Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306722243M, HL306722703M, HL306723642M

Date Concluded: October 30, 2025

Compliance #: HL306723909C, HL306724773C, HL306726968C

Name, Address, and County of Licensee Investigated:
Sunlight Senior Living
400 Western Avenue North
Saint Paul, MN 55103
Ramsey County

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

Evaluator's Name: Yolanda Dawson, RN
Special Investigator
Rhylee Gilb, 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 a resident when the resident did not receive pain medication when experiencing severe pain. Additionally, the resident was neglected when staff did not perform hygiene cares, resulting in skin concerns.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Regarding the pain medication, the facility failed to order the resident's narcotic prescription pain medication after an emergency room (ER) visit. Additionally, the facility failed to reconciling medication orders with the resident's physician.

After seven weeks, the physician ordered a different, but similar narcotic pain medication and the pharmacy delivered the medication the same day. The facility staff failed to administer the medication, after supply was received consistently and the resident went several days without at a time. The resident stated his current medications were not effective and needed a stronger pain medication. Regarding hygiene, the facility failed to order a shower until six weeks after the resident's admission. Nursing did not follow-up with the shower chair order and the resident did not receive a shower for over two months, including the day of the onsite visit. The resident state his bed baths were one time when he had a spider bite, when the staff cleaned up his arm and his peri-area during brief changes. The resident stated the facility should be ashamed.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted social worker, case manager, medical equipment store and the pharmacy. The investigation included review of resident records, clinic records, pharmacy records, medical device records, employee records, facility policies and procedures, and surveillance tape footage. Also, the investigator observed medication administration and glucose monitoring.

The resident resided in an assisted living facility. The resident's diagnoses included heart failure, kidney disease stage 4, stroke, right side paralysis, diabetes type 2 with neuropathy, right knee pain, and adjustment disorder with depressed mood. The resident's service plan included assistance with medication management, blood glucose monitoring, repositioning and transfers, and bath/shower assistance. The resident utilized an electric wheelchair.

PAIN MEDICATION

The resident's medication administration record (MAR) indicated he had pain medication orders for baclofen daily at nighttime and methocarbam (muscle relaxant) twice per day.

Progress notes indicated a couple of days after admission, the resident went to the ER due to diarrhea. The ER discharge instructions included an order for hydrocodone-acetaminophen (narcotic pain medication) once daily in the morning and once per day as needed.

The facility failed to transcribe the hydrocodone-acetaminophen order to the resident's MAR nor had record of requesting a prescription to fill the order.

Progress noted indicated the resident had a face-to-face visit with his physician two days after returning to the facility. The note, written by the director of nursing (DON), indicated the resident requested his "narcotic prescription" to be canceled because it made him dizzy and the physician canceled the order. The note lacked documentation of what medication the DON referred to.

The resident's clinic visit record lacked indication the physician discontinued any orders during the visit.

One month later, requested physician records (not maintained by the facility), included physician orders to discontinue Lyrica (nerve pain medication) and discontinue oxycodone with the words written behind the order “not on.” The resident’s MAR at the time the of the written orders did not include a transcribed order for Lyrica nor an order for oxycodone.

The next month’s MAR also failed to transcribe the hydrocodone-acetaminophen order for a daily scheduled dose and daily as needed dose.

Seven weeks after admission, the physician ordered a narcotic pain medication of a similar name, oxycodone-acetaminophen scheduled daily in the morning and once daily as needed. Additionally, the physician clinic records had a second physician order on the same date for a referral to the pain clinic.

Pharmacy records indicated 14 oxycodone-acetaminophen tablets were dispensed to the facility per provider orders on the same date. Additionally, the pharmacy noted hydrocodone-acetaminophen and Lyrica were never dispensed to the facility.

The resident’s MAR indicated the oxycodone-acetaminophen order was transcribed two days after the order was provided and supply received. However, the order was on “hold” due to lack of supply. Staff continued to document on the MAR however administration of medication, but not continuously. Since the date of the pharmacy delivery, the facility staff still failed to administer 11 out of 22 scheduled daily doses.

Pharmacy staff indicated only fourteen tablets were dispensed because insurance would only pay for that amount at a time, causing the medication to run out before insurance allowed the medication to be refilled. At the time of the investigation the resident had not received oxycodone-acetaminophen for five days.

