Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL336131663M
Compliance #: HL336132768C

Date Concluded: July 8, 2025

Name, Address, and County of Licensee Investigated:
The Sanctuary at St. Cloud
2410 20th Ave. SE
St. Cloud, MN 56304
Sherburne County

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

Evaluator's Name: Erin Johnson-Crosby, 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 did not receive scheduled furosemide (diuretic) medications according to physician orders. The resident experienced fluid overload resulting in hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Physician's orders and facility policies and procedures were not followed by facility staff. The resident did not receive prescribed medication or symptom management monitoring which resulted in hospitalization.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, hospital records, pharmacy records, facility internal investigation documentation, facility incident reports, personnel files, staff schedules, and related facility policies and procedures.

During the onsite visit, the investigator observed medication administration and resident interactions with staff.

The resident resided in an assisted living facility. The resident's diagnoses included congestive heart failure, chronic kidney disease, and anxiety. The resident's service plan indicated assistance with medication administration. Unlicensed staff were directed to obtain and document the resident's weight daily and report to the nurse any weight gain of two pounds in 24 hours or five pounds in a week. Every week, licensed staff were to review vital signs and report to a primary care physician (PCP) any weight gain of two pounds in 24 hours or 5 pounds in a week.

The resident's medical record indicated the resident recently discharged from the hospital following an acute exacerbation of heart failure. The resident was not able to self-administer medications and medication administration was to be completed by facility staff.

Hospital discharge orders included a physician order for furosemide (Lasix) (diuretic-reduce fluid buildup in the body) 20 milligrams (mg) take one tablet take by mouth in the morning. The orders also directed staff to report any change in shortness of breath/edema in legs or abdomen as well as weight changes to the heart failure clinic including a gain of 2-3 pounds overnight or 5-pound gain or loss in a week from goal weight.

The resident's medication administration record (MAR) indicated the order for furosemide 20 mg by mouth in the morning was set up in the electronic medical record (EMR) incorrectly and indicated to administer every other day instead of daily as ordered. The resident missed 16 doses of furosemide.

The resident's medical record did not include documentation that staff monitored for changes in shortness of breath/edema in legs or abdomen. The resident's weight record indicated the resident's weight increased two pounds or more six times in one month, but facility staff did not notify the primary care physician or heart clinic as ordered.

Approximately 30 days later, the resident told staff she felt sick and wanted to go to the emergency room. Staff sent the resident to the emergency room for evaluation where the resident was diagnosed with difficulty breathing, shortness of breath and hospitalized for acute hypoxic respiratory failure.

Hospital records indicated the facility administered furosemide (Lasix) every other day instead of daily as ordered since the last hospital discharge approximately 30 days ago, which likely led to the resident's fluid retention. The resident was started on intravenous Lasix and her weight was back down to previous goal. The resident reported improvement in breathing. The resident spent four days in the hospital before being discharged home.

Hospital staff informed the facility of the noted medication error, and the facility completed an internal investigation. Facility documentation confirmed a transcription error occurred, and the resident missed 15-16 doses of the ordered furosemide medication. Internal investigation documentation also identified that the medication cards did not include the correct order and did not match the resident's electronic medical record for administration. The investigation included re-training for the RN that reconciled the resident's medications incorrectly but facility wide re-education regarding following physician orders including medication inconsistencies, medication administration, weight management, or monitoring for signs of fluid overload was not completed.

During investigative interviews, multiple registered nurses stated the resident's furosemide order was transcribed incorrectly and was caught by hospital staff. The facility's internal process was if there was a medication change the new medication card would be placed in the medication cart with the old medication card so medication would not be wasted. A sticker would then be placed on the old medication card alerting staff of an order change. The licensed staff stated ULP did not notify them regarding the medication discrepancy. The licensed staff stated if there was more than a two-pound weight gain in 24 hours the provider should have been notified and physician orders should have been followed and acknowledged this was not completed.

During an interview, the resident stated the hospital discovered the facility was administering the furosemide incorrectly. The resident stated they took about 10 pounds of fluid off. There were many concerns regarding incorrect medications that she shared with the RN multiple times. The resident stated there were a couple times she was also not given her scheduled warfarin (blood thinner). The resident stated she did not get the care she was supposed to receive from the day she moved in.

During an interview, the family member stated he could not believe a place like that could screw up medications so much. After that error he did not want the resident to return to the facility and took the resident home.

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: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility sent the resident to the hospital for evaluation, completed an internal investigation and re-educated one staff member.

