Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307297664M
Compliance #: HL307294362C

Date Concluded: December 20, 2023

Name, Address, and County of Licensee Investigated:
Edgewood Alexandria
1902 7th Avenue East
Alexandria, MN 56308
Douglas County

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

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 staff failed to provide adequate supervision during mealtime. The resident was found slumped over in her chair and appeared to be choking. Staff attempted the Heimlich maneuver, but the resident died shortly after emergency services arrived.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Facility staff were aware of the resident's recent choking incident and recent change in diet prior to admission. However, nursing staff failed to address the resident's history of choking in the care plan and failed to implement specific interventions to minimize the resident's risk of choking. The resident choked on a piece of meat and died approximately three months after admission to the facility.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the resident’s primary care provider. The investigation included review of the police report, death record, and facility records, including the service plan, assessments, and progress notes. Also, the investigator observed meal service provided at the facility.

The resident resided in an assisted living memory care unit. The resident’s diagnoses included Alzheimer’s disease, dementia, and adjustment disorder with mixed anxiety and depressed mood. The resident’s service plan included assistance with dressing, grooming, bathing, toileting, safety checks, and medication administration. The service plan did not include assistance or supervision for eating. The resident’s assessment indicated the resident had a good appetite and needed some help with meal set up. Staff were to assist with cutting up food as needed and were directed to notify the nurse of any concerns with food intake.

The resident’s medical record included three sets of physician orders signed around the time of admission to the facility.

The first order was initiated one month prior to admission, after the resident choked on a piece of meat and was evaluated in the emergency room. The order included a mechanical soft (pureed, ground, finely chopped, or blended) diet.

The second order, titled General Admission Orders, indicated the resident had a mechanical soft diet. A note next to the order included the following, "Note- This community cannot accommodate diets for modified consistency. Compliance with dietary restrictions is at the discretion of the resident." The orders were signed by the provider three days prior to the resident’s admission to the facility.

A third set of signed orders, sent from the previous assisted living facility, included "diet order change request: Resident sustained a choking episode on [date] due to non-cut up meat. Resident was then placed on a mechanical soft diet. Resident is moving to Edgewood on [date] and they are unable to accommodate a mechanical soft diet. Ok to change to regular texture with cut up assistance?" The provider signed off on the order "ok as above.”

The resident's Department of Human Services Resident Service Plan, provided to the facility by the resident’s case worker, indicated staff were to cut up the resident's food. Page seven of the service plan indicated for staff to "monitor for swallowing concerns (recent Heimlich due to choking, orders for mechanical soft texture diet.)" An acknowledgement of the service plan was signed by the facility’s clinical nurse supervisor (CNS), confirming she reviewed the plan and agreed to provide the services and supports outlined in the document.

An email sent to the memory care registered nurse (RN) from the resident's case manager about one month after the resident admitted to the facility, included the following, "...I noted a couple of things that were in the previous RS [resident service] plan and/or CP [care plan] at

[previous assisted living facility] but am not seeing in her current CP or profile...I maybe missed them but at least wanted to address...eating: [previous assisted living facility] reported that she had an order for mechanical soft diet following her choking episode in March. Was this passed onto Edgewood? Wondering if a note under eating re: her history of needing Heimlich and ER for choking in March should be noted in her care plan? (hoping this info was passed onto Edgewood during the transition)".

The RN failed to include the information outlined in the case manager's email in the resident's care plan or assessments.

The resident's medical record did not address the resident's recent history of requiring the Heimlich maneuver after choking on a piece of meat and/or how the facility would minimize the resident's risk of choking. Two assessments, completed one month prior to the resident's death, did not include information on the resident's recent choking episode or need to monitor the resident while eating. The resident's individual abuse prevention plan (IAPP) lacked any assessment of the past choking incident, the resident's history of eating quickly, or measures to be taken to reduce the resident's risk of choking. The IAPP indicated the resident had adequate nutrition and had a good appetite. Staff were to assist as needed with cutting up food for the resident and notify the nurse if any concerns with intake were noted.

