Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL305965002M
Compliance #: HL305966740C

Date Concluded: October 4, 2024

Name, Address, and County of Licensee Investigated:
Garden Court Chateau
2495 SW 8th Street
Grand Rapids, MN 55744
Itasca County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Substantiated, facility 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 facility neglected the resident when the resident was forced to stay in a room without air conditioning after he was diagnosed with COVID-19. The resident suffered shortness of breath and difficulty breathing and transferred to the hospital.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Facility staff failed to implement appropriate isolation precautions and failed to assess and monitor the resident's change in condition. The resident was sent to the emergency room (ER) and diagnosed with heat exhaustion twice over a 24-hour period after being in isolation with the door shut and no access to outside airflow.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement, the ambulance service, and the case manager. The investigation included review of resident records,

ambulance records, hospital records, facility incident reports, law enforcement report, and related facility policies and procedures. Also, the investigator observed the resident's room and care and services provided in the facility.

The resident resided in an assisted living facility. The resident's diagnoses included chronic obstructive pulmonary disease (COPD) and asthma. The resident's assessment indicated the resident utilized supplemental oxygen and nebulizer breathing treatments and had a history of shortness of breath.

After the resident tested positive for Covid-19 (respiratory illness), he was put into isolation in his room. The resident's room did not have air conditioning and cool air could only enter the room if the door was open. The resident was told if he wanted to cool off, he could open the patio door in his room. Five days later, the resident reported to staff he had trouble breathing and requested to be sent to the emergency room (ER). Staff contacted 911 for transport to the hospital. Staff documented that the resident complained about being in his room with the door closed and noted that the patio door was open and the temperature outside was 90 degrees with 90% humidity.

The ambulance report indicated the resident's room was extremely hot and humid, noting it was similar to the temperature outside. The report indicated the resident had two fans blowing on him, his shirt was unbuttoned, and several cups of milk, water, and coffee were around him. Ambulance personnel documented that the resident was hot, shaking all over, had labored breathing, and had increased his oxygen use. The resident told ambulance personnel he had no trouble breathing after being diagnosed with COVID-19, but struggled to breathe when he got too hot.

Hospital records indicated the resident was diagnosed with heat exhaustion and was very anxious and nervous to return to the facility because his room was too hot. Hospital records indicated facility staff were contacted and told that the resident's room was too hot and agreed to cool down the room prior to the resident's discharge back to the facility. The resident returned to the facility and resumed isolation with his door shut.

The next day, the resident requested to return to the ER. Staff documented the resident was pale, shaking, and noted the use of accessory muscles when breathing. Staff asked the resident what the ER could do for him that staff could not, and he stated, "cool me down". Staff offered the resident cold packs and wet wash cloths, but the resident declined stating that the ER told him to return if he felt this way again. Staff contacted 911 and the resident was transferred back to the ER. Staff documented in the resident's medical record that ambulance personnel told them that the resident's room was just as warm as it was the day before and that the resident should be off quarantine.

Hospital records indicated the resident was evaluated in the emergency room for increased shortness of breath, productive cough, confusion, and nausea. Hospital documentation

indicated the resident's room was “very warm due to being on isolation for COVID." The provider who assessed the resident wrote, "Patient currently on isolation at his assisted living for COVID, it is reported that his room is very warm, this was supposed to be addressed yesterday by [facility] staff, however EMS (emergency medical staff) reported that patient's room still seems to be rather warm and patient reports that it continues to be too warm for him."

The resident discharged back to the facility and tested negative for Covid-19 the next day.

During an interview, a facility maintenance assistant confirmed if the resident's door was shut, there would be no airflow to the room. The maintenance assistance stated there was a ceiling fan in the room but no other heating or cooling ductwork or vents that would bring air into the room if the door was not open. The maintenance assistant stated they brought a few fans into the resident's room while he was in isolation.

During an interview, unlicensed personnel (ULP) stated they tried to keep the resident cool when he was in isolation, but there was no air conditioning, and it was “overly hot” in the resident’s room and a fan was put in the room.