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
Sherburne County Attorney
St. Cloud City Attorney
St. Cloud Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33613	A. BUILDING: _____ B. WING _____	C 05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SANCTUARY AT ST CLOUD	2410 20TH AVENUE SE SAINT CLOUD, MN 56304

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL336132768C/#HL336131663M On May 8, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 114 residents receiving services under the Assisted Living with Dementia Care license. The following correction order is issued for #HL336132768C/#HL336131663M, tag identification 1760, 1940, 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	

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
01760 SS=G	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 medication was administered as prescribed for one of one resident (R1) and failed to follow-up on medication administration practices when R1's medications were not administered for 16 days, resulting in R1 being admitted to the hospital. 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	01760		

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01760	Continued From page 2 situation has occurred only occasionally). The findings include R1 was admitted to the facility on January 22, 2025, with diagnoses of congestive heart failure, chronic kidney disease, chronic obstructive pulmonary disease and anxiety. R1's change in condition assessment dated February 27, 2025, indicated R1 was hospitalized from February 22, 2205, to February 27, 2025, for an acute exacerbation of heart failure. R1 was not able to self-administer medications and medication management was completed by facility staff. R1 was oriented to person, place, time, and situation. R1's service plan dated February 28, 2025, indicated R1 required assistance and received medication administration. R1's service plan included weight monitoring daily and to report any weight gain to a licensed staff of two pounds in 24 hours or five pounds in a week. Unlicensed staff were to obtain and document R1's weight. Every Monday licensed staff would review vital signs and report to a primary care physician (PCP) any weight gain of two pounds in 24 hours or 5 pounds in a week. Hospital discharge orders dated February 27, 2025, included a physician order for furosemide (diuretic-reduce fluid buildup in the body) 20 milligrams (mg) take one take by mouth in the morning. The orders also noted staff should report any change in shortness of breath/edema in legs or abdomen as well as weight changes to heart failure clinic such as a gain of 2-3 pounds overnight or 5-pound gain or loss in a week from goal weight.	01760		

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01760	Continued From page 3 R1's progress notes dated February 27, 2025, indicated R1 returned to the facility after a hospitalization for acute exacerbation of heart failure and R1's medications were reconciled and signed off by facility staff which included furosemide. R1's March 2025, medication administration record (MAR) indicated an order for furosemide 20 mg in the morning, but the order was transcribed incorrectly and set up for every other day. Review of R1's March, 2025, MAR indicated staff administered 20 mg every other day and not daily as prescribed. R1 missed 16 doses of furosemide. R1's weight record indicated R1's weight increased two pounds or more in 24 hours, six times from February 28, 2025 until R1 was admitted to the hospital on March 30, 2025. R1's record included no documentation this was reported to R1's PCP as ordered on R1's Februray 27, 2025 hospital discharge orders. R1's progress notes dated March 30, 2025, indicated R1 felt sick and wanted to go to the emergency room. Vital signs included oxygen saturation of 73% (normal is 95-100%). On March 31, 2025, R1's progres notes indicated R1 was hospitalized for difficulty breathing and shortness of breath and was admitted for acute hypoxic respiratory failure. Hospital records dated April 1, 2025, indicated the facility administered furosemide (Lasix) every other day instead of daily as ordered on February 27, 2025, which likely led to R1's fluid retention.	01760		

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01760	Continued From page 4 R1 was started on intravenous (IV) Lasix and her weight was back down to previous goal. R1 reported improvement in breathing. R1 was discharged home following the hospitalization on April 2, 2025. The licensee's medication error report and internal investigation records indicated R1's furosemide was transcribed incorrectly following hospital discharge on February 27, 2025. The investigation indicated on March 31, 2025 hospital staff contacted the RN regarding the incorrect furosemide order. The director of health services (DHS) was notified on April 1, 2025. The investigation revealed furosemide 20 mg was transcribed incorrectly by the pharmacy and was approved by the RN. The RN did not adjust the scheduling detail of the medication, so furosemide was given every other day instead of daily as ordered. R1 missed approximately 15-16 doses of the diuretic medication. R1 was transferred to the emergency department for shortness of breath/difficulty breathing. The error was corrected in R1's medical record. The RN received education and corrective action. The licensee's internal investigation included pictures of two medication cards that were in the medication cart. The first medication card dated February 12, 2025, furosemide 20 mg, take 1 tab by mouth every other day. The second medication card dated February 25, 2025; furosemide 20 mg take 1 tablet by mouth in the morning. The pictures did not include an order change sticker or direction on what card staff should use. The internal investigation did not include facility wide staff re-education regarding medication administration regarding the medication error.	01760		

