Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL203819965M
Compliance #: HL203818202C

Date Concluded: February 12, 2024

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

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

Evaluator's Name: Peggy Boeck, RN, Special Investigator

Finding: Substantiated, facility responsibility

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

Initial Investigation Allegation(s):
The facility neglected a resident when they failed to ensure staff followed the plan of care for toileting and failed to monitor the resident. Staff left the resident sitting on the toilet for an unknown number of hours and the resident developed wounds on her bottom, leg, elbow, knee, finger, and toes.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility neglected to ensure staff completed safety checks every two hours or provided toileting to the resident per the service plan. Morning staff found the resident sitting on the toilet for an unknown amount of time, the resident was weak and unable to stand up, and staff called 911. The resident was admitted to the hospital with significant skin breakdown including pressure injuries in the shape of a toilet seat on the resident's bottom and thighs, a 5-inch skin tear on the back of her thigh, pressure injuries on

her right elbow and right knee, and injuries to her left pinky and middle toes with missing nails and bleeding.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, hospital records, facility internal investigation, staff schedules, related facility policy and procedures. Also, the investigator observed a photo of the injuries.

The resident lived in an assisted living memory care unit. The resident's diagnoses included metabolic encephalopathy, depression, urinary incontinence, and memory loss. The resident's service plan included assistance with medication administration, meals, dressing, grooming, bathing, and toileting assistance. Toileting assistance included assistance with pulling pants down and up, handling toilet paper and wiping, changing protective undergarments, and directed staff to be alert to the condition of the resident's skin.

A progress note indicated staff discovered the resident one morning sitting on the toilet and needed four staff to lift her, as she was weak and no longer had feeling in her legs. The progress note indicated staff called 911 and sent her to the hospital due to weakness. The progress note did not indicate staff noticed any wounds. The previous day the resident tested positive for COVID-19, but the facility had no documentation of her symptoms.

Hospital records indicated the resident was admitted with significant skin breakdown. The records indicated the resident was admitted with pressure injuries in the shape of a toilet seat on the resident's bottom and thighs, a 5-inch skin tear on the back of her thigh, pressure injuries on her right elbow and right knee, and injuries to her left pinky and middle toes with missing nails and bleeding. The resident remained in the hospital for four days for weakness, COVID-19, and treatment of her wounds. The resident returned to the facility for a little over a week and the facility sent her back to the hospital when the pressure injuries got worse.

The facility had no documentation of staff providing the resident services or safety checks on the evening or night before staff found the resident on the toilet, which was 14 hours after the last confirmed observation by staff who provided the resident her medication.

During an interview an administrator stated the facility investigation indicated the resident may have been on the toilet four to six hours.

During investigative interviews, multiple staff members stated the facility was always short staffed and they were unable to complete all required resident services. Multiple staff stated they were unaware at the time of the incident the resident had been diagnosed with COVID-19 or the resident's need for increased toileting assistance.

During an interview, a resident who wished to remain anonymous stated although there were a few good staff, the constant turnover of administrative staff impacted the accountability of direct care.

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, the resident moved to a care facility for medically complex patients.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility investigated the incident and implemented a form for safety check documentation.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.
You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

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 02/05/2024

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 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: #HL203818202C/ #HL203819965M On February 5, 2024, 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 62 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL203818202C/#HL203819965M, tag identification 0250, 2310, and 2360.	0 000		
0 250 SS=I	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling	0 250		

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0 250	Continued From page 1 individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner;	0 250		

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0 250	Continued From page 2 (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee demonstrated systemic failures in the operation of the facility when the licensee failed to ensure staff provided appropriate care and services, failed to have a system in place to ensure staff completed cares, failed to have a system in place to ensure staff assignments included up to date information on required services based on assessed needs of residents, and failed to ensure staff monitored residents. In addition, the Minnesota Department of Health Office of Health Facility Complaints has held the licensee responsible for neglect of a vulnerable adult five times in the previous nine months. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include:	0 250		

