Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL31968001M
Compliance #: HL31968002C

Date Concluded: September 15, 2021

Name, Address, and County of Licensee Investigated:
Maple Hill Senior Living
3030 Southlawn Drive
Maplewood, MN 55109
Ramsey County

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

Investigator's Name: Peggy Boeck, RN
Special Investigator
Lissa Lin, RN
Special Investigator

Finding: Substantiated, individual responsibility

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

Allegation(s):
It is alleged: Alleged Perpetrators (AP1 and AP2) abused Resident 1 when they forcefully removed Resident 1 from a chair.

It is alleged: AP2 and AP3 abused Resident 2 when AP3 pushed Resident 2 backwards onto his bed, causing a bruise on Resident 2's arm. AP2 laughed and mocked Resident 2.

It is alleged: AP2 and AP3 neglected Resident 2 when they failed to bring him to the bathroom.

It is alleged: The APs neglected Resident 2 when he lost 30 pounds in a month.

Investigative Findings and Conclusion:
Abuse was substantiated. AP1 and AP2 were responsible for the maltreatment. Video from a family-placed camera in Resident 1's room showed that over the course of two nights, AP1 yelled

and swore at Resident 1, forcefully removed Resident 1 from a chair against Resident 1's wishes and threatened to hurt Resident 1. AP2 assisted AP1 to forcefully remove Resident 1 from the chair, and repeatedly mocked R2 with derogatory, belittling statements while AP3 observed, saying nothing.

Neglect is inconclusive. A family-placed video camera recorded one incident that showed AP3 quickly moving Resident 2 from a seated to laying position on the bed, but AP3 had one hand on Resident 2's chest and one hand bracing Resident 2's back. Another video showed AP2 and AP3 fail to bring Resident 2 to the bathroom per the service plan, but no evidence indicated Resident 2 was incontinent during that incident. Regarding Resident 2's weight loss, the facility incorrectly documented Resident 2's admission weight (by 13.7 pounds). Resident 2's service plan did not include monitoring of Resident 2's intake or documentation of Resident 2's weight.

The investigation included interviews with facility staff, including administrative staff, nursing staff, and unlicensed staff. In addition, law enforcement was contacted. The investigators toured the facility, observed resident/staff interactions, and observed video from a family-placed video camera in Resident 2's room. The investigators reviewed facility documents, resident records, policies and procedures related to maltreatment of vulnerable adults, staff orientation/training, supervision of unlicensed personnel, service plan implementation, incident reporting, falls, and the facility code of conduct/memory care etiquette. The investigators interviewed family members of Resident 1 and Resident 2.

Resident 1 lived in the memory care unit. Her diagnoses included schizophrenia and dementia with behavioral disturbance. Resident 1 received bathing assistance and medication administration services from the facility. Nursing staff assessed Resident 1 as not oriented to time and place and required staff to orient her as needed. Resident 1 was a fall risk, bruise risk, and wandering risk.

Resident 2 lived on the memory care unit of the facility due to diagnoses that included dementia. Resident 2 received services from the facility that included assistance with toileting, dressing, grooming, walking, showering, safety checks, meal set-up, eating encouragement, medication administration, behavior redirection, housekeeping, and activities. Resident 2's service plan indicated the staff served morning and noon meals to him in his room. Resident 2 received hospice services from an outside agency.

Video from a family-placed video camera showed that during an overnight shift, AP1 and AP2 entered Resident 2's room looking for a family member's wallet. When they entered the room, they found Resident 1 sitting in Resident 2's room. AP1 and AP2 approached Resident 1 and told her several times she was in the wrong room and needed to leave. AP1 told Resident 1 she needed "to get the fuck out of the room." AP1 said, "Let's go!" eight times in a loud voice and pointed to the door. Resident 1 said she was not going. AP1 told AP2, "You have to talk to them like a baby" and gestured with one hand a circle alongside her head. AP1 told AP2 that she was "not going to fucking talk all week with her [Resident 1]," and they would have to "drag" Resident

1 from the chair to get her up and out of the room. AP2 asked if that would hurt Resident 1. AP1 said, “No, it’s not gonna hurt.” The two APs each grabbed on of Resident 1’s arms and forcefully pulled Resident 1 forward and up from the chair. Resident 1 said, “You are going to hurt me…” as AP1 and AP2 walked her toward the door. AP 1 said, “Yes, because you never listen.” Resident 1 then said she wanted to listen.