A facility incident report indicated the resident was at the table in the dining room eating her dinner when staff noticed she was slumped over with her head down. A staff member started the Heimlich maneuver, called 911, and the on-call nurse. The on-call nurse advised staff to continue with the Heimlich maneuver, however it was unsuccessful, and the resident became unconscious. The resident was lowered to the floor and staff attempted a finger sweep to remove the food from the resident's mouth. Some food was removed, but they were unable to clear the airway. Emergency medical services and police arrived and took over care of the resident. Police were provided the resident's do not resuscitate (DNR) order and the resident was declared dead.

The resident's death record listed food bolus asphyxia (choking on food) as the cause of death. The death record indicated the resident choked on a piece of bratwurst/hotdog and died within minutes.

During interviews with facility staff, including licensed nurses and unlicensed personnel, they stated the resident did not have special dietary needs and they were unaware of any previous choking episodes. Several staff members stated the resident would eat very fast, but they had not received direction on any specific interventions to reduce her risk of choking.

During an interview, the resident's case manager stated she had several verbal and email communications with facility staff, specifically the clinical nurse supervisor (CNS) and registered nurse (RN), regarding the resident's history of choking and the need to monitor for choking since she would no longer be receiving a modified diet. The case manager noticed the facility's

care plan did not address the resident's recent choking episode or her risk for choking again, along with the need to monitor for choking while eating. The case manager reached out to the facility to address her concerns and received a reply that the facility would add the information to their care plan for the resident. The case manager stated she made sure the rate plan for the county reflected the need to monitor for choking, and the facility signed off on the rate plan, so she assumed they read it. The case manager stated facility staff should have been aware the resident was at high risk for choking and it should have been addressed in her care plan.

During an interview, the CNS confirmed the resident's record lacked information on her past choking episode, and there were no interventions put in place to prevent choking after the resident’s diet changed from mechanical soft to regular. The CNS stated she didn't know if anyone had reviewed with the resident's power of attorney the risks related to eating a regular diet versus a mechanical soft one because "that was the doctor's choice; she [the doctor] decided that was correct and agreed to change the diet." The CNS said it would have been the responsibility of the previous facility to review these risks, despite the diet change being made at the request of Edgewood staff as a condition of admission. The CNS confirmed an internal investigation was not initiated after the resident's death and she could not confirm if meat was cut up as it should have been, but trusted staff followed the correct policy. The CNS was not sure why the care plan did not detail the resident's recent choking episode but confirmed it should have and additional interventions should have been developed due to the recent choking incident and the fact she was no longer receiving a mechanical soft diet.

During an interview, a nurse from the resident’s previous assisted living facility stated the resident had choked on food at their facility and required the Heimlich maneuver. The nurse stated after that incident, they put the resident on a mechanical soft diet to prevent further choking episodes. The nurse recalled that the resident would eat very fast so a staff member would usually sit with her for meals. The nurse stated that a few weeks after the chocking incident, a nurse from Edgewood came to their facility to assess the resident and agreed to admit her to Edgewood. After agreeing to admit the resident, the concern with her diet was noted, and Edgewood staff informed her they couldn't accept the resident with the current mechanical soft diet order. Edgewood staff requested for her to contact the resident's provider to change the diet from mechanical soft to regular.

During an interview, the executive director stated she was not aware of the issues related to the resident's past choking episode or the case manager's requests to update the care plan to reflect the resident's history of choking. The executive director stated, "I was only aware she was appropriate [for admission to the facility] and I trust my nurses know how to make those decisions, but I wasn't aware of those conversations [with the case manager.]"

