DEPARTMENT OF HEALTH

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL31337001M
Compliance #: HL31337002C

Date Concluded: October 19, 2021

Name, Address, and County of Licensee Investigated:
Highland GW LLC
750 Main Street Suite 200
Mendota Heights, MN 55118
Dakota County

Name, Address, and County of Housing with Services location:
Highland GW
1925 Graham Avenue
St Paul, MN 55116
Ramsey County

Facility Type: Home Care Provider

Investigator's Name: Peggy Boeck, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:

The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Allegation(s):

It is alleged that the alleged perpetrator (AP) neglected the resident when they left the resident in bed for months, which lead to the resident developing pressure ulcers.

Investigative Findings and Conclusion:

Neglect was substantiated. The facility was responsible for the maltreatment. The resident gained weight and physical/occupational therapy assessments determined the resident could be transferred with a mechanical lift and three staff. The facility did not provide adequate staffing to transfer the resident with the mechanical lift and left him in bed for over six months without attempting to transfer him out of bed. The facility plan to move the resident in the case of an emergency was to call the fire department.

The investigation included interviews with facility staff, including administrative staff, nursing staff, and unlicensed staff. The investigator toured the facility, observed staff/resident interactions, reviewed medical records, facility documents, policies and procedures related to staffing, medication management, wound care, transfer assistance, nursing assessments, service plans, and maltreatment of vulnerable adults.

The resident lived at the facility for several years due to a stroke that left him with weakness on the left side of his body and obesity. The resident received services from the assisted living facility that included bathing assistance, meals, dressing and grooming, nursing assessments, reassurance checks, housekeeping, laundry, mobility assistance, mechanical lift transfers, transfer assistance of two staff, meal/activity reminders, toileting assistance (with a bed pan), BiPAP/CPAP application (to assist with sleep apnea), medication management, and oxygen. The resident had an electric wheelchair that he used to use.

The facility weighed the resident monthly and determined he approached the weight limit of his mechanical lift (a device that takes the strain out of lifting and reduces the risk of injury to transfer a resident when they are unable to bear weight on their feet.) The facility made a referral to an obesity center for an evaluation. The resident remained bedbound and told staff how bored he was. He watched TV, used his computer, and ordered out food.

Three weeks later the staff used the mechanical lift to transfer the resident out of bed to weigh him and found that his weight exceeded the limits of his mechanical lift. The resident bought a new mechanical lift. When the lift came two weeks later it was found to be the wrong size. When the appropriate size mechanical lift arrived (maximum weight 600 pounds), the doctor ordered an outside agency (with occupational therapy and physical therapy) to evaluate and assess the resident for safe transfer with the new mechanical lift.

Another two weeks passed, and physical therapy came to evaluate the resident and train staff on transferring the resident in the new mechanical lift. The manager of the facility requested physical/occupational therapy teach staff how to transfer the resident in/out of bed and in/out of his electric wheelchair. Physical therapy also worked with the resident on range of motion and bed mobility. The physical therapist determined three staff could safely transfer the resident using the mechanical lift, but the facility told the resident they would not provide three staff to transfer him. The facility suggested the resident hire an outside person to come in when he needed a transfer.

For the next five months the resident remained bedbound. The facility looked for alternate placement and required that the resident call around to find his own personal care assistant to facilitate transfers. Although he did not receive the services, facility staff signed off that they assisted and completed mechanical lift transfers and transfer assistance of two staff. The resident developed a pressure ulcer on his bottom that required an outside agency to provide wound care.

Documentation indicated the facility continued to accept admissions as there had been seven new admissions between the date of the initial decision to leave the resident in his bed, and the investigation five months later. The investigator did not receive documentation of the number of resident discharges in the same period.

During interviews, several nurses said that lack of staffing was a major concern at the facility.

During an interview, a member of the facility administration said she had concerns of potential injury to staff if they tried to transfer the resident. The administration member stated she thought the resident was happy being in bed and did not wish to transfer to his wheelchair. The administration member said the facility had no plan to evict the resident.

During an interview the medical doctor stated the facility did not have the staff to care for the resident and questioned whether the resident would fit through the bedroom door in an emergency.

When interviewed the resident's family member stated the facility knew of the resident's size when he moved in. The family member said the resident did not want to lay in bed all the time but did not want to make waves as the resident relied on the facility staff to care for him.

During interview, the resident stated he was on a fixed income, did not qualify for assistance, and the facility continued to charge him for services that he did not receive (mechanical lift transfers, transfer assistance of two staff, and mobility assistance). The resident stated he struggled with weight his entire life. The resident stated the facility spent the previous five months trying to find a different placement for him but made no effort to try to transfer him out of bed. The resident stated he developed pressure ulcers on his bottom from laying in his bed. The resident said he would like to get out of his bed so he could just go outside, visit with his family, or play cards with friends. The resident stated he felt trapped and missed an entire summer while he remained in bed.