Another video from Resident 2’s room showed AP2 and AP3 enter the room during an overnight shift. When AP2 entered the room, she told Resident 2 to get up to go to the bathroom several times. AP3 arrived at the room and asked AP2 if Resident 2 was wet. AP2 did not answer. AP2 and AP3 then focused on getting Resident 2 to lay straight in his bed and did not offer toileting. AP2 and AP3 appeared to move Resident 2’s legs onto the bed and worked together to scoot him up in the bed. Resident 2 was not seen on the video during this, but could be heard moaning and stated, “Oh, please!” After AP2 and AP3 moved Resident 2 up on the bed, he stated, “What did I do?” AP2 began to laugh and repeated Resident 2’s words in a mocking manner. AP2 continued to laugh and say, “What did I do? What did I do?” over and over until she left the room. At one point, AP2 laughed so hard she had to bend over and stop walking. AP3 did not laugh or say anything to stop AP2.

Another video showed AP2 enter Resident 2’s room during the overnight shift, sit in Resident 2’s recliner, and tell Resident 2 to “Get back in bed.” AP3 then entered the room and told AP2 that Resident 2 needed medication. AP2 and AP3 left the room. AP3 returned about 10 minutes later with medication and a cup of water. Resident 2 had gotten out of bed and stood near the bed. AP3 put down the medication and cup of water. AP3 then placed one hand on Resident 2’s shoulder/chest area, the other hand on Resident 2’s back, and pushed him down to his bed. AP3 gave Resident 2 his medication and left. There was no evidence to conclude that action caused a bruise.

Other videos showed AP2 and AP3 telling Resident 2 to either take his medication or go to bed. AP2 and AP3 ignored Resident 2 when he told them to leave his room.

Review of AP1’s personnel file indicated AP1 worked at the facility for several years. The file indicated AP1 received training that included annual dementia training, annual maltreatment/vulnerable adult training, and code of ethics training.

Review of AP2’s personnel file indicated AP2 worked at the facility for about two weeks. AP2 received orientation/training that included dementia training, maltreatment/vulnerable adult training, and code of ethics training.

Review of AP3’s personnel file indicated AP3 worked at the facility for several years. AP3 received training that included annual dementia training, annual maltreatment/vulnerable adult training, and memory care etiquette training.

The facility's Personnel Code of Ethics document indicated residents and their well-being were always the first concern of the facility. The document indicated staff were supposed to give explanations to the resident before giving care and that no treatment or care should be forced on a resident. Staff were instructed to be courteous and friendly in their work, patient and kind with residents, and respect the resident's privacy and dignity.

The facility Memory Care Etiquette document indicated all residents, especially those in memory care, were supposed to be treated with the utmost respect and dignity.

During an interview, the director of nursing (DON) said that she did not watch the videos of Resident 2's room. The DON said she was not involved in the incident investigations as the corporate office took care of it, but moving forward, she would provide staff training on treating residents with dignity and respect.

During an interview, an unlicensed personnel member said AP1 was verbally aggressive and abrupt with the residents and rolled her eyes when staff suggested she use a less aggressive approach to the residents.

During interviews, several unlicensed personnel said they did not feel that they got enough training in communicating with the residents in memory care.