During an interview, a facility registered nurse (RN) stated she was notified by staff that the resident tested positive for COVID-19 and was directed to place the resident in isolation, which included closing the door. The RN was asked if it would be considered safe to close the door given there was no other cool air flow to the room. The RN stated she felt it was safe and since the resident's room was near a public bathroom and common area and it was appropriate to close his door. The RN confirmed daily monitoring was not documented for the resident and didn't know why staff did not update the nurse when the resident complained of feeling warm or why he was only sent to the emergency room per his request.

During an interview, facility management staff acknowledged the incident but stated they were not aware of any concerns from the hospital about the temperature of the resident’s room. Facility management felt that if the hospital had concerns, they should have given the facility time to fix the problem and shouldn’t have sent the resident back to the facility.

During an interview, the resident recalled the incident and stated, " I couldn't breathe, it was so hot in here after a few days, I went crazy. The only cool air comes from out there [the hallway] so if it's shut, I had nothing." The resident wasn't sure what the temperature was in his room, and he opened his patio door to try and get some air in the room because it was so hot. The resident stated, " I don't think they knew how to handle it [COVID-19 isolation]; it went right over the top of their heads, they didn't understand COPD."

In conclusion, the Minnesota Department of Health determined neglect 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.

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
Family/Responsible Party interviewed: Not Applicable
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action taken.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Itasca County Attorney
Grand Rapids City Attorney
Grand Rapids Police Department
Minnesota Board of Nursing
Minnesota Board of Executives for Long Term Services and Supports

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30596	A. BUILDING: _____ B. WING _____	C 08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN COURT CHATEAU	2495 SW 8TH STREET GRAND RAPIDS, MN 55744

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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: #HL305965002M/HL305966740C On August 21, 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 24 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL305965002M/HL305966740C, tag identification 0670, 2310, 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.	
0 670 SS=F	144G.42 Subd. 9a Communicable diseases A facility must follow current state requirements	0 670		

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0 670	Continued From page 1 for prevention, control, and reporting of communicable diseases as defined in Minnesota Rules, parts 4605.7040, 4605.7044, 4605.7050, 4605.7075, 4605. 7080, and 4605.7090 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to follow current state requirements for prevention, control, and reporting of communicable diseases when it did not report an outbreak of COVID-19 and failed to document information related to the outbreak. The deficient practice had the potential to affect residents, employees, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 23, 2024, R1 tested positive for COVID-19. Documentation related to the facility's COVID-19 outbreak was requested, but not provided. On August 22, 2024, at 10:00 a.m., an epidemiologist with the Minnesota Department of Health confirmed the facility did not report any COVID-19 cases in July and their last reported cases were in October 2022.	0 670		

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0 670	Continued From page 2 On August 22, 2024, at 12:45 p.m., licensed assisted living director/registered nurse (LALD/RN)-E stated a few other residents tested positive for COVID-19 around the time R1 was positive. LALD/RN-E stated registered nurse (RN)-B was their infection control nurse and she was responsible for submitting positive cases to the state. LALD/RN-E stated she thought the cases would have been reported as it was one of RN-B's duties. LALD/RN-E stated RN-B would have been responsible for documentation related to the COVID-19 outbreak. On August 23, 2024, at 2:20 p.m., registered nurse (RN)-B confirmed she was the facility's infection control nurse and "I did ask for more specific direction when we had the first covid positive patient and I was directed to a link from MDH that was all I had and link was not very specific." RN-B stated she was not aware cases had to be reported to the state and she had asked for guidance from LALD/RN-E on what needed to be done and was never told the cases had to be reported or how to report them. RN-B stated a few other residents tested positive for COVID-19 around the time R1 tested positive. RN-B confirmed no documentation was maintained related to the facility's COVID-19 outbreak. COVID-19 Reporting Requirements for Minnesota Long-term Care Facilities, dated May 2, 2023, indicated assisted living facilities were to report aggregate case counts to MDH COVID-19 Long-Term Care Report Form and weekly case counts in residents and staff were to be reported to MDH. Minnesota Communicable Disease Rules, Chapter 4605.7080 indicated COVID-19 cases	0 670		