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0 250	Continued From page 3 See tag 2310- Appropriate Care and Services-144G.91 Subdivision 4 (a) The facility failed to implement the following policies: - The Activities of Daily Living Care Documentation (ADL) policy - The Service Plan Process policy - The Infection Control-COVID-19 policy - The Abuse, Neglect, and Exploitation policy - The Individual Abuse Prevention Plan policy - The Minnesota Bill of Rights - The Change of Condition policy During an interview on February 8, 2024, at 8:57 a.m. Interim Assisted Living Director stated she was aware of systemic failures in the operation of the facility with concerns of staff documentation and failure to provide services to the residents of the facility.	0 250		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure staff provided appropriate care and services as required in the individualized service plan of one of one resident (R1) reviewed for maltreatment. The licensee failed to have a system in place to ensure staff assignment sheets included up to date services	02310	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	

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02310	Continued From page 4 based on assessed needs of residents. The licensee failed to have a system in place to verify if staff completed cares/services. The licensee failed to ensure staff monitored R1 who had a recent change in condition with increased weakness and newly diagnosed COVID-19 infection. Harm occurred when R1 was found sitting on the toilet for an unknown number of hours and developed a pressure injury on her bottom, a five-inch skin tear on her right posterior thigh, pressure injuries to her right elbow and knee, and injury to her left pinky and middle toenails that were bleeding and missing nails. This had the potential to affect all residents. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: R1 admitted to the facility on September 14, 2019. R1 resided on the memory care unit due to diagnoses that included metabolic encephalopathy, urinary incontinence, and chronic pain. R1's Individual Abuse Prevention Plan (IAPP) dated September 14, 2019, indicated R1 exhibited memory loss. (The facility failed to provide documentation of an updated IAPP.) R1's Personal Service Plan document dated December 11, 2023, indicated R1 required	02310	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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02310	Continued From page 5 assistance in the bathroom with pulling pants down and up, handling toilet paper and wiping from front to back, changing protective undergarments, and directed staff to be alert to R1's skin for redness, irritation, and skin breakdown. The service plan indicated as of the date of the service plan, R1's skin was intact. R1's progress note dated December 13, 2023, at 12:07 p.m. indicated R1 tested positive for COVID-19. The progress note failed to identify signs/symptoms R1 experienced or changes to R1's service plan related to this new diagnosis. R1's progress note dated December 13, 2023, at 1:56 p.m. indicated pharmacy contacted the facility regarding an order for Paxlovid (an antiviral medication used in people who have mild to moderate symptoms of COVID-19 and have a high risk for complications) for R1. The facility failed to provide requested nursing assessments. UP TO DATE SERVICE ASSIGNMENTS R1's Personal Service Plan document dated December 11, 2023, indicated R1 required assistance in the bathroom with pulling pants down and up, handling toilet paper and wiping from front to back, changing protective undergarments, and directed staff to be alert to R1's skin for redness, irritation, and skin breakdown. R1's night shift staff assignment sheet (undated but included in the facility incident investigation dated December 14, 2023) indicated "community tasks" included completing [every two hours] safety checks on all residents. The assignment	02310		

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02310	Continued From page 6 sheet indicated R1 wore glasses, was independent, used a walker, and required assistance due to memory loss/cognitive impairment. The assignment sheet directed staff to R1's service plan. The assignment sheet did not indicate R1 required bathroom assistance. R1's progress note dated December 14, 2023, at 11:51 a.m. indicated R1 was discovered by AM staff sitting on the toilet. The progress note indicated R1 was unable to stand and required four staff to assist her off the toilet. The progress note indicated R1stated she could not feel her legs when staff touched them. The progress note indicated the facility called 911 and sent R1 to the hospital. The facility failed to provide documentation of an updated IAPP for R1 after the incident. A facility Incident Investigation document dated December 14, 2023, indicated during investigative interviews a PM staff (unlicensed personnel (ULP)-J) told administrators he observed R1 in her recliner at 7:30 p.m., a night shift staff (ULP-F) told administrators he saw R1 in the bathroom at 5:00 a.m. but did not ask her if she needed assistance. A facility Incident Investigation document dated December 14, 2023, indicated the hospital notified the facility that R1 had significant injuries upon admission. The investigation indicated the injuries included a "pressure wound in the shape of a toilet seat, a large skin tear on [R1's] posterior thigh, pressure area on knee and elbow, and left pinky toe and middle toenails missing and toe bed bleeding." The investigation indicated several staff observed R1 spending more time than usual on the toilet in the two days prior, and	02310		