Additionally, it was unknown if the resident received all 12 (11 scheduled and one as needed dose) doses during those 22 days because the facility lacked a narcotic count record tracking the medication. Additionally, on the 7th day of the supply being at the facility, the unlicensed personnel (ULP) documented with the as needed dose administration, the last dose was administered from the pill card and zero tablets remained. However, the MAR indicated nine documented administrations after the ULP’s note.

Two days after the ULP’s note on the MAR of no more supply, a physician order indicated to continue baclofen until oxycodone-acetaminophen pharmacy delivers.

Surveillance records were reviewed when onsite showed a ULP med-passer did not enter the resident’s room to take blood sugar, although it was documented that it was completed. Additional documentation discrepancies were noted on the resident’s MARs. The resident’s record lacked indication of a sending a referral for the pain clinic to evaluate the resident.

During an interview, the DON stated the resident often refused his medications because he did not think they were the correct medications. The DON first stated the oxycodone/acetaminophen was not available for three months because insurance would not pay for it, then she stated it was not available because the resident had utilized all that was received from the pharmacy, and it was too soon to reorder. The DON could not produce a document showing how the medication was used such as medication count documentation. The DON stated she believed the resident's case worker followed up on the insurance issue with the oxycodone/acetaminophen therefore she did not.

During an interview, the resident stated staff did not give him the correct medications or did not give them at all and was in constant pain. Resident stated staff often left medication at the bedside and proceeded to show an Altoids mint tin full of pills that he had saved. The resident stated his nerve pain medication no longer worked and he needed something stronger.

SHOWERS

The resident's service plan and contract indicated the resident required two staff assistance with showers two days per week.

The resident's ER discharge instructions included orders of medical equipment that included a hydraulic mechanical lift, hospital bed, commode/shower chair and a power wheelchair.

The facility failed to order the shower chair for six weeks. The facility received a shower chair quote, however there was an issue with authorization and the equipment was not sent. A week later the facility received a sales order number for the shower chair. At the time of the investigation, the resident did not have a shower chair for the resident and had not received a shower in 75 days.

During an interview, a ULP stated the resident often refused bed baths and they did not have a shower chair available to get him into the shower.

During an interview, the resident stated he had not had a shower since before his admission and the only time he received peri care was when staff changed his brief. The resident stated that was the extent of his bed baths. The resident stated one time the staff wiped his arm after a spider bite. The resident stated the facility should be "ashamed" (regarding their bathing cares).

During an interview, the DON stated the resident often refused showers on scheduled shower days. The DON stated staff attempted to utilize a shower chair that belonged to another resident; however, the chair was too small for the resident. A bigger chair was ordered, but the

shower chair had not arrived at the time of the investigation. The DON stated there was no follow-up by nursing or management on when the chair would arrive.

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.

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

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

The facility directed an erroneous order, direction, or care plan.

(2) The facility was not in compliance with regulatory standards.

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

The facility provided adequate staffing levels.

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

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

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

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: No, attempted, resident is his own guardian.
Alleged Perpetrator interviewed: Yes

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
Ramsey County Attorney
St. Paul City Attorney
St. Paul Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30672	A. BUILDING: _____ B. WING _____	C 06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNLIGHT SENIOR LIVING	400 WESTERN AVENUE SAINT PAUL, MN 55103

(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: HL306722243M/HL306723909C HL306723642M/HL306726968C HL306722703M/HL306724773C On June 17, 2025, 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 37 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for HL306722243M/HL306723909C, HL306723642M/HL306726968C, and HL306722703M/HL306724773C tag identification 450, 1760, 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.	
0 450 SS=G	144G.41 Subdivision 1 Minimum requirements	0 450		

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0 450	Continued From page 1 All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to services in a person-centered manner for one of one resident (R1) record reviewed when staff did not provide showers and only provided incomplete bed baths due to not obtaining a required and appropriately sized shower chair. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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). The findings include: R1 admitted to the licensee on April 3, 2025, with diagnoses to include heart failure, kidney disease stage 4, cerebral infarction (stroke), right side	0 450		

