULP-D and C1. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: C1's medical record was reviewed. C1's medical diagnoses included anxiety, chronic obstructive pulmonary disease (COPD), depression, history of right hip replacement, and osteoporosis. C1's assessment dated August 29, 2020, indicated she was at-risk for falls, had impaired judgment, and became confused or anxious requiring staff to reorient her. C1's assessment indicated C1 ambulated independently and her gait/balance was normal. C1 received well-being checks. C1 did have behaviors at times of refusing showers and some of activities of daily living (ADLs); staff were instructed to re-approach and try again.	0 805		

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0 805	Continued From page 3 Review of ULP-I's RTasks note dated August 30, 2020, at 6:32 p.m., indicated an altercation occurred between ULP-D and C1 on August 29, 2020. ULP-I reported information she heard from ULP-D and ULP-E. ULP-I also indicated in the RTasks note C-1 had a skin tear on her hand. The RTask note indicated the cameras should be reviewed regarding the altercation; there was no documentation in RTask from the date of the incident. In staff note dated August 31, 2020, at 7:07 p.m., RN-A identified she had received a call from ULP-I on August 30, 2020, at 8:26 p.m. ULP-I asked if RN-A had received the RTasks message about the possible abuse that occurred over the weekend and no documentation. RN-A called and spoke with the Director of Resident Services (DRS)-B regarding the incident. The plan was to review camera footage the morning of August 31, 2020, and to talk to ULP-E. ULP-D was not scheduled for August 31, 2020. On August 31, 2020, after interview with ULP-E, camera footage review, and calling to suspend ULP-D, RN-A, DRS-B, President (P)-C, and Case Manager (CM)-J made the decision to file a MAARC report. The MAARC report was filed by the licensee on August 31, 2020, at 12:04 p.m. for the incident that occurred the afternoon of August 29, 2020, between ULP-D and C1. During an interview on May 25, 2021, at 4:30 p.m., ULP- D indicated she received vulnerable adult abuse training. ULP-D recalled the incident occurred towards the end of her work shift on August 29, 2020. ULP-D identified she did not document the incident in RTasks but thought she might have mentioned it verbally to the oncoming	0 805		

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0 805	Continued From page 4 shift. ULP-D stated when she grabbed C1's wrist she may have caused the bruising but did not recall causing a skin tear. During an interview on May 26, 2021, at 2:30 p.m., ULP-E identified she received training upon hire and yearly regarding vulnerable adult abuse. ULP-E said if there is a possible abuse situation, she would report it right away to a nurse. ULP-E said on the morning of August 31, 2020, she went to RN-A to report what she had saw and heard on August 29, 2020, between ULP-D and C1. ULP-E said she did not report it the day of the incident since it was the end of the shift, and she felt C1 was safe. ULP-E said she heard a commotion and turned around to see arms flailing, some scuffling between ULP-D and C1. ULP-E said she saw ULP-D behind C1 pushing her all the way down the hall to C1's room. During an interview on June 1, 2021, at 1:01 p.m., the director of health services (RN-A), DRS-B, and P-C said RN-A was notified on August 30, 2020, at 8:26 p.m., about ULP-D allegedly abusing C1. The interviewees stated staff are expected to complete annual vulnerable adult training and report suspected abuse. The interviewees stated ULP-I said the incident had not been documented but it was verbally obtained from staff over the weekend. ULP-I said the evening of August 29, 2020, a skin tear was identified on C1's left hand. The skin tear also was not documented as to the time of when it was identified, or information related to skin tear. The staff assumed C1's skin tear was obtained during the altercation with ULP-D. ULP-D and ULP-E worked together over the weekend. ULP-E did not report her recall of the incident until the morning of August 31, 2020, when she was at work. RN-A stated she did not come in on the	0 805		

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0 805	Continued From page 5 night of August 30, 2020, when it was initially reported to her. RN-A stated it would have been too late, and C1 would have been in bed. RN-A said she had plan to come in early the morning of August 30, 2020, to review the information. Review of licensee policy titled "Mandated Reporting to the Common Entry Point (CEP) or Minnesota Adult Abuse Reporting Center (MAARC)", not dated, identified reported of suspected maltreatment should be immediately made to the MAARC. Internal reporting process indicated any person who witnesses or suspects any form of maltreatment must report immediately to the director of health service/RN. Immediate report to MAARC upon hearing a description of the incident or if the if the incident appears to be suspected abuse should be made. If staff observes an unexplained physical injury will report immediately to the director of health services/RN. No further information provided. TIME PERIOD TO CORRECT: Twenty-one (21) days.	0 805		
02015 SS=D	626.557, Subd. 3 Timing of Report Subd. 3.Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the	02015		

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02015	Continued From page 6 individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event	02015		