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0 670	Continued From page 3 were required to be reported. No further information was provided. Time Period for Correction: Two (2) days	0 670		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards when facility staff failed to assess a change in condition for one of one resident (R1) when staff placed a resident in COVID-19 isolation, which cut off his access to cool air when outdoor temperatures were in excess of 90 degrees Fahrenheit. R1 was sent to the emergency room twice within 24 hours and diagnosed with heat exhaustion. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	02310		

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02310	Continued From page 4 The findings include: R1's diagnoses included chronic obstructive pulmonary disease (COPD) and asthma. R1's most recent assessment dated July 17, 2024, indicated the resident used supplemental oxygen and also received nebulizer breathing treatments. The resident had a history of feeling short of breath. R1's progress notes contained the following entries: -July 23, 2024, the resident tested positive for COVID-19. The resident's vital signs were noted to be temp: 101.8, P [pulse] 91, R [resperations] : 24, BP [blood pressure]130/72, O2 [oxygen] 91% on 4 Liters. "Resident is complaining of body aches, chills, shortness of breath, and generally not feeling well. Resident did request to go to the ER [emergency room]. 911 was called at 0921." The resident returned from the ER a few hours later. -July 25, 2024, "Resident tested today for COVID 19 and resident remains positive and will remain in isolation." -July 27, 2024, a unlicensed personnel (ULP) wrote, "Resident requested to be sent into ER via ambulance stating he was unable to breath. (sic) Adamant about ER visit. Earlier this shift upon delivery of AM meds resident stated that having his door closed to the facility was really getting to him and he wanted to have words with the person that says it needs to be closed. Explained that writer was not responsible for writing the policies, only following them. Call placed to RN NM [registered nurse, nurse manager] on speaker phone, resident complained of difficulty breathing and that he knows his copd and that he needs to	02310		

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02310	Continued From page 5 be seen. Use of accessory muscles noted with inhalation And exhalation. Would alternate between using nasal cannula in his nose and his mouth. Resistive towards non pharmalogical interventions offered. Called 911 per resident request at 1238. Ambulance arrived at 1248. O2 96% on his nasal cannula. Ambulance departed at 1258. Obtained larger fan for facility to put into residents room. Due to the amount of boxes stored in resident room of his belongings, all walls are surrounded and unable to get to any plug ins to plug additional fan into besides the bathroom. Resident patio door was also open, with the outside temperature being over 90 degrees and a 90% humidity. Room temp did go down after closing patio door and additional fan in place." -July 27, 2024, another ULP documented a behavior note, writing "Mood Behavior: Resident was very agitated about being in quarantine which he was in his room; Resident insisted that he go to the hospital because he couldn ' t breathe. Staff on medication cart called 911 and an ambulance came to facility to pick him up." -July 27, 2024, RN-B wrote, "Resident was tested for COVID 19 and remains positive at this time." The ambulance report indicated emergency crews arrived on July 27, 2024, at 12:43 p.m., and "Upon arrival, nursing staff led us to the patient's room, where his door was closed. When opening the door, it was extremely hot and humid in the patient's room, and similar to the temperature outside. The patient had 2 fans blowing on him and his shirt unbuttoned. The patient had on a nasal cannula that was in his mouth, he stated it was easier to take a deep breath that way. His oxygen was at 4.5 Lpm, and he is normally at 4 Lpm. He appeared to have labored breathing and was speaking in 4-5 word sentences. He stated he was shaking all over and	02310		