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0 450	Continued From page 2 paralysis, diabetes type 2 with neuropathy, right knee pain, adjustment disorder with depressed mood. R1 utilized an electric wheelchair. R1's service plan dated May 6, 2025, indicated R1 received assistance with repositioning and transfers, and bath/showers. The directive indicated R1 required two staff to transfer into the shower. R1's addendum to the Assisted Living Contract, printed on June 17, 2025, indicated the frequency of bathing was two days per week. R1's emergency room (ER) discharge instructions dated April 6, 2025, included orders for medical equipment; a hydraulic mechanical lift, hospital bed, commode/shower chair and a power wheelchair. R1's documented services dated April, May, and June 2025, indicated inaccurately documented R1 received assistance with a bath/shower on the following dates: April 10, 2025 April 13, 2025 April 17, 2025 May 4, 2025 May 8, 2025 May 18, 2025 May 22, 2025 May 25, 2025 May 29, 2025 June 1, 2025 June 5, 2025 June 12, 2025 June 15, 2025 A medical supply order record dated May 20, 2025, indicated a shower chair with a 400 pound capacity was ordered.	0 450		

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0 450	Continued From page 3 The licensee lacked records for a delivery of the shower chair, lacked documented efforts to coordinate with the case manager or medical supply company to obtain a chair prior to the supply order on May 20, 2025. The licensee lacked documented efforts to follow up on the status to obtain the chair afterwards. During an onsite visit on June 17, 2025, the licensee lacked a shower chair for R1 to provide his showers. During an interview on June 17, 2025, at 12:06 p.m., unlicensed personnel (ULP)-A stated R1 often refused bed baths, and they did not have a shower chair available to get him in the shower. During an interview on June 17, 2025, at 10:28 a.m., director of nursing (DON)-D stated R1 often refused showers on shower days. DON stated staff attempted to utilize a shower chair that belonged to another resident; however, the chair was too small for R1. A bigger chair was ordered on May 20, 2025. The shower chair had not arrived at the time of the investigation on June 17, 2025. DON-D stated there was no follow-up by nursing or management on when the chair would arrive. During an interview on June 17, 2025, at 8:47 a.m., R1 stated he had not had a shower since before his admission to the facility in April. R1 stated bed baths were staff attending to his peri area and that was all, no other part of his body was washed. R1 stated one time they washed his arm after a spider bite and the facility should be ashamed (of their bathing cares).	0 450		

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0 450	Continued From page 4 A licensee policy titled, Bill of Rights, dated August 1, 2021, indicated the following: 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. A licensee policy titled, Competency Training Evaluation, dated August 1, 2021, indicated when a registered nurse of licensed health professional staff of Sunlight Senior Living delegates tasks, prior to the delegation of services they must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the task. TIME PERIOD FOR CORRECTION: Seven (7) days	0 450		
01760 SS=G	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.	01760		

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01760	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed for one of one resident (R1) when staff failed to ensure R1 received pain medication and glucose monitoring. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) 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). The findings include: R1 admitted to the licensee on April 3, 2025, with diagnoses to include heart failure, kidney disease stage 4, cerebral infarction (stroke), right side paralysis, diabetes type 2 with neuropathy, right knee pain, adjustment disorder with depressed mood. R1 utilized an electric wheelchair. R1's service plan dated dated May 6, 2025, indicated R1 received assistance with medication management, and blood glucose monitoring. R1's emergency room (ER) discharge instructions, printed April 6, 2025, for an ER admission on April 5, 2025, included an order for hydrocodone-acetaminophen 10-325 milligram (mg) tablet, once daily in the morning and once daily as needed.	01760		

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01760	Continued From page 6 R1's progress notes dated April 6, 2025, indicated R1 returned from the ER and scheduled for a face-to-face visit with his physician on April 8, 2025. A progress note dated April 8, 2025, written by director of nursing (DON)-D, indicated R1 requested his "narcotic prescription" be canceled because it made him dizzy. DON-D documented the provider canceled. The note lacked documentation as to what medication DON-D was referring to. R1's medication administration record (MAR) dated April 2025, failed to include the transcribed order for hydrocodone-acetaminophen. The MAR lacked indicated any transcribed medication had been discontinued per DON-D's note. R1 failed to receive ordered hydrocodone-acetaminophen during the month of April. R1's record lacked any physician order discontinuing a medicaiton on April 8, 2025. R1's clinic visit notes dated April 8, 2025, lacked indication R1's physician discontinued any orders during the visit. R1's physician records provided by the clinic and not the licensee, indicated an order dated May 6, 2025, discontinue Lyrica (nerve pain medication) and discontinue oxycodone. The words "not on" were written behind oxycodone. The licensee lacked record of the physician order dated May 6, 2025, no documentation there was clarification since R1 was not prescribed oxycodone or Lyrica nor were they listed on the April 2025 MAR or on the May 2025 MAR prior to May 6, 2025.	01760		