During an interview, the resident’s power of attorney (POA) stated she spoke with the facility nurse and the executive director about the resident’s past choking episode and wanted to make sure it didn’t happen again. The POA stated the choking episode in March was “a significant factor why she had to go to a smaller facility” and a leading factor in why she admitted to this

facility, because staff assured her they would monitor for choking issues and provide better supervision. The POA stated she spoke with the executive director when completing admission paperwork and she was told they would put her at a big table, and someone would sit with her while she ate. The POA stated both she and the county case manager told the facility the resident needed a soft diet because of the recent choking incident, and she was told by facility staff “everyone is a soft diet with low salt.” The POA stated that shortly after the resident was admitted, she came in to visit and was concerned to see the resident eating alone in her room, so she told the nurse that the resident couldn’t eat alone because she had a history of choking. The POA stated, “[the resident] walked herself to the dining room that day, her health wasn’t failing, and she sat in a room full of people, choking to death, and no one was helping her.”

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: No, deceased.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility reported the incident to MAARC.

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
Douglas County Attorney
Alexandria Police
Alexandria City Attorney
Minnesota Board of Executives for Long Term Services and Supports
Minnesota Board of Nursing
Medical Examiner

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30729	A. BUILDING: _____ B. WING _____	C 11/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD ALEXANDRIA SENIOR LIVING	1902 7TH AVENUE EAST ALEXANDRIA, MN 56308

(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: #HL307297664M/#HL307294362C On November 13, 2023, 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 51 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL307297664M/#HL307294362C, tag identification 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 License 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 144G.31 subd. 1, 2, and 3.	
02310 SS=J	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted	02310		

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02310	Continued From page 1 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 ensure care and services were provided based on resident need, according to an up-to-date service plan and accepted health care standards, for one of one resident (R1) when R1's assessments and plan of care failed to address R1's recent history of choking and additional interventions were not developed or implemented to minimize R1's risk for choking. Facility staff were aware of R1's recent choking incident and failed to implement interventions to reduce the risk of choking or mitigate risk since R1 was no longer receiving a mechanical soft diet. R1 choked on a piece of bratwurst at the facility and died. This practice resulted in a level four violation (a violation that results in 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). The findings include: R1's diagnoses included Alzheimer's disease, dementia, adjustment disorder with mixed anxiety and depressed mood. R1 admitted to the facility on April 28, 2023, after needing more supervision than her previous assisted living facility was able to provide.	02310		

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02310	Continued From page 2 R1's service plan, dated April 28, 2023, did not include assistance or supervision for eating. The resident's assisted living contract signed April 28, 2023, included "the community does not provide specialized therapeutic diets" on page three. The licensee's UDALSA (Uniform Disclosure of Assisted Living Services and Amenities), dated May 11, 2023, indicated the facility could provide feeding in common area with one staff member per resident and set-up and cut food at meal time. The UDALSA indicated modified texture diets were not available. The resident's signed provider orders dated April 25, 2023, included an order for mechanical soft texture, regular consistency. The order was initiated on March 23, 2023, after the resident was evaluated in the emergency room when she choked on a piece of meat and had to have the Heimlich maneuver performed while she was living at a different assisted living facility. A second set of signed orders titled General Admission Orders indicated the resident had a mechanical soft diet. A note next to it included the following, "Note- This community cannot accommodate diets for modified consistency. Compliance with dietary restrictions is at the discretion of the resident." The orders were signed by the provider on April 25, 2023. A third set of signed orders sent from her previous assisted living facility to Edgewood included [R1] diet order changes dated April 27, 2023, and indicated there was a "diet order change request: Resident sustained a choking	02310		