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01760	Continued From page 5 On May 8, 2025, at 2:47 p.m., registered nurse (RN)-A (assistant director of health services) stated the order was supposed to be daily and was entered by the pharmacy incorrectly and verified by a licensed staff. The staff checking in the medication from the pharmacy should have checked the medication card to ensure it matched the physician orders. RN-A stated there were order changes all the time and sometimes the label would not match the order on the electronic medical record (EMR). If there was an order change and there was two medication cards with incorrect labels, licensed staff should have applied a sticker indicating the label was incorrect and staff should have followed the direction on the EMR and not the information on the label. RN-A stated it would not be considered a medication error if ULP administered the medication ordered on the EMR but it did not match the label. RN-A stated she did not know if facility wide education was completed after the medication error. RN-A stated staff should have followed R1's physician orders regarding weight monitoring and contacted the PCP. On May 8, 2025, at 3:05 p.m., licensed assisted living director (LALD)-B stated she was aware of the medication error but did not conduct the internal investigation. LALD-B stated if there was a discrepancy between the EMR and the medication card label staff should be contacting a nurse for instruction. LALD-B did not know if facility wide training had been completed after the medication error. LALD-B stated her expectation would be for staff to follow physician orders and notify the PCP if there is a greater than two pound weight gain in 24 hours. On June 11, 2025, at 10:00 a.m., registered nurse (RN)-C/ director of health services (DHS) stated	01760		

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01760	Continued From page 6 hospital staff first notified the facility of the furosemide discrepancy. RN-C checked the medication cart and noticed two medication cards stapled together. One medication card was labeled furosemide 20 mg every other day and the other card stapled behind it was furosemide 20 mg daily. RN-C confirmed R1 received furosemide 20 mg every other day instead of every day. RN-C stated it was an internal process to not waste medications so if there was a new medication order, the mediation cards would be put in the cart together. RN-C stated a sticker should have been placed on the medication card alerting unlicensed staff there was a change in the order. RN-C did not believe there was a sticker on either of the medication cards. RN-C stated she had not been notified by ULP regarding the discrepancy of the medication cards and EMR. RN-C verified there had not been facility wide training following the medication error or weight management procedures. RN-C confirmed R1's PCP should have been notified if there was a weight gain and they were not. R1 was admitted to the hospital on March 30, 2025, and hospitalized until April 2, 2025, and was discharged home. On June 11, 2025, at 3:00 p.m., RN-D stated she reconciled R1's medications on February 27, 2025, when R1 returned from the hospital. RN-D stated she verified the furosemide order without ensuring the detail description was correct in the EMR. The furosemide 20 mg was entered in the detailed instruction to give every other day instead of every day as ordered so it would only notify staff every other day to administer the furosemide. RN-D stated if there was a new medication card sent from pharmacy, staff would keep both cards and put a sticker on the medication card indicated there was a change in	01760		

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01760	Continued From page 7 the medication. RN-D stated when the pharmacy delivered medications, the nurse would confirm the medications were correct and then check the medication in and then would put it in the medication cart. RN-D stated unclicensed staff would obtain R1's weight and would be able to see the previous weight. ULP were supposed to let licensed staff know of a weight greater than two pounds in 24 hours or five pounds in a week. Weekly checks were completed by the licensed staff and would notify to PCP if needed. RN-D stated she received re-education but did not know if facility wide training was completed after this incident. On June 18, 2025, at 3:30 p.m., R1 stated the hospital discovered the furosemide order was incorrect. R1 stated they took about 10 pounds of fluid off of me. R1 said she had many concerns regarding receiving incorrect medications while she resided at the facility and brought the concerns up to the facility RN multiple times. R1 said there were a couple times facility staff did not give her scheduled warfarin. R1 stated she did not get the care she was supposed to from the day she moved in. R1 stated the facility "looked fancy, but the care isn't there at all." On June 18, 2025, at 3:40 p.m., family member (FM)-E stated, "I couldn't believe a place like that can screw up medications and stuff so badly." After that hospitalization FM-E said he did not want R1 to return to the facility so she moved back home with him. A change in condition policy was requested. The licensee provided a document titled, The Essential Guide Assisted Living in Minnesota. A policy was not provided.	01760		

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01760	Continued From page 8 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01940 SS=G	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.	01940		

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01940	Continued From page 9 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to prepare and include in the service plan a written statement of the treatment services to be provided to the resident and failed to develop and maintain an individualized treatment management record containing the required content for one of one resident (R1). R1's service plan and treatment record failed to identify physician's orders for fluid overload and weight monitoring as directed by R1's physician. Facility staff failed to complete required symptom monitoring and failed to update R1's physician with weight fluctuations as prescribed. 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 R1 was admitted to the facility on January 22, 2025, with diagnoses of congestive heart failure, chronic kidney disease, chronic obstructive pulmonary disease and anxiety. R1's change in condition assessment dated February 27, 2025, indicated R1 was hospitalized from February 22, 2205, to February 27, 2025, for an acute exacerbation of heart failure. R1's service plan dated February 28, 2025, indicated R1 required assistance and received	01940		

