Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL331698662M
Compliance #: HL331696161C

Date Concluded: April 24, 2025

Name, Address, and County of Licensee Investigated:
The Harbors Senior Living
5300 4th St NE 212
Fridley, MN 55421
Anoka County

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

Evaluator's Name:
Jana Wegener, 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 resident was neglected when facility staff failed to follow the residents plan of care and the resident was not repositioned or provided incontinence care for 7 hours causing a coccyx pressure ulcer.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident was actively dying and dependent on staff for repositioning every 4 hours and incontinence care every 2 hours. The resident's plan of care and services failed to indicate the resident utilized an air mattress and lacked direction for settings to reduce the resident's risk for pressure ulcers. The facility failed to ensure incontinence care and repositioning were scheduled on the resident's service tasks for staff to implement. Facility staff failed to provide the resident care for 7 hours. The resident was found incontinent of stool and urine, and the air mattress on the residents bed was set at a hard static setting. The resident had multiple reddened pressure areas and developed a coccyx pressure ulcer.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident record(s), death record, facility incident reports, call light logs, staff schedules, and related facility policy and procedures. Also, the investigator observed resident's and staff at the facility.

The resident resided in an assisted living dementia care facility with diagnoses including Alzheimer's Disease, Adult failure to thrive, and moderate protein calorie malnutrition.

The resident's change of condition hospice admission assessment completed prior to the incident indicated the resident was severely cognitively impaired, unable to report pain, or respond to questions, and received hospice for end-of-life care. The assessment indicated the resident was dependent on staff for incontinence care and repositioning every 2 hours. The assessment identified the resident had no skin wounds or pressure ulcers present.

The resident's service plan at the time of the incident included assistance with incontinence care and bed mobility 3 times daily. The service plan failed to direct staff on the frequency repositioning and incontinence care were to be provided.

The resident's care plan at the time of the incident indicated the resident was dependent on staff for incontinence care and repositioning every 2 hours.

A review of hospice nursing progress notes prior to the incident included documentation indicating the resident's skin integrity was good with no signs or symptoms of pressure, shearing, or breakdown present.

A hospice provider order 2 days prior to the incident included orders to reposition the resident every 4 hours for comfort. There was no indication the order was updated on the resident's plan of care or scheduled in the resident service tasks for staff to implement. The orders failed to include a change in the frequency of incontinence care, indicating staff should have continued to provide incontinence care every 2 hours as assessed and as indicated in the resident's plan of care.

A hospice nursing progress note the day of the incident indicated at 10:00 a.m. the resident was unresponsive, actively dying, laying on her left side, with blankets bunched up under her body and the air bed on the hardest setting. The resident's family reported staff had not been in the resident's room to provide incontinence care or repositioning since 3:00 a.m. (7 hours prior). The nurse documented when she pulled the covers back the resident was saturated with dark foul-smelling urine through her brief, gown, and bedding. The nurse documented when she changed the resident's brief there was a baseball sized hard stool hanging out of the resident's rectum. The nurse documented the resident had 2 deep dark red purple pressure areas from the resident's buttocks to her left sacrum measuring 5 centimeters (cm) by 5 cm, and multiple

reddened pressure areas on the resident ’s hip, scapula, and 4 ribs on her left side. The note indicated the nurse applied a dressing to the resident’s coccyx pressure ulcers, and reported the concerns to facility nursing leadership who indicated repositioning was not provided due to shortage of staffing.

The resident’s service delivery record at the time of the incident included assigned tasks to provide incontinence care and repositioning in the AM, PM, bedtime, and overnight. The tasks failed to include the scheduled frequency with specific times for repositioning for staff to implement as assessed, ordered, and according to the resident’s plan of care. As a result, the service delivery record lacked documentation to show incontinence care was provided every 2 hours, or repositioning every 4 hours prior to the incident. In addition, the service delivery record indicated the hospice order was not implemented, and the services were not updated to reposition the resident every 4 hours until the day after the incident occurred (3 days after the order was written).

The resident’s record of death indicated she died 5 days after the incident occurred of natural causes.

When interviewed facility and nursing leadership verified the resident had no skin issues or pressure ulcers prior to the incident, and indicated the resident’s services and plan of care for repositioning were not followed when the resident developed the coccyx pressure ulcer. Leadership staff denied staffing issues were the cause of the incident and stated repositioning and incontinence care were not provided because there was a lack of shift-to-shift communication about when the resident was last repositioned. Leadership explained day shift staff assumed the resident was repositioned during last rounds, which typically occurred between 5:00 a.m. and 6:00 a.m. but she was not. Nursing leadership verified staff were unaware the resident had not received incontinence care or been repositioned until after the hospice nurse arrived and the family reported staff had not provided the services since 3:00 a.m. (7 hours prior).