During an interview, AP1 said Resident 1 was someone who will say "no" if she does not want to do something. AP1 said she leaves her alone because Resident 1 could not be forced to do something against her will. On the night of the incident, AP1 said she and AP2 had to move Resident 1 out of the room because Resident 2's son was on the phone and upset that there was a someone in his father's room. AP1 said she and AP2 "lifted" Resident 1 under her arms. AP1 said she does speak loudly sometimes, but she would never swear or yell at a resident.

During an interview, AP2 said Resident 1 often wandered the memory care unit at night and could be found sleeping on one of the couches in the activity rooms or in another resident's room. AP2 said that night she and AP1 talked to Resident 1 and told her several times she was in the wrong room. When Resident 1 said she was not leaving, AP1 and AP2 decided to "lift" Resident 1 from the chair and get her out of Resident 2's room. AP2 said Resident 1 was not injured when they pulled her from the chair, but neither she nor AP1 checked Resident 1's arms for bruising or skin tears after they walked her to the hallway.

AP2 said that she would usually ask Resident 2 if he needed anything when she made safety checks if he was awake. AP2 denied laughing at Resident 2 on the night of the incident but said, "If I did repeat what he said it was not to make fun of" Resident 2. AP2 said that she would usually ask Resident 2 if he needed anything when she made safety checks if he was awake.

During an interview, AP3 said that she did not help Resident 2 much on the night shift. AP3 said that Resident 2 usually refused to let her help him to the toilet. AP3 said that she did not recall

AP2 laughing at Resident 2 on the night of the incident but did identify herself standing right next to AP3 on the video during the incident. AP3 said that type of behavior should be reported.

During an interview, Resident 1's family member said she was made aware of the incident and was surprised that happened in memory care. She said a nurse called her to tell her about the incident, Resident 1 was not injured, and did not recall the incident when asked about it the following day. The family member did not ask to see the video and said, overall, she was happy with the care at the facility.

During an interview, Resident 2's family member stated the facility told them that they would provide Resident 2 with one-to-one care, shaving, dressing, and feeding, but staff did not do so. The family member visited often and would see Resident 2 walking around without pants on or without socks on, unshaven, and saw food sitting on the table in the Resident 2's room from the night before. The family member said there were concerns about how the staff treated Resident 2 due to the bruises they saw on him. The family member said the facility told them that Resident 2 had falls, but only called once about a fall. The family member said that he was shocked at what he saw on the video. The family member said elderly people did not deserve to be treated that way.

During an interview, another family member of Resident 2 said Resident 2 did not get cleaned up, and the facility did not know what or if he ate his meals, but always checked it off on the paperwork. The family member said the staff would set a tray in the room and leave, sometimes there were three trays of food sitting in the room. The family member said Resident 2 lost over 30 pounds while at the facility.

In conclusion, abuse was substantiated against AP1 and AP2; neglect was inconclusive.

Abuse: Minnesota Statutes section 626.5572, subdivision 2
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;

(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Vulnerable Adult interviewed: Investigators spoke with Resident 1, but she was not interview able due to her diagnosis. Resident 2 had passed away.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrators interviewed: Yes.

Action taken by facility:
AP1 and AP2 no longer work at the facility. The facility conducted an internal investigation and had residents complete a survey about safety/abuse/neglect.

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.

cc: The Office of Ombudsman for Long-Term Care
Maple Grove Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31968	A. BUILDING: _____ B. WING _____	C 08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILL SENIOR LIVING LLC	**3030 SOUTHLAWN DRIVE MAPLEWOOD, MN 55109**

(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 Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.10 to 144G.93, the Minnesota Department of Health issued correction orders pursuant to an investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On August 18 and 19, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL31968001M/#HL31968002C and #HL31968003M/#HL31968004C. At the time of the investigation, there were #74 clients receiving services under the assisted living facility with dementia care license. The following correction orders are issued for #HL31968001M/#HL31968002C and #HL31968003M/#HL31968004C, tag identification 0510 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.	
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to COVID-19. The facility failed to ensure staff and visitors entering or re-entering the building were screened for COVID-19 with documented temperatures and symptom screening questions. The facility failed to ensure staff wore eye protection and/or face masks while working in the facility. In addition, the facility failed to promote social distancing and wearing of facemasks for residents in memory care. This had the potential to affect all 74 residents, staff, and visitors at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 510		