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02015	Continued From page 7 meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately (within 24 hours) report suspected abuse for one of one client (C1) reviewed. Unlicensed personnel (ULP)- I reported suspected abuse to the registered nurse (RN)-A both electronically and by phone the day after ULP-D allegedly abused C1. RN-A reported the suspected abuse to the Minnesota Adult Abuse Reporting Center (MAARC) two days after the incident between ULP-D and C1. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: C1's medical record was reviewed. C1's medical diagnoses included anxiety, chronic obstructive pulmonary disease (COPD), depression, history of right hip replacement, and osteoporosis. C1's assessment dated August 29, 2020, indicated she was at-risk for falls, had impaired judgment, and became confused or anxious requiring staff to reorient her. C1's assessment	02015		

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02015	Continued From page 8 indicated C1 ambulated independently and her gait/balance was normal. C1 received well-being checks. C1 did have behaviors at times of refusing showers and some of activities of daily living (ADLs); staff were instructed to re-approach and try again. Review of ULP-I's RTasks note dated August 30, 2020, at 6:32 p.m., indicated an altercation occurred between ULP-D and C1 on August 29, 2020. ULP-I reported information she heard from ULP-D and ULP-E. ULP-I also indicated in the RTasks note C-1 had a skin tear on her hand. The RTask note indicated the cameras should be reviewed regarding the altercation; there was no documentation in RTask from the date of the incident. In staff note dated August 31, 2020, at 7:07 p.m., RN-A identified she had received a call from ULP-I on August 30, 2020, at 8:26 p.m. ULP-I asked if RN-A had received the RTasks message about the possible abuse that occurred over the weekend and no documentation. RN-A called and spoke with the Director of Resident Services (DRS)-B regarding the incident. The plan was to review camera footage the morning of August 31, 2020, and to talk to ULP-E. ULP-D was not scheduled for August 31, 2020. On August 31, 2020, after interview with ULP-E, camera footage review, and calling to suspend ULP-D, RN-A, DRS-B, President (P)-C, and Case Manager (CM)-J made the decision to file a MAARC report. The MAARC report was filed by the licensee on August 31, 2020, at 12:04 p.m. for the incident that occurred the afternoon of August 29, 2020, between ULP-D and C1. During an interview on May 25, 2021, at 4:30	02015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H21355	A. BUILDING: _____ B. WING _____	C 05/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWAY SENIOR LIVING	715 SOUTH GERMAN STREET #100 NEW ULM, MN 56073

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02015	Continued From page 9 p.m., ULP- D indicated she received vulnerable adult abuse training. ULP-D recalled the incident occurred towards the end of her work shift on August 29, 2020. ULP-D identified she did not document the incident in RTasks but thought she might have mentioned it verbally to the oncoming shift. ULP-D stated when she grabbed C1's wrist she may have caused the bruising but did not recall causing a skin tear. During an interview on May 26, 2021, at 2:30 p.m., ULP-E identified she received training upon hire and yearly regarding vulnerable adult abuse. ULP-E said if there is a possible abuse situation, she would report it right away to a nurse. ULP-E said on the morning of August 31, 2020, she went to RN-A to report what she had saw and heard on August 29, 2020, between ULP-D and C1. ULP-E said she did not report it the day of the incident since it was the end of the shift, and she felt C1 was safe. ULP-E said she heard a commotion and turned around to see arms flailing, some scuffling between ULP-D and C1. ULP-E said she saw ULP-D behind C1 pushing her all the way down the hall to C1's room. During an interview on June 1, 2021, at 1:01 p.m., the director of health services (RN-A), DRS-B, and P-C said RN-A was notified on August 30, 2020, at 8:26 p.m., about ULP-D allegedly abusing C1. The interviewees stated staff are expected to complete annual vulnerable adult training and report suspected abuse. The interviewees stated ULP-I said the incident had not been documented but it was verbally obtained from staff over the weekend. ULP-I said the evening of August 29, 2020, a skin tear was identified on C1's left hand. The skin tear also was not documented as to the time of when it was identified, or information related to skin tear.	02015		

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02015	Continued From page 10 The staff assumed C1's skin tear was obtained during the altercation with ULP-D. ULP-D and ULP-E worked together over the weekend. ULP-E did not report her recall of the incident until the morning of August 31, 2020, when she was at work. RN-A stated she did not come in on the night of August 30, 2020, when it was initially reported to her. RN-A stated it would have been too late, and C1 would have been in bed. RN-A said she had plan to come in early the morning of August 30, 2020, to review the information. Review of licensee policy titled "Mandated Reporting to the Common Entry Point (CEP) or Minnesota Adult Abuse Reporting Center (MAARC)", not dated, identified reported of suspected maltreatment should be immediately made to the MAARC. Internal reporting process indicated any person who witnesses or suspects any form of maltreatment must report immediately to the director of health service/RN. Immediate report to MAARC upon hearing a description of the incident or if the if the incident appears to be suspected abuse should be made. If staff observes an unexplained physical injury will report immediately to the director of health services/RN. No further information provided. TIME PERIOD TO CORRECT: Twenty-one (21) days.	02015		