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01940	Continued From page 10 medication administration. R1's service plan included weight monitoring daily and to report any weight gain to a licensed staff of two pounds in 24 hours or five pounds in a week. Unlicensed staff were to obtain and document R1's weight. Every Monday licensed staff would review vital signs and report to a primary care physician (PCP) any weight gain of two pounds in 24 hours or 5 pounds in a week. Hospital discharge orders dated February 27, 2025, included staff should report any change in shortness of breath/edema in legs or abdomen as well as weight changes to heart failure clinic such as a gain of 2-3 pounds overnight or 5-pound gain or loss in a week from goal weight. R1's progress notes dated February 27, 2025, indicated R1 returned to the facility after a hospitalization for acute exacerbation of heart failure and R1's medications were reconciled and signed off by facility staff. R1's medical record, treatment record, or service plan did not include direction/documentation staff monitored for signs of fluid overload- changes change in shortness of breath/edema in legs or abdomen as ordered on R1's Februray 27, 2025 hospital discharge orders. R1's weight record indicated R1's weight increased two pounds or more in 24 hours, six times from February 28, 2025 until R1 was admitted to the hospital on March 30, 2025. R1's record included no documentation this was reported to R1's PCP as ordered on R1's Februray 27, 2025 hospital discharge orders. R1's progress notes dated March 30, 2025, indicated R1 felt sick and wanted to go to the	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33613	A. BUILDING: _____ B. WING _____	C 05/08/2025

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01940	Continued From page 11 emergency room. Vital signs included oxygen saturation of 73% (normal is 95-100%). On March 31, 2025, R1's progres notes indicated R1 was hospitalized for difficulty breathing and shortness of breath and was admitted for acute hypoxic respiratory failure. Hospital records dated April 1, 2025, indicated due to fluid retention R1 was started on intravenous (IV) Lasix to get her weight was back down to previous goal. R1 reported improvement in breathing. R1 was discharged home following the hospitalization on April 2, 2025. The licensee's medication error report and internal investigation records indicated R1's medication and discharge orders were transcribed incorrectly following hospital discharge on February 27, 2025 and R1 was transferred to the emergency department on March 30, 2025 for shortness of breath/difficulty breathing. On May 8, 2025, at 2:47 p.m., registered nurse (RN)-A (assistant director of health services) stated staff should have followed R1's physician orders regarding weight monitoring and contacted the PCP and acknowledged these orders were not followed. On May 8, 2025, at 3:05 p.m., licensed assisted living director (LALD)-B stated her expectation would be for staff to follow physician orders and notify the PCP if there is a greater than two pound weight gain in 24 hours and acknowledged this was not completed by facility staff. On June 11, 2025, at 10:00 a.m., registered nurse (RN)-C/ director of health services (DHS)	01940		

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01940	Continued From page 12 confirmed R1's PCP should have been notified if there was a weight gain and they were not and all physician orders should have been followed and transcribed correctly but they were not. R1 was admitted to the hospital on March 30, 2025, and hospitalized until April 2, 2025, and was discharged home. On June 11, 2025, at 3:00 p.m., RN-D stated she reconciled R1's discharge orders on February 27, 2025, when R1 returned from the hospital. RN-D stated unlicensed staff would obtain R1's weight and would be able to see the previous weight. ULP were supposed to let licensed staff know of a weight greater than two pounds in 24 hours or five pounds in a week. Weekly checks were completed by the licensed staff and the PCP should have been notified as needed. RN-D stated she received re-education but did not know if facility wide training was completed after this incident. On June 18, 2025, at 3:30 p.m., R1 stated they [the hospital] took about 10 pounds of fluid off of me. R1 said she had many concerns regarding receiving incorrect medications while she resided at the facility and brought the concerns up to the facility RN multiple times. R1 said there were also a couple times facility staff did not give her scheduled warfarin. R1 stated she did not get the care she was supposed to from the day she moved in. R1 stated the facility "looked fancy, but the care isn't there at all." On June 18, 2025, at 3:40 p.m., family member (FM)-E stated, "I couldn't believe a place like that can screw up medications and stuff so badly." After that hospitalization FM-E said he did not want R1 to return to the facility so she moved back home with him.	01940		

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01940	Continued From page 13 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
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. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	