When interviewed several unlicensed staff who provided care and services to the resident indicated the resident needed repositioning and incontinence care which should have been scheduled a specific time on their assigned task list to complete. Staff indicated if incontinence care and repositioning wasn't scheduled with specific time for staff to complete on the assigned service task list it could be missed.

When interviewed the hospice nurse stated when she entered the resident room that day the family said no one had repositioned or changed the resident since 3:00 a.m. The nurse stated the resident was laying on her left side and appeared to be in discomfort with a furrowed brow. When the nurse pulled the covers back to assess the resident, she was soaked with dark foul-smelling urine that saturated her brief, gown, and bedding. The nurse indicated the resident had a towel and bedding bunched up under her body and the resident’s bed was on the hardest static setting that was not appropriate for her size or weight increasing the risk for

pressure ulcers. The nurse stated when she turned the resident over, she saw 2 non blanchable dark red purple pressure ulcers on the resident's coccyx. The nurse stated the resident's left side had blanchable redness on 4 ribs, scapula, and hip as a result of prolong pressure and not being repositioned.

The resident's family stated they were with the resident continuously during the last week of her life. The family stated staff routinely did not provide repositioning especially during the overnight shift.

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: N/A

Action taken by facility:
The facility reported the incident to the Minnesota Adult Abuse Reporting Center (MAARC), and staff were re-educated following the incident.

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

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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Anoka County Attorney
Fridley City Attorney
Fridley Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33169	A. BUILDING: _____ B. WING _____	C 03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HARBORS SENIOR LIVING FRIDLEY	5300 4TH STREET NE FRIDLEY, MN 55421

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL331698662M/#HL331696161C On March 17, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 41 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL331698662M/#HL331696161C, tag identification 1650, and 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
01650 SS=G	144G.70 Subd. 4 (f) Service plan, implementation and revisions to	01650		

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01650	Continued From page 1 (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure one of one residents (R1)'s service plan included a description of the services to be provided, and the frequency of each service for staff to implement. R1 was harmed when the licensee failed to implement repositioning and incontinence care as assessed and ordered for hospice for end of life care. As a result, staff failed to reposition or provide	01650		

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01650	Continued From page 2 incontinence care to R1 for 7 hours. R1 was found saturated in incontinent urine and stool with multiple pressure areas and a coccyx pressure ulcer. In addition, the licensee failed to assess/monitor R1's pressure ulcer, implement interventions with directions for staff to reduce the resident's risk for new or worsening pressure ulcers, and failed to implement providers orders for wound care and scheduled Morphine. 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 was admitted to the facility on February 1, 2021, with diagnoses including Alzheimer's Disease, adult failure to thrive, and moderate protein calorie malnutrition. R1's change of condition hospice admission assessment dated October 18, 2024, prior to the incident indicated R1 was severely cognitively impaired, unable to report pain, or respond to questions, and received hospice services for end-of-life care. The assessment indicated R1 was dependent on staff for incontinence care and repositioning every 2 hours. The assessment identified R1 had no skin wounds or pressure ulcers present. R1's care plan at the time of the incident updated on October 18, 2024, included assistance with	01650		

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01650	Continued From page 3 incontinence care and bed mobility 3 times daily. The service plan failed to direct staff on the frequency repositioning and incontinence care were to be provided. R1's care plan indicated R1 was dependent on staff for incontinence care and repositioning every 2 hours. R1's service plan dated October 17, 2024, indicated the resident needed assistance with incontinence care and repositioning 3 times daily. R1's service delivery record included toileting and repositioning AM, PM, bedtime, and overnight. The services failed to include scheduled times and the frequency for staff to implement as assessed and indicated on R1's plan of care. On January 15, 2025, at 1:45 p.m. a hospice visit progress notes prior to the incident indicated R1 skin had no pressure injuries noted. On January 16, 2025, at 2:02 p.m. another hospice visit progress note prior to the incident included documentation indicating the resident's skin integrity was good with no signs or symptoms of pressure, shearing, or breakdown present. On January 15, 2025, a hospice provider order 2 days prior to the incident included orders to reposition R1 every 4 hours for comfort. There was no indication the order was updated on R1's scheduled services for staff to implement. The orders failed to include a change in the frequency for incontinence care, indicating staff should have continued to provide incontinence care every 2 hours as assessed and as indicated the in R1's plan of care. On January 17, 2025, at 10:00 a.m. a hospice	01650		