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0 510	Continued From page 2 Findings include: The Minnesota Department of Health's (MDH) electronic COVID-19 Toolkit: Information for Long Term Care Facilities, dated March 8, 2021, indicated on page 7: Screen all staff for fever and symptoms of illness before starting each shift. In addition to staff, conduct health screening for other essential health care personnel including therapy personnel, hospice, home care, dialysis, ombudsman, state surveyors, chaplain at end of life, mortician, etc. Conduct assessment for fever and ask about new symptoms of illness (measured or subjective fever, cough, shortness of breath, chills, headache, muscle pain, sore throat, or new loss of taste or smell). During observation on August 18, 2021, at 8:35 a.m., MDH investigators entered the facility. There were no COVID-19 screening signs at the facility's main entrance. A staff member, administrative assistant (AA)-N, asked the investigators to sign in at the COVID-19 screening table at the main entrance. AA-N took the temperatures of both investigators and asked them to write the results in the COVID-19 log. AA-N did not ask the investigators to self-answer any COVID-19 screening questions, and she did not ask the investigators the screening questions. During this time, a [unknown] person entered the facility through the main doors, bypassed the COVID-19 screening table, walked across the main lobby past two residents, and down a hallway to the kitchen. MDH investigators asked AA-N if the woman worked in the building. AA-N said yes, she would probably be back to screen. The unscreened staff person did not return to the COVID-19	0 510		

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0 510	Continued From page 3 screening table while the MDH investigators were in the lobby. During interview on August 18, 2021, at 9:33 a.m., AA-N stated she had worked at the facility for approximately four weeks. AA-N stated everyone used the main entrance (i.e., staff, residents, visitors), and she was responsible for screening and ensuring people sign in at the COVID-19 screening table. AA-N stated the staff person who did not stop and screen when the MDH investigators signed in was the head of the dining area. AA-N was not sure if she had returned to self-screen. AA-N stated staff knew to come to the screening table before working and if AA-N is away from the COVID-19 screening table, someone else fills in for her. During an observation on August 18, 2021, at 9:35 a.m., MDH investigators observed dietary server (DS)-O setting tables. She wore a face mask and gloves but no eye protection. During an interview on August 18, 2021 at 9:40 a.m., culinary director (CD)-P stated she usually screened herself because no one was at the front desk. However, CD-P said she did not complete a COVID-19 screen today because she was running late and just got back from vacation. CD-P said dietary servers wear eye protection when serving food. On August 18, 2021, at 9:45 a.m., AA-N checked the COVID-19 screening log and said CD-P had not returned to the front desk to sign in or screen for COVID-19. During an observation on August 18, 2021, at 10:25 a.m., unlicensed personnel (ULP)-R led an exercise activity in one of the memory care TV	0 510		

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0 510	Continued From page 4 activity rooms. Six unmasked residents participated. Four residents sat together on one couch, shoulders and knees touching. ULP-R did not encourage social distancing or donning of facemasks for residents. During an observation on August 19, 2021, at 8:30 a.m., MDH investigators entered the facility and had their temperatures taken for COVID-19 screening by AA-N. MDH investigators were not instructed to read and answer the COVID-19 screening questions, and AA-N did not ask them the screening questions. During an observation on August 19, 2021, at 1:20 p.m., MDH investigators re-entered the facility after lunch and waited in the entrance near the COVID-19 screening table. AA-N looked at the MDH investigators and asked if they needed something. One of the investigators asked if their temperatures needed retaking since they had been out of the building. AA-N said they did not need to do anything. Executive Director (ED)-E instructed the MDH investigators to use hand sanitizer, and no screening was needed. Video recordings inside resident (R)2's room showed R1 entered R2's room (time stamped 08-04, presumed to be August 4, 2021) from R2's bathroom at 22:57:18 (not identified as a.m. or p.m.). R1 walked to a chair and sat down. ULP-K entered R2's room at 23:00:41 with no mask on and wearing prescription glasses (no goggles or approved eye protection). ULP-J entered R2's room at 23:00:46 wearing a mask under her chin and no eye protection. ULP-K and ULP-J interacted with R1 for several minutes, grabbed R1 by the arms, and escorted her out of R2's room.	0 510		

