Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL307453901M
Compliance #: HL307454393C

Date Concluded: September 26, 2024

Name, Address, and County of Licensee Investigated:
Lino Lakes Assisted Living
725 Town Center Pkwy
Lino Lakes, MN 55014
Anoka County

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

Evaluator's Name: Brooke Anderson, 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 the resident when the resident had unexplained bruising and was hospitalized with a brain bleed. In addition, the resident's room was soiled with urine and feces.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Facility nursing staff failed to assess, monitor, and develop interventions to ensure the resident's safety after changes in behavior and injuries of unknown origin were observed. Additionally, the resident's room was soiled with urine and feces related to the lack of scheduled assistance for the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement. The investigation included review of the resident records, hospital records, facility incident reports,

personnel files, staff schedules, a law enforcement report, related facility policies and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living memory care unit with a diagnosis of Alzheimer's disease. The resident's service plan included assistance with medication administration, behavioral management, and safety checks three times per day. The resident's assessment indicated the resident had a history of becoming agitated with facility staff and residents and wandered into other resident's rooms.

Over the course of two months, six incidents occurred involving the resident which included a fall, aggressive behavior towards staff, wandering into other resident rooms, and injuries of unknown origin, including a black and blue eye and abrasions. Staff documented the incidents, but no follow-up or assessment was completed by the facility nurse and no interventions were developed or implemented to mitigate further incidents. No measures were taken to address other resident or staff safety related to the aggressive behavior or wandering into other resident rooms and unlicensed staff were not educated on resident specific behavior interventions. Staff reported concerns related to the resident's aggressive behavior, but the concerns were not followed up on by nursing or administrative staff.

One incident report indicated that staff arrived to work and found the resident with swelling on his right check and eyebrow. The resident reported to staff that he was in a bar fight. Staff notified the nurse of the resident's injury; however, the nurse did not assess or treat the resident injuries and did not update the resident's family or medical provider of the incident. There was no ongoing monitoring of the injury and no investigation into the cause of injury or the resident's report of getting into a fight.

Eleven days later, staff contacted emergency services after the resident was found naked in another resident's room and fell and hit his head on a door frame after he tripped during an altercation with the staff who attempted to remove him from the room. The police report indicated the responding officer observed a red mark above the resident's right eye and several bruises on his face, arms, and body, that appeared to various stages of healing and the resident reported he was thrown to the ground by facility staff. The officer questioned staff on the incident and the resident was transported to the hospital for further evaluation.

According to the police report, staff were unable to identify why the resident had bruising on various parts of his body, there was no supervisor available, and unlicensed staff were unable to provide the officer with requested documentation from the resident's medical record. The police report indicated there were concerns with the facility environment including that the floors were so sticky his boots stuck to the ground, the area smelled of urine, the carpet was loose, and there were spilled liquids on the floor in the common area.

Hospital records indicated the resident was diagnosed with a brain bleed and admitted to the hospital.

During an interview, a facility staff member stated the resident needed help with redirection and concerns about the resident were reported to the facility management. The staff member stated there was no follow up to concerns or injuries reported to management and no education was provided on how to manage the resident's behaviors.

The nurse employed at the time the incidents occurred no longer worked at the facility and could not recall any details about the resident.

During an interview, facility management staff recalled that the resident had a few incidents involving falls and combative behaviors and acknowledged that the nurse at the time should have assessed the resident, implemented interventions, and increased services to prevent further incidents. Facility management stated that staff did what they could for the resident but acknowledged that the medical record lacked evidence of action taken to ensure the resident's safety. Facility management described the care that the resident received at the facility as "unfortunate".

During an interview, a family member stated they noted several concerns throughout the resident's short stay at the facility. The family members stated that approximately 2-3 weeks after moving in, the resident began having urinary incontinence and an increase in agitation. The family member stated the resident's room was disgusting because staff did not assist the resident with cares or cleaning. The family reported concerns to facility management, but nothing was done to help the resident. The family indicated that the facility only contacted them three times and never communicated concerns about the resident. The family member stated they were not provided with documentation or incident reports they requested, and the resident did not return to the facility.

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. Resident unavailable
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
No action taken.