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02310	Continued From page 7 one indicated R1 had at least two episodes of diarrhea. During an interview on February 5, 2024, at 2:41 p.m. Interim Health and Wellness Director (IHWD)-A stated R1 had COVID-19 infection at the time of the incident, but the facility did not connect her COVID-19 symptoms to the incident. IHWD-A stated during the facility investigative interviews the night unlicensed personnel (ULP)-F told administrators that R1 was observed on the toilet at 5:00 a.m. but ULP-F did not interact with her. (The facility did not provide current contact information for ULP-F, so the Minnesota Department of Health investigator was unable to interview ULP-F.) During an interview on February 6, 2024, at 1:35 p.m. unlicensed personnel (ULP)-C stated several days prior to the incident R1 had difficulty using the toilet independently due to weakness. ULP-C stated on the day of the incident she passed medications and saw R1 on the toilet around 9:00 a.m. so she left to pass medications on a different floor. ULP-C stated she returned to R1's room at 10:00 a.m. and found R1 still sitting on the toilet. ULP-C stated she was unable to assist R1 off the toilet because R1 was unable to stand. ULP-C stated it took four staff to lift R1 off the toilet because R1 could not move her legs. ULP-C stated the facility required staff to provide safety checks every two hours for all residents, but staff did not always do the safety checks. During an interview on February 6, 2024, at 2:06 p.m. registered nurse (RN)-D stated R1 had a change in condition a week or two before the incident and RN-D completed an assessment. RN-D stated staff reported to her R1 was weaker and required assistance to get up from bed, the	02310		

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02310	Continued From page 8 toilet, and her recliner. RN-D stated she recommended increased services, but the facility practice required a supervisor to change the service plan, so she forwarded the assessment to the interim executive director. RN-D stated she did not know where the assessment went from there. RN-D stated she visited R1 at the hospital on the day of the incident and observed R1's pressure injury, which was in the shape of the toilet seat, skin tear on the back of her leg, and ripped nails. RN-D stated the interim executive director told her the facility would investigate the incident before deciding if a report should be filed with the state agency because "that's how it is done here". During an interview on February 8, 2024, at 8:15 a.m. ULP-H stated he provided cares for R1 the two days before R1 was sent to the hospital. ULP-H stated he did not know R1 had tested positive for COVID-19. ULP-H stated he observed R1 constantly in the bathroom in the two days prior to hospitalization. COMPLETION OF CARES/SERVICES R1's ADL sheet dated December 2023, identified the AM/PM/Night cares required for R1 which included for AM's: assisting with grooming/dressing, assisting with incontinence pad, providing a shower on Monday and Friday am, completing R1's laundry on Wednesdays, reminding R1 to wear glasses and hearing aid, providing housekeeping on Thursdays, escorting R1 to the dining room and life enrichment activities, and assisting with mobility. R1's ADL sheet dated December 2023 identified the cares required for R1 on PM shift included: assisting with undressing, assisting with showers,	02310		

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02310	Continued From page 9 assisting with grooming/dressing, assisting with incontinence pads, completion of housekeeping on Wednesdays, reminders to remove R1's glasses and hearing aid before bed, completing R1's laundry on Saturday and Sunday, and charging R1's hearing aid. R1's ADL sheet identified the cares required for night shift included: conducting sleep checks every two to four hours, assisting with AM cares (see above) and completing R1's laundry. R1's ADL sheet for December 2023, indicated staff were to initial each box upon completion of the care. R1's ADL sheet lacked evidence of completion of R1's services on five of 13 AM shifts, 13 of 13 PM shifts, and 13 of 13 night shifts December 1, 2023, through December 13, 2023. A review conducted February 5, 2024, of ADL Sheets for February 2023 for all residents on the third-floor memory care unit found a lack of evidence of completion of cares for the following days: February 1, 2024: no documentation for AM cares, PM cares, or night cares for nine of nine residents. February 2, 2024: no documentation for night cares for two of nine residents. February 3, 2024: no documentation for night cares for nine of nine residents. February 4, 2024: no documentation for AM cares for eight of nine residents, no documentation of PM cares for seven of nine residents, no documentation of night cares for nine of nine residents. During an interview on February 5, 2024, at 2:41 p.m. IHWD-A stated staff consistently failed to	02310		