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01650	Continued From page 4 visit progress note the day of the incident indicated R1 was unresponsive, actively dying, laying on her left side, with blankets bunched up under her body and the air bed on the hardest setting. R1's family reported staff had not been in R1's room to provide incontinence care or repositioning since 3:00 a.m. (7 hours prior). Hospice Licensed Practical Nurse (LPN)-C documented when she pulled the covers back R1 was saturated with dark foul smelling urine through her brief, gown, and bedding. LPN-C documented when she changed R1's brief there was a baseball sized hard stool hanging out of R1's rectum. LPN-C documented R1 had 2 deep dark red purple pressure areas from R1's buttocks to her left sacrum measuring approximately 5 centimeters (cm) by 5 cm, and multiple reddened pressure areas on R1's hip, scapula, and 4 ribs on her left side. The note indicated LPN-C contacted the provider with orders received to schedule R1's morphine 2.5 milligrams (mg) orally/sublingual every 4 hours and every hour as needed (PRN), and apply a foam Mepilex dressing to R1 coccyx and change PRN if it becomes soiled or falls off. The note indicated LPN-C applied a dressing to R1's coccyx, and reported the concerns to Registered Nurse Director of Nurses (RNDON)-A. On January 17, 2025, the licensee provided hospice communication note to the facility included communication that R1's buttocks was breaking down. The note included orders to turn and reposition R1 every 4 hours, and to schedule R1's Morphine 2.5 mg every 4 hours, and every hour PRN. On January 17, 2025, at 10:00 a.m. a licensee skin breakdown form signed and dated by RNDON-A on January 17, 2025, indicated R1 had	01650		

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01650	Continued From page 5 a suspected deep tissue injury (pressure ulcer). The form indicated staff should describe the breakdown including approximate size, but no documentation of the wound assessment to include description of the wound size, depth, color, odor, and pain was provided. The form indicated the hospice nurse informed RNDON-A who documented the family requested repositioning every 4 hours, and a foam boarder dressing was applied for comfort. On January 17, 2025, the licensee provided bluestone provider orders included instructions to apply a foam Mepilex dressing to R1 buttocks to protect fragile skin, and change PRN if soiled or falls off. The orders indicated the facility should change/apply the dressing if hospice was not present, and directed staff to turn and reposition R1 every 4 hours and PRN. R1's record (plan of care, services, service delivery record, and progress notes) failed to indicate wound assessment/monitoring, dressing changes, or repositioning every 4 hours were implemented or provided by the licensee as ordered. R1's January 2025, medication administration record (MAR) failed to include the providers orders for scheduled Morphine, indicating R1's order for scheduled morphine were never implemented. R1's care plan updated January 18, 2025, the day following the incident included incontinence care and repositioning scheduled every 4 hours. The care plan failed to indicate R1 had an air bed, and failed to provide any direction to staff on the settings needed to reduce R1's risk for pressure ulcers. The care plan indicated R1 had the start of a Kennedy ulcer (a non preventable terminal ulcer in dying patients), with a suspected deep	01650		

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01650	Continued From page 6 tissue injury. However, R1's record lacked any indication R1's coccyx wound was a Kennedy ulcer. R1's care plan lacked assessment of the coccyx pressure ulcer to include description, size, depth, drainage, pain, and stage. The care plan failed to indicated the wound would be monitored or assessed for changes and the frequency. The plan of care failed to indicate R1 had a Mepilex dressing on her coccyx pressure ulcer, and had no direction for staff to monitor or change the dressing if it became soiled or fell off as ordered. R1's facility record lacked any documentation of wound assessment, monitoring, progression, or wound care services provided by the licensee. R1's service delivery record at the time of the incident included assistance with bed mobility and incontinence care in the AM, PM, bedtime, and overnight, the task list failed to include the scheduled frequency for the services to be provided for staff to implement. In addition, the services were not updated after the hospice orders to reflect the resident needed repositioning every 4 hours until the day after the incident occurred (3 days after the order was written). As a result, there was no indication R1 was provided incontinence care or repositioning as assessed/indicated on R1's services, plan of care, or as ordered. In addition, R1's service delivery record lacked direction for staff to monitor or change R1's Mepilex dressing if soiled or if it fell off as ordered by the provider. A facility investigation following the incident indicated staff confirmed they had not repositioned or provided incontinence cares to R1 for 7 hours, and indicated they were re-education to reposition R1 every 2-4 hours. Although R1's service delivery record was	01650		

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01650	Continued From page 7 updated on January 18, 2025, the day after the incident to include scheduled repositioning times as ordered by hospice 3 days prior, the service delivery record indicated repositioning was not provided on January 19, 2025, at 2:00 a.m., and 6:00 a.m. with no documentation of refusal or why the services were not provided. The record indicated R1 had not been repositioned from 10:00 p.m. to 10:00 a.m. (12 hours). As a result, the record showed the licensee had ongoing concerns with failure to provide repositioning as ordered and according to R1's plan of care and services. R1's record of death indicated she died on January 22, 2025, (5 days after the incident occurred) of natural causes. On March 17, 2025, at 10:50 a.m. during an entrance conference Licensed Assisted Living Director (LALD)-B and RNDON-A stated R1 had no skin issues or pressure ulcers prior to the incident, and indicated R1's services and plan of care for repositioning were not followed when R1 developed the coccyx pressure ulcer. RNDON-A denied staffing issues were the cause of the incident and stated repositioning and incontinence care were not provided because there was a lack of shift-to-shift communication about when R1 was last repositioned. RNDON-A explained day shift staff assumed R1 was repositioned during last rounds, which typically occurred between 5:00 a.m. and 6:00 a.m. but R1 was not. RNDON-A stated staff were unaware R1 had not received incontinence care or been repositioned until after the hospice nurse arrived at 10:00 a.m. and the family reported R1 had not been provided the services since 3:00 a.m. (7 hours prior). RNDON-A reviewed R1's record and stated no wound assessment, wound care, or	01650		