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
Anoka County Attorney
Lino Lakes City Attorney
Lino Lakes Police Department
Minnesota Board of Executives for Long Term Services and Supports
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30745	A. BUILDING: _____ B. WING _____	C 08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINO LAKES ASSISTED LIVING	725 TOWN CENTER PARKWAY LINO LAKES, MN 55014

(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: #HL307454393C/#HL307453901M #HL307455340C/#HL307454361M #HL307456117C/#HL307454782M On August 14, 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 83 residents receiving services under the provider's Assisted Living license. No correction orders were issued for HL307455340C/#HL307454361M. The following correction orders are issued for #HL307454393C/#HL307453901M, tag identification 2360, #HL307456117C/#HL307454782M, tag identification 0630, 0800, 1620, 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.	

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0 630	Continued From page 1	0 630		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete an individualized review and assessment of the resident's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults following observed changes in behavior and injuries of unknown origin for one of one resident (R3) reviewed. R3's individualized abuse prevention plan (IAPP) was not updated following multiple incidents of wandering and involving aggressive behavior towards staff and other residents and injuries of uknown origin. 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	0 630		

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0 630	Continued From page 2 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). The findings include: R3 admitted to the facility on March 19, 2024, due to diagnoses that included Alzheimer's disease and chronic kidney disease. R3's service plan undated indicated R1 required assistance with safety checks two times a day, medication management, and behavioral management. R3's IAPP assessment dated April 15, 2024, indicated R3 had a self-care deficit related to cognitive decline, physical limitations, and frustration over loss of independence. R3 was at risk for elopement and wandering. IAPP interventions included for staff to provide diversion or distraction. R3's progress notes dated May 4,2024, indicated R3 was found on the floor during safety checks. R3 did not know what happened. R3's room was very cold, and staff turned up the heat. BP was 153/94 and O2 was 76% when R3 was up in the chair his O2 increased to 91%. Staff were instructed to continue safety checks and call triage with any changes. R3's progress not lacked evidence follow up was completed. R3's medical record included no evidence that R3 was assessed following the fall, R3's provider was not updated, and no interventions were put in place to prevent further occurrences. R3 was not monitored for additional injuries following the fall.	0 630		

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0 630	Continued From page 3 R3's incident report dated May 8,2024, indicated R3 was threatening staff, combative, and kicked staff in the abdomen and upper thigh. Redirection was attempted but R3 continued to follow staff. R3's medical record lacked evidence that R3 was assessed or that follow up of the incident was completed and no changes were made to R3's Individual Abuse Prevention Plan (IAPP) to address the change in behavior. R3's incident report dated May 9, 2024, indicated R3 was in another resident's room 4 times. R3 was redirected and became aggressive. R3 was redirected again and R3 told staff to shut your damn mouth. R3's medical record lacked evidence that R3 was assessed following the incident and R3's IAPP was not updated to reflect the change in R3's behavior. No additional interventions were implemented to mitigate further incidents or protect R3 or other residents' safety. R3's incident report dated May 20, 2024, indicated when staff arrived to work R3 had swelling on his right check and brow. R3 stated he got into a bar fight. The facility nurse was notified. The May 20th 2024, incident report lacked evidence the medical provider was updated and lacked evidence action was taken to assess, monitor, or treat the injury and no interventions were implemented to prevent further injury. There was no evidence of follow-up completed related to the resident's report of getting into a fight or review of how the injuries may have occurred. R3's incident report dated May 27, 2024,	0 630		

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0 630	Continued From page 4 indicated R3 was throwing things in another resident's room. The other resident pulled his call light and reported R3 was in his room to staff. R3 was removed from the other resident's room. Facility management was notified. The incident report lacked evidence that the medical provider or R3's family were updated on change in the resident's behaviors. R3's medical record lacked evidence that R3 was assessed following the incident and R3's IAPP was not updated to reflect the change in R3's behavior or interventions to prevent further incidents or protect R3 or other residents' safety. R3's incident report dated May 31, 2024, indicated R3 was naked in a female resident's room. Facility staff attempted to get R3 out of another resident's room. R3 became extremely aggressive while hitting the staff, tripped and hit his head against the door. R3's incident report indicated R3 was sent to the ER for a head strike. Staff called 911 to have the resident transported to the emergency room. Police responded to the staff's 911 call for resident transport to the hospital and the police report dated May 31, 2024, indicated R3 had a red mark on his forehead above R3's right eye. R3 had several bruises on his face, arms and body that appeared to be in various stages of healing. R3's medical record did not reflect documentation, assessment, or monitoring of the injuries present on R3's body that were identified in the police report. The licensee failed to assess and monitor R3 after an increase in aggressive behavior and	0 630		

