Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL203811461M
Compliance #: HL203812671C

Date Concluded: May 26, 2023

Name, Address, and County of Licensee Investigated:
Brookdale Edina
3330 Edinborough Way
Edina, MN 55435
Hennepin County

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

Evaluator's Name: Christine Bluhm, 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):
It is alleged: The facility neglected the resident when the resident fell and staff did not assist the resident off the floor per resident care plan or facility policy.

It is alleged: It is alleged that abuse occurred when the resident was found with multiple facial injuries not consistent with the fall incidents that were reported.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. An alleged perpetrator was not identified, and the cause of the resident's unexplained injuries could not be explained. However, the Minnesota Department of Health determined that neglect was substantiated. The facility failed to assess and evaluate the resident after she had two consecutive falls with unexplained injury and increased pain. In addition, the facility failed to administer the resident's ordered medications when supply ran out and the resident missed medications.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also interviewed the resident's doctors. The investigation included a review of resident records, including medication administration records (MARs), facility policies, hospice records and the medical examiner report. Also, the investigator observed direct resident care, medication pass and staff and resident interactions during a visit to the facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's dementia and chronic obstructive pulmonary disease (a lung disease). The resident's service plan indicated the resident required assistance with all activities of daily living, bathing, dressing, and grooming, meals, housekeeping, and medication management.

Review of the resident's MAR records indicated that for the last two weeks at the facility, she did not receive all her regularly prescribed medications, which included an anti-depressant and an anti-psychotic. Staff documented the medications were out of supply.

Review of the nursing progress notes indicated staff gave as needed medications when the resident had agitation and/or anxiety but this was not always effective.

Review of hospice nursing notes indicated that one night facility staff called hospice on call to report the resident had two separate falls one evening. The following day, facility staff called hospice to report the resident had right leg pain and a slightly swollen face. The note indicated that hospice would not make a visit that day but would visit on the following day.

Review of the facility incident reports indicated evening staff found the resident on the floor next to her bed. Staff documented the resident had carpet burns to both knees and numerous dark purple spots on both arms. Later that evening, staff found the resident on the floor again and documented the resident fell out of bed twice on her right side. A family member was notified of the falls by phone, and it was agreed to position the bed up against the wall and place the floor mat on the open side of the bed for safety.

During interview, family members verified the only falls reported to them were the two that occurred on that same evening. Two days after the falls, a family member made a visit and stated she was shocked at what she saw. The resident was in bed, soiled, had facial injuries, was incoherent and crying in pain.

Four days after the falls, by request of the family, the hospice doctor made a visit to the facility, and met with the resident. The doctor ordered the resident to be sent to the hospital for an emergency evaluation.

Records lack that a facility registered nurse evaluated the resident from the time of the falls to the time she was sent to the hospital or contacted to evaluate the increase in the resident's

agitation. The record also lacks communication to the doctor that medications were not given as ordered.

Hospital and doctor admission records indicated the resident had left sided chest wall pain with bruising, significant left hip pain, left elbow pain with swelling, abrasions on both cheeks, chin and bilateral knees. The desired x-rays could not be obtained because of the resident's severe pain. The resident also had a urinary tract infection. Review of photographs taken indicated bruises of different stages based on the color of the bruises and included a large bruise under the left breast area. The resident passed away at the hospital on comfort care approximately a week later.

A doctor who was interviewed stated the resident's facial injuries were unusual in that she had abrasions on both cheeks. Regarding the medications, the doctor stated that most anti-depressants can show symptoms of withdrawal if stopped abruptly and abrupt stopping of anti-psychotics can possibly produce restlessness or anxiety.

A second doctor stated there was a slow response from the facility with communication for medication orders and that doctor was not made aware that the resident did not receive her medications as ordered.

The resident underwent an autopsy examination and broken ribs were noted. The resident's death certificate indicated the resident died of infectious complications of Alzheimer dementia and the manner of death was listed as natural.

In conclusion, the Minnesota Department of Health determined neglect was substantiated and abuse was inconclusive.

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.

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.

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;

Vulnerable Adult interviewed: No, the resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility conducted an internal investigation after the resident was sent to the hospital.

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
Hennepin County Attorney
Edina City Attorney
Edina Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20381	A. BUILDING: _____ B. WING _____	C 03/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE EDINA	3330 EDINBOROUGH WAY EDINA, MN 55435

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING 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: #HL203811461M/#HL203812671C On March 7, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 72 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL203911461M, HL203812671C, tag identification 0620, 1760 and 3000.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting 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 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.	