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01760	Continued From page 7 R1's MAR dated May 2025, failed to include the order for hydrocodone-acetaminophen. R1 failed to receive ordered hydrocodone-acetaminophen during the month of May. On May 20, 2025, Lyrica was transcribed to administer a dose at 8:30 p.m. Unlicensed personnel (ULP) inaccurately documented they administered a dose on May 21, 2025. The transcribed Lyria order ended on May 21, 2025. R1's physician orders dated May 27, 2025, indicated an order for oxycodone/acetaminophen 10 mg once daily in the morning and once daily as needed. R1's MAR dated May 2025, indicated oxycodone-acetaminophen was transcribed for a start date of May 29, 2025, however the order was grayed out due to being on hold, reason: no supply. A dose on May 30, 2025 was documented. The licensee failed to administer oxycodone-acetaminophen Pharmacy records indicated an order for hydrocodone-acetaminophen was never dispensed. A prescription for oxycodone-acetaminophen 10-325 mg, one tablet daily and once as needed dated May 27, 2025, dispensed 14 tables on the same date. The licensee failed to administer oxycodone-acetaminophen four out of five scheduled daily doses after it was received on May 27, 2025 in May 2025. R1's physician orders dated June 3, 2025, indicated an order to continue baclofen until pharmacy delivers oxycodone as ordered for pain. The physician also ordered a pain clinic	01760		

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01760	Continued From page 8 evaluation. R1's MAR dated June 2025, indicated oxycodone/acetaminophen 10 milligram (mg) was scheduled every morning and one as needed dose a day. The order was grayed out due to being on hold. There were documented administrations, however R1's record lacked narcotic records to support oxycodone/acetaminophen was administered. Additionally, the licensee lacked documentated administrations of oxycodone/acetaminophen on June 7, 9, 13 through 17, 2025. During observation on June 17, 2025, at 11:30 a.m., the investigator viewed surveillance records from 5:00 a.m. to 11:00 a.m., and it was noted ULP-A was the med-passer. R1's MAR dated June 2025, indicated an order for sliding scale insulin three times daily, including direction if the blood sugar is between 69-149, no insulin is given. On June 17, 2025, the 8:00 a.m. scheduled insulin and blood sugar check indicated ULP-A signed as administered at 8:43 a.m. and documented "given." During an interview on June 17, 2025, at 12:06 p.m., ULP-A stated she did not complete R1's scheduled 8:00 a.m. blood sugar check. However, ULP-A stated she erroneously documented a blood sugar of 143 and that insulin was given. During an interview on June 17, 2025, at 10:28 a.m., DON-D stated R1 often refused his medications because he did not think they were the correct medications. DON-D first stated the oxycodone/acetaminophen was not available for	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30672	A. BUILDING: _____ B. WING _____	C 06/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNLIGHT SENIOR LIVING	400 WESTERN AVENUE SAINT PAUL, MN 55103

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01760	Continued From page 9 three months because insurance would not pay for it, then she stated it was not available because R1 had utilized all that was received from the pharmacy, and it was too soon to reorder. However, DON-D could not produce a document showing how the medication was used such as medication count documentation. DON-D stated she believed R1's case worker followed up on the insurance issue with the oxycodone/acetaminophen therefore she did not. During an interview on June 17, 2025, at 8:47 a.m., R1 stated staff did not give him the correct medication or they did not give them at all. R1 stated staff often left medication at the bedside and proceeded to show an altoids mint tin full of pills that he had saved. Later in the interview, R1 asked DON-C who changed his medications because the gabapentin [methocarbam] did not work. R1 stated he need higher pain medications because he was still in pain. A licensee policy titled, Medication Management, dated August 1, 2021, indicated the following. For active assistance with medications from the dosage box system, the ULP will use the MAR for documenting medications given from a dosage box and will refer to the medications profile listing the medication name, dosage, sate and time administration. It will also include the purpose of the medication and any special instructions if applicable. A licensee policy titled, Competency Training Evaluation, dated August 1, 2021, indicated when a registered nurse of licensed health professional staff of Sunlight Senior Living delegates tasks, prior to the delegation of services they must make certain the unlicensed personnel is trained	01760		

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01760	Continued From page 10 in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the task. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	01760		
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. 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 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		