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02310	Continued From page 3 episode on 3/22/23 due to non-cut up meat. Resident was then placed on a mechanical soft diet. Resident is moving to Edgewood on 4/28/23 and they are unable to accommodate a mechanical soft diet. Ok to change to regular texture with cut up assistance?" The provider signed off "ok as above" on April 26, 2023. The resident's Department of Human Services Resident Service Plan provided to Edgewood Vista Alexandria for service dates of April 28, 2023, through March 31, 2024, indicated staff were to cut up the resident's food. Page seven of the service plan indicated staff were to "monitor for swallowing concerns (recent Heimlich due to choking, orders for mechanical soft texture diet.)" An acknowledgement sent to the facility on May 31, 2023, was signed by clinical nurse supervisor (CNS)-A confirming she had reviewed the plan and agreed to provide the services and supports as outlined. An email sent to registered nurse (RN)-M on May 26, 2023, from the resident's case manager included the following, "...I noted a couple of things that were in the previously RS [resident service] plan and/or CP [care plan] at [previous assisted living facility] but am not seeing in her current CP or profile...I maybe missed them but at least wanted to address...eating: [previous assisted living facility] reported that she had an order for mechanical soft diet following her choking episode in 3/2023. Was this passed onto Edgewood? Wondering if a note under eating re: her history of needing Heimlich and ER for choking on 3/2023 should be noted in her care plan? (hoping this info was passed onto Edgewood during the transition)" RN-M failed to include the information in the resident's care plan or assessments.	02310		

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02310	Continued From page 4 The resident's IAPP, last updated July 31, 2023, lacked any assessment of the past choking incident, the resident's history of eating quickly, or what measures should be taken to reduce risk since the resident had to switch diets in order to be admitted to the facility. The IAPP indicated the resident had adequate nutrition and had a good appetite. Staff were to assist as needed with cutting up food for the resident and notify the nurse if any concerns with intake were noted. All the medical records for R1 provided to the investigator did not address the resident's recent history of requiring the Heimlich maneuver after choking on a piece of meat and how the facility would minimize the risk of choking again. Assessments completed on July 31, 2023, and July 11, 2023, lacked any assessment of the past choking incident, the resident's history of eating quickly, or what measures should be taken to reduce risk since the resident had to switch diets in order to be admitted to the facility. An incident report dated August 2, 2023, indicated the resident was at the table in the dining room eating her dinner at 5:30 p.m. Staff noticed the resident had "slumped over and had her head down. Staff started the Heimlich maneuver and called 911." The on-call nurse (RN-C) advised staff to continue the Heimlich, however it was not successful and the resident became unconscious. Staff lowered the resident to the floor and attempted a finger sweep in the resident's mouth. Some food was removed but staff were unable to clear the airway. Emergency medical services and police arrived and declared the resident dead. The police report indicated 911 was dispatched to	02310		

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02310	Continued From page 5 the facility at 5:34 p.m. for a "female that was choking. While enroute, dispatch advised that the victim's lips were turning blue." The resident was unresponsive when police arrived and CPR was initiated until the resident's do not resuscitate (DNR) order was confirmed." The resident's death record listed food bolus asphyxia (choking on food) as the cause of death. The death record indicated the resident had choked on a piece of bratwurst/hotdog and died within minutes. On November 13, 2023, at 10:40 a.m., unlicensed personnel (ULP)-K stated R1 was a very fast eater and she was usually the first one done, even if she was fed last. ULP-K stated the resident had a normal diet and didn't think she had choked on anything before. On November 15, 2023, at 9:05 a.m., ULP-E stated the resident did not have any special diets and she had not heard anything about the resident choking on food previously. On November 15, 2023, at 10:00 a.m., RN-B stated the resident did not have any special diet needs and she was not aware of any past choking episodes. RN-B stated she had not observed the resident eating and wasn't aware of any concerns with her intake. On November 15, 2023, at 10:35 a.m., the resident's power of attorney (POA)-I stated she had spoken with the facility nurse and the executive director about the resident's past choking episode and that she wanted to make sure it didn't happen again. POA-I stated the choking episode in March was "a significant factor why she had to go to a smaller facility" and	02310		