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0 510	Continued From page 5 Video recordings inside R2's room showed ULP-J enter R2's room (time stamped 08-05, presumed to be August 5, 2021) at 08:21:45 (not identified as a.m. or p.m.). ULP-J wore a mask under her chin and no eye protection. At 08:30:19, ULP-H entered R2's room wearing a mask that covered her mouth, but not her nose, and prescription glasses (no goggles). At 08:40:58, ULP-H entered R2's room wearing a mask that covered her mouth, but not her nose, and prescription glasses (no goggles) Video recordings inside R2's room showed ULP-H entered R2's room (time stamped 08-05, presumed to be August 5, 2021) at 08:41:50 (not identified as a.m. or p.m.). ULP-H wore a mask that covered her mouth, but not her nose, and prescription glasses (no goggles). Video recordings inside R2's room showed ULP-J entered R2's room (time stamped 08-05, presumed to be August 5, 2021) at 11:51:51 (not identified as a.m. or p.m.) ULP-J wore a mask that covered her mouth, but not her nose, and wore no eye protection. ULP-H entered R2's room at 11:52:13. ULP-H wore a mask that covered her mouth, but not her nose, and prescription glasses (no goggles). ULP-J and ULP-H provided care to R2 for several minutes and then left the room. Review of the "Prevent COVID-19 Resident and Visitor Screening Logs" dated August 18 and 19, 2021, indicated 79 people signed the log. Three people lacked recorded temperatures, and six people did not answer the COVID-19 screening questions. During an interview on August 19, 2021, at 3:13 p.m., director of nursing (DON)-D stated all staff	0 510		

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0 510	Continued From page 6 should be screened for COVID-19, but if they leave the building and come back, they only need to sanitize their hands. During an interview on August 19, 2021, at 3:51 p.m., ED-E reviewed the "Prevent COVID-19 Resident and Visitor Screening Log" for August 18 and 19, 2021. ED-E verified that the log also included staff. ED-E compared the log with the staff schedule for August 18 and 19, 2021 and stated four of the 14 staff listed on the schedule did not get screened for COVID-19 before entering the building. ED-E stated that the facility did not require staff be rescreened if they left the building and returned. ED-E further stated that all staff were required to wear masks and eye protection. ED-E stated that she took ultimate responsibility for ensuring staff were screened but had not reviewed the logs prior to that moment. Licensee's policy titled, Social Distancing, dated April 2, 2021, indicated that activities could resume at the facility with less than six feet of distance between residents, and masks were to be worn during all activities. Licensee's COVID-19 policy dated August 1, 2021, indicated facemask's must be worn at all times in the community (the facility). The policy indicated goggles must be worn at all times in the community, and staff must complete COVID-19 screening when entering the building. The screening included a temperature check and symptom questions. The policy indicated residents were encouraged to wear face masks when not in a resident's room and that residents would be given facemasks to wear when outside of their rooms. Time Period to Correct: SEVEN (7) DAYS	0 510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31968	A. BUILDING: _____ B. WING _____	C 08/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILL SENIOR LIVING LLC	**3030 SOUTHLAWN DRIVE MAPLEWOOD, MN 55109**

(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
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: Based on observations, interviews, and document review, the facility failed to ensure two of two residents (R1, R2)reviewed were free from maltreatment. R1 and R2 were abused. Findings include: On September 15, 2021, the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and that two individual staff persons were 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.	