In conclusion, 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:
(a) 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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: No, unable to reach
Alleged Perpetrator interviewed: N/A

Action taken by facility:

The facility removed completed mechanical lift transfers and transfer assistance of two staff from the unlicensed personnel check off list on the day of the investigation.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:
https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

The responsible party will be notified of their right to appeal the maltreatment finding.

cc: The Office of Ombudsman for Long-Term Care
Ramsey County Attorney
St. Paul City Attorney
St. Paul Police Department

Minnesota Department of Health

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	31337	A. BUILDING: ______ B. WING ______	C 09/30/2021

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HIGHLAND GW LLC	1925 GRAHAM AVENUE SAINT PAUL, MN 55116

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0 000	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On September 30, 2021, the Minnesota Department of Health conducted an investigation at the above provider, and the following correction orders are issued. At the time of the investigation, there were 31 residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL31337002C/HL31337001M, tag identification 0470, 1620, 1640, and 2360.	0 000	The Minnesota Department of Health documents the State Licensing 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that 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. Per Minnesota Statute §144G.41, subd. 3, the home care provider must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.41, subd. 3.	
0 470 SS=G	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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determining its staffing level that:
(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;
(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and
(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;
(12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:
(i) awake;
(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;
(iii) capable of communicating with residents;
(iv) capable of providing or summoning the appropriate assistance; and
(v) capable of following directions;

This MN Requirement is not met as evidenced by:
Based on interview and document review the facility failed to ensure sufficient staffing to meet the scheduled needs of one of one resident (R1) reviewed for pressure ulcers when physical therapy assessed R1 needed assistance of three staff with a mechanical lift for transfers. The facility did not transfer R1 from his bed for over five months due to lack of staff availability and R1 developed a pressure ulcer. The facility did not have evidence of staffing metrics used and did

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not have a plan to move the resident in an emergency.

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).

Findings include:

R1's medical record indicated the resident moved into the facility September 3, 2017, due to diagnoses that included history of stroke with left side weakness, type 2 diabetes, hypertension, atrial fibrillation, and obesity.

R1's service plan dated January 29, 2021 indicated R1 received services from the facility that included bathing assistance, meals, dressing and grooming, nursing assessments, reassurance checks, housekeeping, laundry, mobility assistance, mechanical lift transfers, transfer assistance of two staff, meal/activity reminders, toileting assistance, BiPAP/CPAP application, and oxygen.

R1's progress note dated March 11, 2021 at 1:25 p.m. indicated R1's weight at 498.5 pounds. The progress note indicated a discussion held with the nurse and house manager concluded R1 would remain in bed "for safety" as R1's mechanical lift had a maximum weight limit of 500 pounds.

R1's physical therapy assessment dated April 21, 2021 indicated staff needed education on safety

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and technique with use of new bariatric hoyer (mechanical lift).

R1's occupational therapy evaluation dated April 27, 2021 indicated an occupational therapist assessed R1 with a hoyer (mechanical lift) that accommodated up to 650 pounds. The evaluation indicated the sling provided fit well and the therapist made staff aware of safe donning of the sling and transfer of R1. The evaluation concluded that a three-person transfer was recommended which directed one staff to operate the lift, and two staff to maneuver R1 due to R1's size, fall risk, and safety needs.

R1's homecare nursing progress note dated August 16, 2021 indicated education provided to staff on proper equipment needs for R1 to have the ability to transfer out of bed, including correct lift equipment, appropriate number of staff to transfer the resident, and to declutter room. The progress note indicated the previous items needed correction to provide a safe environment for R1.

R1's homecare nursing progress note dated August 16, 2021 indicated R1 had a pressure ulcer on his left buttock that measured 0.5 centimeters (cm) by 0.2 cm by 0.1 cm.

During interview on September 30, 2021, at 2:45 p.m., R1 stated the facility never tried to use three people with the mechanical lift after the physical therapy/occupational therapy evaluations. R1 stated the physical therapist told him three people were required to maneuver him while in the mechanical lift, but the lift could hold his weight. R1 stated the facility did not have enough staff to help him and often did not reposition him every two hours. R1 stated the

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housing manager told him they would have to hire a third person to use the mechanical lift to transfer R1 out of bed. R1 stated he would like to get out of his bed, was bored, and had many things he would like to do such as visit family, play cards with his friends, or just go outside.

During an interview on September 30, 2021, at 3:27 p.m., regional director (RD)-B stated the facility did not transfer R1 due to his weight, inability to transfer, and the potential for work related injuries. RD-B stated R1 was happy to remain in bed, and she believed that R1 did not wish to get out of bed.