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01650	Continued From page 8 monitoring was completed for the pressure ulcer reported by LPN-C. On March 17, 2025, at 11:51 a.m. Unlicensed Personnel (ULP)-E indicated she had never seen repositioning scheduled on R1's assigned task lists for staff to implement. ULP-E stated residents who were actively dying were usually repositioned every 2 hours. ULP-E stated a hospice nurse one night gave a verbal order for R1 to be repositioned every 4 hours for comfort. ULP-E indicated she went by the task list assigned to her in Rtasks to know what care services a resident needed and when. ULP-E stated she had noticed resident needs not on the assigned services, and indicated she would report it to RNDON-A to fix it. ULP-E indicated if an assigned task was not on the scheduled tasks list, it would not pop up as a task to be completed at a specific time, and they would not know to do it. On March 17, 2025, at 1:58 p.m. ULP-F stated R1 needed repositioning every 2 hours. ULP-F indicated R1's services should be scheduled in Rtasks, and indicated if it wasn't scheduled with specific time for staff to complete it could be missed. On March 17, 2025, at 1:31 p.m. ULP-H stated R1's care plan indicated she needed repositioning every 2 hours, and thought it was assigned to a task list with specific times that staff sign off when completed. On March 17, 2025, at 12:47 p.m. ULP-I stated repositioning and incontinence cares should be a assigned a specific time scheduled in Rtasks for staff to complete.	01650		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HARBORS SENIOR LIVING FRIDLEY	5300 4TH STREET NE FRIDLEY, MN 55421

(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
01650	Continued From page 9 On March 31, 2025, at 1:49 p.m. LPN-C stated on January 17, 2025, when she entered R1's room the family said "no one had repositioned or changed R1 since 3:00 a.m." LPN-C stated R1 was laying on her left side and appeared to be in discomfort with a furrowed brow. When LPN-C pulled the covers back to assess R1, she was soaked with dark foul-smelling urine that saturated her brief, gown, and bedding. LPN-C indicated R1 had a towel and bedding bunched up under her body and R1's bed was on the hardest static setting causing increased pressure that was not appropriate for her size or weight increasing R1's risk for pressure ulcers. LPN-C stated when she turned R1 over, she saw 2 non blanchable dark red purple pressure ulcers on R1's coccyx area. LPN-C stated R1's left side had blanchable redness on 4 ribs, scapula, and hip from prolong pressure and not being repositioned. On April 2, 2025, at 12:04 p.m. R1's family member (FM)-J stated they were with R1 continuously during the last week of her life. FM-J stated staff routinely did not provide repositioning or incontinence care as indicated on her plan of care, especially during the overnight shift. The family stated R1 did not receive scheduled morphine as ordered and indicated they had to ask for the medication to be given and for repositioning to be provided when R1 was uncomfortable. FM-J indicated the licensee nurse never looked at R1 coccyx wound, and no one other than hospice had changed R1's dressing even though it was observed saturated with bloody drainage leaking out of the dressing. A licensee policy and procedure titled "Medication and Treatment Orders - Implementing", dated August 1, 2021, indicated upon receipt of an	01650		

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01650	Continued From page 10 order the nurse would take action to implement the orders within the next 24 hours, and make changes to the resident's service plan as needed. A licensee policy and procedure titled "Service Plan", dated August 1, 2021, indicated in section 8. Staff providing services indicated in the service plan shall be informed of the current written service plan. Section 9. Indicated a service plan will include: a. A description of the services that are to be provided based on the most recent assessment and resident preferences c. The frequency of each service to be provided based on the most recent assessment and resident preferences. A licensee policy and procedure titled "Resident Record - Documentation", dated August 1, 2021, indicated staff would document all services provided to the resident. Section 4. indicated when services were not performed per the service agreement and schedule, staff must document the reason why. Section 5. indicated tasks not completed would be followed up on to meet the resident's needs. Section 6. indicated scheduled tasks should be documented in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01650		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.	02360		

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02360	Continued From page 11 This MN Requirement is not met as evidenced by: Based on interviews and document review, the licensee failed to ensure one of one residents (R1) reviewed 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		