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0 630	Continued From page 5 injuries of unknown origin were noted by facility staff. During an interview August 11, 2024, registered nurse (RN)-E stated the facility nurse should have assessed, monitored, put interventions in place and investigated the root cause of the incidents to prevent an incident from happening again and confirmed this was not completed for R3. In an email dated August 28, 2024, RN-H indicated assessments should be completed every 90 days and with a change in condition. Any newly identified areas or new vulnerabilities would be followed up with a care plan review and any needed interventions added at that time would also prompt a new service plan to be reviewed and signed. The licensee's policy dated December 28, 2023, titled "Individual Abuse Prevention Plan" indicated the licensee will implement and update an IAPP for each resident that assesses specific measures to minimize the risk of abuse to the resident and other vulnerable adults. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to keep the physical environment in a continuous state of good repair with regard to the health, safety, comfort, and well-being for one of one resident (R3) when R1's room was repeatedly observed to be in an unkempt state in visibly soiled clothing, with piles of urine-soaked clothing. In addition, the carpet in the hallways were rippled creating a potential fall hazard for residents. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: R3 was admitted to the facility on March 19, 2024, with diagnoses including moderate late onset Alzheimer's dementia with mood disturbances. R3's service plan undated indicated R3 required assistance with safety checks two times a day, medication management, and behavioral management and housekeeping weekly. R3's IAPP assessment dated April 15, 2024, indicated R3 had a self-care deficit related to cognitive decline, physical limitations, and	0 800		

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0 800	Continued From page 7 frustration over loss of independence. R3 was at risk for elopement and wandering. IAPP interventions included for staff to provide diversion or distraction. A photo of R3 on his bed showed the bed did not have sheets, blanket, or pillow on his bed. A photo of R3's room showed soiled clothing in R3's room. A police report dated May 27, 2024, indicated R3 did not have a pillow on his bed. R3's room had a "very strong odor of urine." R1's bathroom had wet toilet paper on the floor with a "large" puddle of yellow liquid that appeared to be urine. A police report indicated photos were taken. A police report dated May 31, 2024, indicated officers noticed "several things in the facility that caused concern." Officers noted the carpet in the hallway in front of R3 was loose and creased upward which created a tripping hazard. The police report indicated a pool of liquid on the floor underneath a table and chair in the common area that created a slipping hazard. The police report indicated the floors were sticky causing their boots to stick to the ground. The general areas smelled of urine. During an observation August 14, 2024, at 10:58 a.m. while walking in the halls the carpet was observed by the MDH investigator to be rippling. On August 15, 2024, at 1:00 p.m. during an interview with R3's family member (FM)-A stated the facility did not provide hands-on care and assistance for R3 and R3 needed more assistance than the facility provided. FM-A stated R3's room was disgusting with piles of urine and	0 800		

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0 800	Continued From page 8 feces-soaked clothing. FM-A stated concerns were reported to facility management on multiple occasions, and nothing was done for R3. On August 21, 2024, at 9:00 a.m. during an interview with a corporate registered nurse (CRN), she stated the nurse should have completed an assessment, increased services for the resident, and put interventions in place to help R3 with his increased needs and the care R3 received was unfortunate at the end. On August 29, 2024 at 9:04 a.m. during an email exchange registered nurse (RN)-E stated the carpet has been rippled for a long time. Requests have been made to get it fixed daily. There are contractors working to install new carpet but it could take weeks. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
01620 SS=G	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be	01620		

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01620	Continued From page 9 completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to assess, monitor, and implement interventions after changes in behavior and injuries of unknown origin were observed for one of one resident (R3). 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). The findings include: R3 admitted to the facility on March 19, 2024, due to diagnoses that included Alzheimer's disease and chronic kidney disease. R3's service plan undated indicated R1 required assistance with safety checks two times a day, medication management, and behavioral	01620		