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0 620	Continued From page 1	0 620		
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for two of three residents (R4, R5) with records reviewed. 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, 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: R4 had a diagnosis of diabetes, chronic pain, and lymphedema. R4 ' s service plan dated October 24, 2022, indicated R4 received medication administration services from the licensee. R5 had a diagnosis of diabetes and chronic pain syndrome. R5 ' s service plan dated March 8, 2023, indicated R5 received medication administration services from the licensee.	0 620		

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0 620	Continued From page 2 Licensee's investigation records indicated that on the morning of January 16, 2023, staff noted the narcotics counts to be incorrect for two residents and alerted administration. Individual narcotic record page 32 for R4: Oxycodone immediate release 5 mg tablet, date received July 1, 2022, quantity received 30. Amount remaining on January 16, 2023, at 07:15 a.m., was zero. Individual narcotic record page 33 for R4: Oxycodone immediate release 5 mg tablet, date received July 1, 2022, quantity received 15. December 24, 2022, amount remaining was seven tablets. Sticker on page indicated no cards #32/#33. Amount remaining on January 16, 2023, at 07:15 a.m., was zero. Individual narcotic record page 106 for R5: Hydrocodone-Acetaminophen 10 mg-325mg tab, date received is blank, quantity 30. On January 11, 2023, amount remaining was 16 tablets. Amount remaining on January 16, 2023, at 07:15 a.m., was zero. During interview on March 8, 2023, at 4:00 p.m., Executive director (ED)-A stated the incident was not reported to the MN Adult Abuse Reporting center (MAARC) because she was advised it did not have to be reported. ED-A verified the licensee conducted full investigation and police were notified. Policy titled Abuse, Neglect & Exploitation Policy MN-1, dated August 2021 indicated External reporting/notification per MN Statutes 626.557, Reporting to the Common Entry Point, (1) If a	0 620		

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0 620	Continued From page 3 determination is made that there is reasons to believe that a resident has been abused, neglected or exploited, or if a resident has a physical injury that cannot reasonably be explained, the Executive director or designee should make a report to the Common Entry Point as soon as practicable. TIME PERIOD TO CORRECT: Seven (7) days.	0 620		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medications were administered as prescribed for three of three residents (R1, R2, R3) with records reviewed. In addition, the licensee failed to ensure medication orders were transcribed to the medication administration record (MAR) accurately for one of one resident (R2) with records reviewed.	01760		

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01760	Continued From page 4 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included Alzheimer's dementia and chronic obstructive pulmonary disease (COPD, a condition affecting the lungs). Hospice visit note dated February 10, 2022, under section titled medication management, indicated facility staff managed medications. R1's service plan dated May 13, 2022, indicated the resident received services which included medication administration. R1' s Individualized medication management plan also dated May 13, 2022, indicated the registered nurse (RN)/licensed practical nurse (LPN), and unlicensed staff, were responsible for monitoring of medication supplies, ordering refills on a timely basis and handling changes to prescriptions, communications with pharmacy or prescriber. Park Nicollet hospice except Omnicare of MN for levothyroxine (hormone medication). The electronic medication administration record (eMAR) dated May 2022, indicated the following: Mirtazapine tablet 15 mg, take one tablet by	01760		

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01760	Continued From page 5 mouth at bedtime. The following dates marked not given. May 1 coded 07 sleeping. May 2, 3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 18, 19, 20, 22 and 23, coded 09 other/see nurses notes. R1's Nurses notes indicated medication out of supply. Quetiapine Fumarate tablet 25 mg, take one tablet by mouth at bedtime for mood. The following dates marked not given. May 1, coded 07 sleeping. May 2, 3, 4, 5, 6, 7, 8, 9, 11, 13 coded 09 other/see nurses notes. R1's Nurses notes indicated medication out of supply. During interview on April 7, 2023, at 2:10 p.m., RN-C was asked to view R1 's medication record and verified the MAR was marked not given for these dates. During interview on April 11, 2023, at 4:30 p.m., medical doctor (MD)-D stated hospice was not made aware that R1 had not received all her scheduled medications. A review of the following website under Drug Uses, Dosage & Side Effects - Drugs.com indicated. (www.drugs.com/seroquel.html) Seroquel is an antipsychotic medicine. Seroquel is also used together with antidepressant medications to treat major depressive disorder in adults. How should I take Seroquel? You should not stop using Seroquel suddenly. Stopping suddenly may make your condition worse.	01760		

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01760	Continued From page 6 (www.drugs.com/mirtazapine.html) Mirtazapine is used to treat depression. How should I take Mirtazapine? Do not stop taking this medicine abruptly. Talk to your doctor before stopping this medicine. Do not stop using mirtazapine suddenly, or you could have unpleasant symptoms (such as dizziness, vomiting, agitation, sweating, confusion, numbness, tingling, or electric shock feelings). Ask your doctor how to safely stop using this medicine. R2 R2's diagnoses included diabetes, hypertensive chronic kidney disease with dialysis and congestive heart failure. R2's most recent signed service plan dated October 21, 2022, indicated R2 received assistance with medication administration, and handling of changes to prescriptions, communication with pharmacy or prescriber was the role of the RN/LPN. R2's eMAR dated December 2022 indicated an entry for duloxetine hydrochloride (an antidepressant) with a start date of December 29, 2022. R2's progress notes dated December 29, 2022, at 8:38 p.m., under physicians order note indicated Duloxetine HCL oral capsule 60 mg was entered into the system by RN-D. Progress notes dated December 30, 31, January 1, 2, 3, 4, 6, 9, 10, 11, indicated duloxetine was not given because of no supply.	01760		