During interview on October 1, 2021, at 12:13 p.m., home health registered nurse (RN)-D stated during a home health assessment on August 11, 2021, for wound management, staff informed her that R1 had not been out of bed for months because they did not have enough staff. RN-D stated the facility had a mechanical lift that could hold R1's weight, but the facility had not tried due to lack of staff.

During an interview on October 13, 2021, at 9:20 a.m. medical doctor (MD)-E stated the facility requested she write on order to leave R1 in bed and she said no. MD-E stated the facility did not have the staff to care for R1 and R1 could not fit through the door out of his room if there was an emergency.

During an interview on October 13, 2021, at 1:12 p.m. facility registered nurse (RN)-F stated the facility did not have enough staff to transfer R1 because they scheduled two staff in the memory care, and neither could leave. RN-F stated the first floor where R1 lived had one staff. RN-F stated that "things did not get done" due to short

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staffing. RN-F stated the facility leadership told her if there was an emergency, they should call the fire department to get R1 out of his room.

The Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated May 20, 2021 indicated the number of unlicensed direct care staff typically scheduled per shift as follows:
Day shift- four staff or more depending on census/level of acuity
Evening shift- four staff or more depending on census/level of acuity
Night shift- 2+ staff

Staff schedules from August 1, 2021, through August 31, 2021, indicated there were 6 shifts that had only three staff scheduled (August 1, 2021-day shift, August 9, 2021-day shift, August 10, 2021-evening shift, August 27, 2021 day shift and evening shift, and August 31, 2021 day shift). Requested schedules from September 1, 2021 through September 29, 2021 were not provided by the facility.

The facility schedule dated September 30, 2021 indicated the following:
Day shift- four staff
Evening shift- three staff
Night shift- two staff

The Resident List dated September 30, 2021, indicated 31 residents lived at the facility (assisted living and memory care). One resident in assisted living since December 2017, required the assistance of two staff with a mechanical lift for transfers, and another assisted living resident who lived at the facility since November 2020, required the assistance of two staff for transfers.

The COVID-19 Staffing Contingency policy dated

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0 470	Continued From page 6 October 22, 2020, indicated the facility must prepare for staffing shortages, have contingency plans, and ensure resident safety during a pandemic/outbreak. The policy provided general suggestions (canceling events or activities, adjusting schedules, adding incentives or bonuses for staff, bringing additional staff from outside, or using volunteers for non-clinical tasks.) The Staffing Backup policy dated September 1, 2021, indicated the house manager, nursing, and leads took responsibility to cover any staffing needs. The policy indicated staff would be contacted to offer to come in, and if no one able to cover, the house manager, nurse or lead would come in to assist. The facility did not provide requested documentation of development or implementation of a staffing plan/policy to ensure sufficient staffing. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 470		
01620 SS=G	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an	01620		

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individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.
(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to reassess the service needs of one of one resident (R1) reviewed for pressure ulcers when R1 had a change in needs. R1 gained an unknown amount of weight and the facility determined they did not have enough staff to use a mechanical lift to transfer R1, R1 remained bedbound for over five months, and developed a pressure ulcer.

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).

Findings include:

R1's medical record indicated the resident was

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admitted September 3, 2017, due to diagnoses that included history of stroke with left side weakness, type 2 diabetes, hypertension, atrial fibrillation, and obesity.

R1's most recent service plan dated January 29, 2021 indicated R1 received services from the facility that included bathing assistance, meals, dressing and grooming, nursing assessments, reassurance checks, housekeeping, laundry, mobility assistance, mechanical lift transfers, transfer assistance of two staff, meal/activity reminders, toileting assistance, BiPAP/CPAP application, and oxygen.

R1's most recent nursing assessment dated February 8, 2021 indicated R1 required the transfer assistance of two staff with a hoyer (mechanical) lift, R1 used an electric wheelchair for mobility, and R1 required assistance of one person to reposition/sit up.

R1's physician progress note dated July 27, 2021 ordered skilled nursing to evaluate and treat for sacral pressure ulcer on right buttock, and to reposition R1 every three hours.

The Team Sheet (a document provided to unlicensed personnel directing services) for first floor west wing (undated but provided on September 30, 2021) directed unlicensed personnel to reposition R1 every two hours.

During an interview on September 30, 2021, at 1:37 p.m., registered nurse (RN)-A stated R1 remained bedbound and received repositioning every two to three hours. RN-A stated R1 gained weight and physical therapy recommended the facility use three staff to transfer R1 with a mechanical lift. RN-A stated nursing was

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responsible for conducting assessments and updating the service plan and confirmed that neither R1's nursing assessment nor R1's service plan was updated.