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01620	Continued From page 10 management. R3's IAPP assessment dated April 15, 2024, indicated R3 had a self-care deficit related to cognitive decline, physical limitations, and frustration over loss of independence. R3 was at risk for elopement and wandering. IAPP interventions included for staff to provide diversion or distraction. R3's progress notes dated May 4,2024, indicated R3 was found on the floor during safety checks. R3 did not know what happened. R3's room was very cold, and staff turned up the heat. BP was 153/94 and O2 was 76% when R3 was up in the chair his O2 increased to 91%. Staff were instructed to continue safety checks and call triage with any changes. R3's progress not lacked evidence follow up was completed. R3's medical record included no evidence that R3 was assessed following the fall, R3's provider was not updated, and no interventions were put in place to prevent further occurrences. R3 was not monitored for additional injuries following the fall. R3's incident report dated May 8,2024, indicated R3 was threatening staff, combative, and kicked staff in the abdomen and upper thigh. Redirection was attempted but R3 continued to follow staff. R3's medical record lacked evidence that R3 was assessed or that follow up of the incident was completed and no changes were made to R3's Individual Abuse Prevention Plan (IAPP) to address the change in behavior. R3's incident report dated May 9, 2024, indicated R3 was in another resident's room 4 times. R3 was redirected and became aggressive. R3 was	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30745	A. BUILDING: _____ B. WING _____	C 08/14/2024

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01620	Continued From page 11 redirected again and R3 told staff to shut your damn mouth. R3's medical record lacked evidence that R3 was assessed following the incident and R3's IAPP was not updated to reflect the change in R3's behavior. No additional interventions were implemented to mitigate further incidents or protect R3 or other residents' safety. R3's incident report dated May 20, 2024, indicated when staff arrived to work R3 had swelling on his right check and brow. R3 stated he got into a bar fight. The facility nurse was notified. The May 20th 2024, incident report lacked evidence the medical provider was updated and lacked evidence action was taken to assess, monitor, or treat the injury and no interventions were implemented to prevent further injury. There was no evidence of follow-up completed related to the resident's report of getting into a fight or review of how the injuries may have occurred. R3's incident report dated May 27, 2024, indicated R3 was throwing things in another resident's room. The other resident pulled his call light and reported R3 was in his room to staff. R3 was removed from the other resident's room. Facility management was notified. The incident report lacked evidence that the medical provider or R3's family were updated on change in the resident's behaviors. R3's medical record lacked evidence that R3 was assessed following the incident and R3's IAPP was not updated to reflect the change in R3's behavior or interventions to prevent further incidents or protect R3 or other residents' safety.	01620		

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01620	Continued From page 12 R3's incident report dated May 31, 2024, indicated R3 was naked in a female resident's room. Facility staff attempted to get R3 out of another resident's room. R3 became extremely aggressive while hitting the staff, tripped and hit his head against the door. R3's incident report indicated R3 was sent to the ER for a head strike. Staff called 911 to have the resident transported to the emergency room. Police responded to the staff's 911 call for resident transport to the hospital and the police report dated May 31, 2024, indicated R3 had a red mark on his forehead above R3's right eye. R3 had several bruises on his face, arms and body that appeared to be in various stages of healing. R3's medical record did not reflect documentation, assessment, or monitoring of the injuries present on R3's body that were identified in the police report. The licensee failed to assess and monitor R3 after an increase in aggressive behavior and injuries of unknown origin were noted by facility staff. During an interview August 11, 2024, registered nurse (RN)-E stated the facility nurse should have assessed, monitored, put interventions in place and investigated the root cause of the incidents to prevent an incident from happening again and confirmed this was not completed for R3. In an email dated August 28, 2024, RN-H indicated assessments should be completed every 90 days and with a change in condition. Any newly identified areas or new vulnerabilities	01620		

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01620	Continued From page 13 would be followed up with a care plan review and any needed interventions added at that time would also prompt a new service plan to be reviewed and signed. The licensee's policy dated August 2021 titled Nursing "Assessments, Reviews, and Monitoring" indicated resident assessment and monitoring will be conducted as needed based on changes in the needs of the resident. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
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 two of three residents reviewed R1 and R3 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		