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02310	Continued From page 6 felt too hot. He stated he had not been sweating and had been trying to stay hydrated with cups of milk, water, and coffee around him. The patient stated he didn't have difficulty breathing after being diagnosed with covid, but started struggling when he got too hot." Hospital records indicated the resident was evaluated in the emergency room for shortness of breath with a history of COPD and COVID-19 on July 27, 2024. "The patient states he thinks his shortness of breath got worse due to the heat, patient's room was as warm as outside (90ish degrees) per EMS. AC comes in from hall and staff had room closed due to isolation." The resident was treated in the emergency room and given Ativan (an anti-anxiety medication) as the resident was "anxious and nervous to go back home because he is unsure whether his room will be cool or of it is going to be hot again...We did call Garden court Château and inform them that we think his hot room could be contributing to his COPD flare today. They will make attempts to have the room be cooler for the patient." Hospital staff spoke with RN-B and she "stated patient requested to come in due to being hot and not sweating anymore and having a hard time breathing. Writer asked if they have a portable AC unit or any other way to cool room, RN stated no. Writer asked if they can look into it. RN will make a phone call and get back to this writer...RN called writer back and stated that someone had opened his sliding door. staff was advised to close door and open patient's bedroom door while he is gone. RN stated they will do that." The provider who assessed the resident in the emergency room documented the resident had "a bad combination of still getting over COVID, history of COPD, and slight heat exhaustion...be sure to stay in a cool room."	02310		

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02310	Continued From page 7 In a progress note dated July 28, 2024, the day after the resident returned from the emergency room, a ULP documented, "Resident had call light on, requesting return to the ER around 1100. Offered resident his noon nebulizer treatment, resident declined. Resident breathing thru his mouth with his nasal cannula blowing into his mouth. Resident shaking, noted in his upper extremities and abdomen. Use of accessory muscles with inhalation and exhalation. Skin color pale, not flushed. Lips pink and moist. Call placed to RN NM [nurse manager] on speaker phone with resident. Resident adamant about ER eval, declining any pharmacological and non pharmacological interventions offered, becoming more upset with resident with each offered intervention. Asked resident what the ER was able to do for him that staff could not provide here for him and he stated "cool me down". Again offered cold compressed, cold packs, wet wash clothes and resident declined stating that the ER told him yesterday that if he felt like that again to come back to the ER. Inquired as to resident fluid intake that was not coffee, resident stated water and juice. When asked how much juice and water, resident replied sharply that he was getting confused and could not recall. 911 called at 1111. Ambulance arrived at 1121. EMT staff made comments regarding how (in their opinion) resident should be off quarantine by now and that one EMT was with resident upon returning from the ER yesterday and that his room is just as warm as it was yesterday. Explained to EMT that resident last tested positive for Covid yesterday, and listed all of the interventions staff had offered resident and that he had declined today, including his scheduled medications to help manage his COPD. Resident also complained that the facility fan was pulling too much electricity from the plug	02310		

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02310	Continued From page 8 in resulting in his concentrator not working correctly and him having to use his portable oxygen instead. Ambulance departed at 1128. Left voicemail for [resident's case manager] on her cell phone regarding both ER transfers. Moved large facility fan from inside resident room and plugged it in outside of his room, blowing cooler air into his room. Turned off concentrator also while resident is gone to help cool down his room." Hospital records indicated the resident was evaluated in the emergency room for increased shortness of breath, productive cough, confusion, and nausea on July 28, 2024. Documentation indicated the resident's room "is very warm due to being on isolation for COVID." The provider who assessed the resident wrote "Patient currently on isolation at his assisted living for COVID, it is reported that his room is very warm, this was supposed to be addressed yesterday by nursing home staff, however EMS reported that patient's room still seems to be rather warm and patient reports that it continues to be too warm for him." RN-B tested the resident for COVID-19 twice on July 29, 2024, and again on August 3, 2024, all three tests were negative. On August 21, 2024, at 9:30 a.m., R1 stated, " I couldn't breathe, it was so hot in here after a few days, I went crazy. The only cool air comes from out there [the hallway] so if it's shut I had nothing." R1 stated he wasn't sure what the temperature in his room was but "it was extremely hot and the sun comes right in through that window." R1 stated, " I don't think they knew how to handle it [COVID-19 isolation], it went right over the top of their heads they didn't understand COPD." R1 stated he had opened his patio door	02310		