During interview on September 30, 2021, at 3:27 p.m., regional director (RD)-B stated the facility had a care conference (unknown date) and it was suggested that the facility could not provide the services that R1 needed. RD-B stated R1's service plan should have been changed.

During an interview on September 30, 2021, at 3:56 p.m., house manager (HM)-C stated when R1 gained weight the facility could no longer provide the care he required. HM-C stated she believed the nurses monitored R1 for skin breakdown and the service plan would reflect that. HM-C stated nursing and the whole healthcare team was responsible for updating the service plan.

During an interview on October 13, 2021 at 1:12 p.m. RN-F stated she thought she completed an assessment of R1 sometime between April and September 2021.

The Initial and On-Going Nursing Assessment policy dated September 20, 2020 indicated the RN would reassess each resident on an on-going basis and would revise the resident's service plan based on the resident's needs. The policy indicated the RN would reassess the resident any time the resident had a change in condition and document in the resident's record.

TIME PERIOD FOR CORRECTION: Seven (7) Days

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND GW LLC	**1925 GRAHAM AVENUE SAINT PAUL, MN 55116**

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01640	Continued From page 10	01640		
01640 SS=D	144G.70 Subd. 4 Service plan, implementation, and revisions t (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure the service plan reflected the current services provided for one of one resident (R1) reviewed for service plans. The facility no longer provided transfers for the resident, leaving him bedbound, but staff continued to document that they provided mechanical lift transfers, and transfer assistance of two staff per the service plan. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01640		

Minnesota Department of Health

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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 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).

Findings include:

R1's medical record indicated R1 was admitted to the facility on September 3, 2017, due to diagnoses that included history of stroke with left side weakness, type 2 diabetes, hypertension, atrial fibrillation, and obesity.

R1's service plan dated January 29, 2021, indicated R1 received services from the assisted living facility that included bathing assistance, meals, dressing and grooming, nursing assessments, reassurance checks, housekeeping, laundry, mobility assistance, mechanical lift transfers, transfer assistance of two staff, meal/activity reminders, toileting assistance, BiPAP/CPAP application, and oxygen.

R1's progress note dated March 11, 2021, at 1:25 p.m. indicated R1's weight at 498.5 pounds. The progress note indicated a discussion held with the nurse and house manager concluded that R1 would remain in bed "for safety" as R1's mechanical lift had a maximum weight limit of 500 pounds.

R1's occupational therapy note dated April 27, 2021, indicated R1 was assessed with his new mechanical lift that accommodated up to 650 pounds. The note indicated the sling fit well and staff were provided with instruction. The note recommended three persons to transfer R1 (one

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to operate the lift, and two to maneuver R1).

R1's progress note dated April 28, 2021, at 4:35 p.m. indicated the nurse and house manager met with R1 to inform him that staff would not transfer him with his new mechanical lift because it was beyond the capabilities of the facility.

R1's service checkoff list for May 2021, indicated staff signed off completion of mechanical lift transfers 58 times and transfer assistance with two persons 66 times.

R1's service checkoff list for June 2021, indicated staff signed off completion of mechanical lift transfers 68 times and transfer assistance with two persons 64 times.

R1's service checkoff list for July 2021, indicated staff signed off completion of mechanical lift transfers 65 times and transfer assistance with two persons 49 times.

R1's service checkoff list for August 2021, indicated staff signed off completion of mechanical lift transfers 25 times and transfer assistance with two persons 25 times.

R1's service checkoff list for September 2021, indicated staff signed off completion of mechanical lift transfers 55 times and transfer assistance with two persons 62 times.

During an interview on September 30, 2021 at 1:37 p.m. registered nurse (RN)-A stated that nurses were responsible to ensure the accuracy of the service checkoff lists.

During an interview on September 30, 2021 at 2:45 p.m., R1 stated he was being charged for

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01640	Continued From page 13 transfers with the mechanical lift with two staff, but that had not happened for months. R1 stated he felt the facility charged him for services he did not receive. During an interview on September 30, 2021, at 3:27 p.m. regional director (RD)-B confirmed that staff documented in May, June, July, August, and September 2021, that they completed mechanical lift transfers with R1 and that they also provided transfer assistance to R1 with two persons. RD-B stated she did not know why staff documented they completed a service that had not been completed. The Development and Revisions to the Service Plan policy dated September 1, 2020, indicated each resident's service plan was reviewed by the registered nurse whenever changes were needed to the services to be provided because of a change in the client's condition. The Unlicensed Personnel Job Description (undated) indicated unlicensed personnel were responsible to document services provided accurately and consistent with agency policies. The facility did not provide the requested documentation policy. TIME PERIOD FOR CORRECTION: Seven (7) Days	01640		
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	02360		

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02360	Continued From page 14 covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was neglected. Findings include: On September 30, 2021, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	