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02310	Continued From page 10 document completion of cares/services. During an interview on February 6, 2024, at 3:30 p.m. ULP-E stated the facility practice was for staff to sign off verifying they completed cares on a document (ADL sheet), but administration never verified or even looked at the document. ULP-E stated it was well known night shift staff had a reputation for not completing their work. MONITORING OF RESIDENTS "Intentional Rounding" documents reviewed on February 5, 2024, indicated by signing, staff "attest to purposeful checking on the residents every two hours to proactively address a resident's need." The documents lacked evidence of two-hour checks of residents for the following dates and shifts: January 1, 2024 - no documentation for AM checks (7:00 a.m. to 3:00 p.m.) January 2, 2024 - no documentation for night shift checks (11:00 p.m. to 7:00 a.m.) January 4, 2024 -no documentation for AM checks, PM checks (3:00 p.m. to 11:00p.m.), or night shift checks. January 5, 2024 - no documentation for night shift checks. January 6 and 7, 2024 - no sheets found for these dates. January 8, 11, 14, 18, 2024 - no documentation for night shift checks. January 19, 2024 - no documentation for AM checks or night shift checks. January 20,21, 2024 - no documentation for night shift checks. January 22, 2024 -no documentation for PM checks.	02310		

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 02/05/2024

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

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02310	Continued From page 11 January 23,24, 25, 26, 28, 2024 -no documentation for night shift checks. January 29, 2024 -no documentation for PM checks (after 3:00 p.m.) or night shift checks. January 30, 2024 -no documentation for PM checks or night shift checks. January 31, 2024 -no documentation for AM checks or PM checks. During an interview on February 5, 2024, at 2:41 p.m. IHWD-A stated there was no one following up on staff compliance with the Intentional Rounding forms and she was not sure if was fully implemented. During an interview on February 6, 2024, at 2:06 p.m. RN-D stated all staff were required to check on residents every two hours and required to document on the Intentional Rounding document. During an interview on February 6, 2024, at 3:30 p.m. ULP-E stated after an incident during which R1 was left on the toilet for several hours administration started a new document named Intentional Rounding. ULP-E stated staff were to document when they did two-hour checks on residents, but administration did not follow through with review of the sheets or holding staff responsible for not completing resident checks. During an interview on February 8, 2024, at 8:57 a.m. interim assisted living director (IALD)-I stated she investigated the incident during which R1 was left on the toilet. IALD-I stated that R1 was on the toilet anywhere from four to six hours. IALD-I stated the investigation did not identify a person responsible for failure to check on R1, because multiple staff failed to document cares and resident checks. IALD-I stated the facility had a systemic problem of staff not doing their work.	02310		

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02310	Continued From page 12 The Activities of Daily Living Care Documentation (ADL) policy dated November 2018, indicated ADLs included toileting, transferring, and continence cares. The policy indicated ADL cares not performed during a shift would be reported to the manager on duty and entered in the shift log or progress notes. The Service Plan Process policy dated March 2020, indicated the resident's service plan would be revised as necessary following a change in condition that resulted in altered care need over a period of greater than two weeks. The Change of Condition policy dated February 2021, indicated a change of condition should be evaluated and documented for residents who exhibit significant deviation in physical or mental status. The policy required an update to the resident's record and service plan. The Staffing Requirements policy dated August 2021, indicated staff were scheduled based on the residents' needs 24-hours a day, seven days a week. The facility did not provide a staffing plan or matrix. The Caregiver Job Description document dated August 2021, indicated the caregivers provided direct care to residents per the individual service plan. The Minnesota Bill of Rights, dated August 1, 2022, indicated residents have the right to care and assisted living services that appropriate based on the resident's needs and according to an up to date service plan subject to accepted health care standards.	02310		

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02310	Continued From page 13 The Medication Technician Job Description document dated September 2022, indicated the medication technician provided residents with services in accordance with health care provider orders regarding administration of medications, treatments, and direct resident care per the individual service plan. The COVID-19 Playbook document (undated) indicated the facility would document all positive test results and update services within 24 hours. The document indicated residents testing positive should be isolated from others for 10 days from emergence of symptoms. The document directed staff to monitor residents every two to four hours and report any change in condition. TIME PERIOD FOR CORRECTION: Two (2) days.	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility.	02360	No plan of correction is required for this tag.	

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02360	Continued From page 14 Please refer to the public maltreatment report for details.	02360		