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02310	Continued From page 9 in an effort to try and get some air in the room because it was so hot. On August 21, 2024, at 10:00 a.m., maintenance assistant (MA)-C confirmed if the resident's door is shut, there would be no airflow to the room. MA-C stated there was a ceiling fan in the room but no other heating or cooling ductwork or vents that would bring air into the room if the door was not open. MA-C stated they had brought a few fans into the resident's room as it was hot in the room while he was in isolation. On August 21, 2024, at 10:45 a.m., ULP-D stated, "We tried to keep it cool but with him in isolation, there was no AC going in there. I'd say it was overly hot in there. They did put a fan in and that helped." On August 22, 2024, at 12:45 p.m., licensed assisted living director/registered nurse (LALD/RN)-E stated shortly after the resident moved into the facility, they had offered him a different room that had the ability to have an air conditioner but he declined. LALD/RN-E was asked if it would be considered safe to close the resident's door during his quarantine given that was the only way he could access cool air. LALD/RN-E stated "I guess I would say optimally it would have been but my concern was more or less the moldy boxes getting out of there...He did agree to move away from the door, he didn't have to be in front of the door because he won't use a regular bed." LALD/RN-E stated the hospital never sends any paperwork back with residents so she wasn't aware of the concerns identified in the hospital paperwork. LALD/RN-E stated "We're not a hospital, we don't have a room specifically for COVID or infectious disease. If it was that big of a concern, they should have kept	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30596	A. BUILDING: _____ B. WING _____	C 08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDEN COURT CHATEAU	2495 SW 8TH STREET GRAND RAPIDS, MN 55744

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02310	Continued From page 10 him over there and given us a chance, it would have been easier had they kept him." LALD/RN-E was asked if it would be appropriate to admit someone to the hospital when the facility should have had a plan in place to ensure the resident had access to cold air. LALD/RN-E stated, "Are you not aware of the fact everything goes over the hospital everything to the ER, if they're admitted that paperwork doesn't follow on the medical floor. They have all the information showing he had been in the room and had COVID and you know I guess if they were that concerned, they should have kept him there and given us a chance to make it better for him. He's been anxious since he came in here because of the fact he has COPD, it's end stage basically, he's very apprehensive about it. I think that's normal, he also went to the hospital several times where they did nothing...they just shipped him right back to us without giving us a chance to fix the problem in the room. Why did they send him back?" LALD/RN-E stated that even with the door open, "I don't think he would have gotten enough cool air." On August 23, 2024, at 2:20 p.m., registered nurse (RN)-B stated she was notified by staff the resident had tested positive for COVID-19 and she was directed to place the resident in isolation, which included closing the door. RN-B was asked if it would be considered safe to close the door given there was no other cool air flow to the room and by closing the door, cool air wouldn't be able to get in the room. RN-B stated she felt it was safe and since the resident's room was near a public bathroom and common area and it was appropriate to close his door. RN-B stated the resident had opened his patio door, which made the room get warmer. RN-B was asked why the resident might have opened the door and she	02310		

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02310	Continued From page 11 stated she wasn't sure. RN-B confirmed daily monitoring was not documented for the resident. RN-B stated she didn't know why staff did not update the nurse that the resident had complained of feeling warm and he was only sent to the emergency room after he requested to be sent in. Infection control guidance from the CDC titled Infection Control Guidance: SARS-CoV-2, last updated May 8, 2023, included a section for patient placement. The guidance indicated "Place a patient with suspected or confirmed SARS-CoV-2 infection in a single-person room. The door should be kept closed (if safe to do so). Ideally, the patient should have a dedicated bathroom." The facility failed to determine if the resident's room would be considered unsafe if the door was closed. A section titled Optimize the Use of Engineering Controls and Indoor Air Quality indicated the facility should "explore options, in consultation with facility engineers, to improve ventilation delivery and indoor air quality in patient rooms and all shared spaces." The facility failed to identify ways to ensure the resident had access to cool air or better air circulation while he was isolating in his room. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02360	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.	02360		

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02360	Continued From page 12 This MN Requirement is not met as evidenced by: The facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility 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.	