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02310	Continued From page 6 a leading factor why she admitted to this facility because staff assured her they would monitor for choking issues and provide better supervision. POA-I stated she spoke with the executive director when completing admission paperwork and she was told they would put her at a big table and someone would sit with her while she ate. POA-I stated both she and the county case manger told them the resident needed a soft diet because of that recent choking incident and she was told by facility staff "everyone is a soft diet with low salt." POA-I stated shortly after the resident admitted, she came in to visit and was concerned to see the resident eating alone in her room so she told the nurse the resident couldn't eat alone because she had a history of choking. POA-I stated, "[the resident] walked herself to the dining room that day, her health wasn't failing and she sat in a room full of people, choking to death, and no one was helping her." On November 15, 2023, at 11:15 a.m., on call RN-C stated she answered the call regarding the resident choking in August 2, 2023, and felt staff had done exactly what they should have done. RN-C stated the resident did not have any past history of choking or any special diets or dietary needs. On November 15, 2023, at 11:25 a.m., CNS-A confirmed the resident's record lacked any information on her past choking episode and there were no interventions put in place to prevent choking after her diet changed from mechanical soft to regular. CNS-A stated she didn't know if anyone reviewed with the resident's POA the risks related to eating a regular diet versus a mechanical soft one because "that was the doctor's choice, she decided that was correct and agreed to change the diet." CNS-A stated it	02310		

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02310	Continued From page 7 would be the responsibility of the facility the resident was previously at to review the risks, even though they only requested the diet change at the request of Edgewood staff as a condition of admission. CNS-A confirmed an internal investigation was not initiated after the resident's death and she could not confirm if meat was cut up as it should have been but that "she trusted staff to follow the correct policy." CNS-A stated she was not sure why the care plan did not detail the resident's recent choking episode and confirmed it should have and additional interventions should have been put in place due to the recent choking and the fact she was no longer receiving a mechanical soft diet. On November 15, 2023, at 2:20 p.m. a nurse at the resident's prior assisted living facility (RN)-L stated the resident had previously choked on food at their facility and required the Heimlich maneuver. RN-L stated after that, they put the resident on a mechanical soft diet to prevent further choking episodes. RN-L stated a few weeks after that incident, a nurse from Edgewood came over to their facility to assess the resident and they agreed to admit her to the facility. After agreeing to admit her, the concern with her diet was noted and Edgewood staff advised her they couldn't accept the resident with the current mechanical soft diet order. Edgewood staff requested she contact the resident's provider to change the diet from mechanical soft to regular. RN-L stated R1 would eat very fast so a staff member would usually sit with her for meals. On November 16, 2023, at 9:00 a.m., the resident's case manager (CM)-J stated she had several verbal and email communications with facility staff, specifically CNS-A and RN-M, regarding R1's history of choking and the need to	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30729	A. BUILDING: _____ B. WING _____	C 11/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD ALEX SENIOR LIVING	1902 7TH AVENUE EAST ALEXANDRIA, MN 56308

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02310	Continued From page 8 monitor for choking since she would not longer be receiving a modified diet. CM-J stated she noticed the facility's care plan did not address the resident's recent choking episode or her risk for choking again, along with the need to monitor for choking while eating. CM-J stated she reached out to the facility to address her concerns and received a reply back that the facility would add that to their care plan for the resident. CM-J stated she made sure the rate plan for the county reflected the need to monitor for choking and the facility signed off on the rate plan so she had assumed they read it. CM-J stated facility staff should have been aware the resident was at high risk for choking and should have that in her care plan. On November 16, 2023, at 9:25 a.m., executive director (ED)-G stated she was not aware of any of the issues related to the resident's past choking episode or the case manager's requests to update the care plan to reflect the resident's history of choking. ED-G stated, "I was only aware she was appropriate [for admission to the facility] and I trust my nurses know how to make those decisions, but I wasn't aware of those conversations [with the case manager.]" On November 17, 2023, at 10:05 a.m., the resident's primary care provider (PCP)-H stated the resident had always been a fast eater and her choking risk was related more to her habit of eating fast versus the diet texture. PCP-H confirmed interventions should have been in place related to the resident's fast eating habits to minimize the risk of choking. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7)	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02310	Continued From page 9 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. 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.	