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01760	Continued From page 7 Review of email dated January 30, 2023, at 3:25 p.m., indicated a possible explanation for a transcription error. Review of incident report dated February 23, 2023, indicated a medication was incorrectly added to R2's eMAR. Duloxetine HCL (Cymbalta) 60 mg was entered on R2's eMAR on December 29, 2022, by RN-D, was sent to the physician for signature and approval was sent to pharmacy for fill. R2 received the first dose on January 9, 2023 and received a total of nine doses. R2 did not suffer apparent harm or injury. On March 8, 2023, at 4:00 p.m., executive director (ED)-A stated RN-D stated it (the transcription error) would not happen again. ED-A stated RN-D would not agree to retraining. ED-A confirmed RN-D was still employed by facility and role includes transcribing medication orders. R3 R3's diagnoses included dementia (memory disorder), delirium and anxiety. Service plan dated February 27, 2023, indicated R3 received assisted with medication administration. On March 7, 2023, at 5:30 pm, R3 was observed lying on her bed in her room. When asked how R3 was doing, R3 replied "Well, I know I am dying." A green colored capsule was on the bedside table. Unlicensed staff person (ULP)-E brought in R3's supper tray. ULP-E was asked why there was a capsule on the bedside table. ULP-E put on a glove, picked up the capsule and stated she would address it with the med passer	01760		

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01760	Continued From page 8 on duty, ULP-F. ULP-F came into the room a few minutes later and stated he had not given R3 any medications this shift, and it must have been left from this morning. ULP-F could not identify the capsule. During interview on March 8, 2023, at 4:00 p.m., ED-A acknowledged the finding and stated the medication must have been left by the morning med passer. ED-A looked at the staff schedule and named the possible staff person. Policy titled Medication & Treatment - Administration/Assistance CS-40-2 indicated medication assistance and administration should be in accordance with the prescriber's orders and the individual assisting with the medication should observe the resident ingesting the medication prior to documenting the administration on the medication record. Time period for correction: Seven (7) days.	01760		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred,	02360	No plan of correction is required for this tag.	

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02360	Continued From page 9 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		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section	03000		

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(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
03000	Continued From page 10 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for two of three residents (R4, R5) with records reviewed. 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, 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: R4 had a diagnosis of diabetes, chronic pain, and lymphedema. R4 ' s service plan dated October 24, 2022, indicated R4 received medication	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20381	A. BUILDING: _____ B. WING _____	C 03/07/2023

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03000	Continued From page 11 administration services from the licensee. R5 had a diagnosis of diabetes and chronic pain syndrome. R5 ' s service plan dated March 8, 2023, indicated R5 received medication administration services from the licensee. Licensee's investigation records indicated that on the morning of January 16, 2023, staff noted the narcotics counts to be incorrect for two residents and alerted administration. Individual narcotic record page 32 for R4: Oxycodone immediate release 5 mg tablet, date received July 1, 2022, quantity received 30. Amount remaining on January 16, 2023, at 07:15 a.m., was zero. Individual narcotic record page 33 for R4: Oxycodone immediate release 5 mg tablet, date received July 1, 2022, quantity received 15. December 24, 2022, amount remaining was seven tablets. Sticker on page indicated no cards #32/#33. Amount remaining on January 16, 2023, at 07:15 a.m., was zero. Individual narcotic record page 106 for R5: Hydrocodone-Acetaminophen 10 mg-325mg tab, date received is blank, quantity 30. On January 11, 2023, amount remaining was 16 tablets. Amount remaining on January 16, 2023, at 07:15 a.m., was zero. During interview on March 8, 2023, at 4:00 p.m., Executive director (ED)-A stated the incident was not reported to the MN Adult Abuse Reporting center (MAARC) because she was advised it did not have to be reported. ED-A verified the	03000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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03000	Continued From page 12 licensee conducted full investigation and police were notified. Policy titled Abuse, Neglect & Exploitation Policy MN-1, dated August 2021 indicated External reporting/notification per MN Statutes 626.557, Reporting to the Common Entry Point, (1) If a determination is made that there is reasons to believe that a resident has been abused, neglected or exploited, or if a resident has a physical injury that cannot reasonably be explained, the Executive director or designee should make a report to the Common Entry Point as soon as practicable. TIME PERIOD TO CORRECT: Seven (7) days.	03000		