Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL369024806M
Compliance #: HL369021012C

Date Concluded: August 27, 2025

Name, Address, and County of Licensee Investigated:
A Daughter's Love
25184 Thunder Road
Staples, MN 56479
Todd County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, 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 it failed to ensure trained staff were available to respond to resident needs 24 hours per day and failed to administer pain medications as prescribed after they were requested by the resident. Staff working overnight were not trained to administer medications and the resident had to wait four hours to receive pain medication.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility employed unlicensed personnel (ULP) who chose not to be medication trained. The facility failed to have a system in place on how to handle administering medications when the ULP was scheduled to work alone. As a result, a resident had to wait several hours to receive pain medications.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the case manager. The

investigation included review of the resident record, facility incident reports, personnel files, staff schedules, and related facility policy and procedures.

The resident resided in an assisted living facility. The resident’s diagnoses included adult failure to thrive and anxiety. The resident’s service plan included assistance with medication administration. The resident’s assessment indicated all medications were managed by the facility nurse and administered by trained staff per physician order and facility policy and procedure.

The facility’s staffing plan failed to identify that some unlicensed personnel were not trained to give medications and failed to identify the facility’s plan if a person not trained to administer medications was working alone.

The resident’s record indicated the resident had all her teeth removed in preparation to get dentures. New orders for pain medication including 800 milligrams (mg) of Motrin/ibuprofen and hydrocodone/acetaminophen (Norco) 5/325 mg were written.

A complaint received by the facility indicated the resident had asked for pain medication on an overnight shift but didn’t get any pain medication due to staff not being trained to administer medications. The complaint noted night shift staff did not contact the manager to come give the medications.

The employee record for the ULP working the night shift indicated she had worked at the facility for about two years and had not been trained to administer medications.

During an interview, the resident stated staff couldn't give her medications because the staff member wasn't qualified to give them. The resident stated, "what could I say, ok I'll suffer?...she couldn't give out meds, they should have someone on call that could." The resident stated she was in a lot of pain so she went back to sleep until the morning shift came and could give her medication.

During an interview, the ULP working the day shift stated when she came into work, the resident was in tears because she was in so much pain. The ULP stated the resident had said she asked for pain medication, but the staff member told her she wasn’t able to give them. The ULP stated she knew some overnight staff were not trained to give medications and she had previously brought concerns to management about staff not being trained to give medications.

During an interview, the ULP working the night shift stated she had worked at the facility for almost two years but declined to get medication trained as she did not want to deal with it. The ULP stated usually there were two people working nights but sometimes she would work alone. On the night the resident requested pain medications, the ULP stated the resident told her around 3 or 4 in the morning that she had pain and wanted pain medication, and she had told her she was not able to give it as she wasn’t trained. The ULP stated the resident told her it was

ok, and she could wait until morning. The ULP stated a few days after this happened, a manager reached out to her to get more information and told her that in the future if this happened, she should call her to come administer the medications. The ULP stated prior to this incident, it had never been communicated to her how to handle residents who request medications on overnights when she was the only person working.

During an interview, the facility nurse stated that at the time of the incident, four overnight ULP were not trained to give medications and that sometimes there was only one person working on the overnight shift. The nurse stated staff would be expected to call the manager who lived nearby who would come in and give medications if needed and she was not sure why the ULP failed to notify the nurse or manager that the resident had requested pain medication.

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 had four ULP not trained to administer medications at the time of the incident. Three ULP have since been trained. The facility educated staff on the policy to contact the manager if medications need to be given and staff are not able to administer them.

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
Todd County Attorney
Staples City Attorney
Staples Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36902	A. BUILDING: _____ B. WING _____	C 08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A DAUGHTERS LOVE INC	25184 THUNDER ROAD STAPLES, MN 56479

(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: #HL369024806M/ #HL369021012C On August 18, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 13 residents receiving services under the provider's Assisted Living license. The following correction order is issued for #HL369024806M/ #HL369021012C, tag identification 0470, 0495, 0620, 0800, 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.	
0 470 SS=I	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 1 (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the clinical nurse supervisor (CNS) developed and implemented a staffing plan to determine staffing levels to meet the needs of all residents. This had the potential to affect all residents, staff, and visitors.	0 470		

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0 470	Continued From page 2 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), 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). The findings include: The licensee held an assisted living license effective November 1, 2024, with an expiration date of October 31, 2025. The facility was licensed for a capacity of 18 and had a current census of 13 residents. The licensee's complaint log indicated on July 11, 2025, R1 asked for pain medication due to having all her teeth removed on July 8, 2025. "Night staff are NOT med trained and did not contact the manager [LALDIR-A] to come to the facility and administer said pain medication. [R1] waited until 6 a.m. when morning staff arrived to get any sort of pain medicine..." The complaint was reviewed by licensed practical nurse (LPN)-C who took the following action, "Talked with resident about this. Will talk to employees about this. Employee was contacted was very apologizing for not contacting nursing or management." The licensee's uniform disclosure of assisted living services and amenities (UDALSA) dated February 24, 2025, indicated two unlicensed personnel (ULP) would be scheduled on the night shift. The licensee's staffing plan, updated by clinical	0 470		

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0 470	Continued From page 3 nurse supervisor (CNS)-B on April 10, 2025, did not identify that there were ULP who were not trained to administer medications and there were times when they would be working alone. The staffing plan failed to identify how the facility would handle staffing when staff not able to administer medications would be working alone. The staffing plan indicated there were three to four residents who required an assist of two and 14 residents who received medication administration. Three residents were on hospice. The staffing plan indicated one to two ULP would work the overnight shift. The staffing plan failed to identify how residents requiring an assist of two would be helped when only one staff was working. The staffing plan indicated a minimum of two direct-care staff would be scheduled and available to assist at all times whenever a resident required an assist of two direct-care staff for scheduled reasonably foreseeable and unscheduled needs. ULP-E was hired on November 22, 2023, to provide direct care and services to the licensee's residents. ULP-E's record indicated she was not trained to administer medications. The licensee's schedule for the overnight shift on July 11, 2025, indicated only one ULP, ULP-E, was working the night shift. On August 18, 2025, at 1:05 p.m., R1 stated the staff couldn't give her medications because the staff member wasn't qualified to give them. R1 stated, "what could I say, ok I'll suffer?...she couldn't give out meds, they should have someone on call that could." R1 stated she was in a lot of pain so she went back to sleep until the morning shift came and could give her	0 470		

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0 470	Continued From page 4 medication. On August 20, 2025, at 10:30 a.m., unlicensed personnel (ULP)-E stated she had worked at the facility for about two years and she had decided to not be trained on medications as she did not want to administer medications. ULP-E stated there was usually two people on overnights but there were several shifts where only one person was working. ULP-E stated on the overnight shift, R1 had asked for pain medications around 3 or 4 in the morning and she had told her she wasn't trained on medications so she wasn't able to give them. ULP-E stated the resident told her it was ok and she would just wait. ULP-E stated at the time, she was not aware she should call the nurse or manager if a resident needed medications on a shift that she was working alone but was educated on the policy after the incident. On August 20, 2025, at 11:15 a.m., clinical nurse supervisor (CNS)-B stated at the time of the incident, there were four ULP who were not trained to administer medications and sometimes there was only one person working on the overnight shift. The nurse stated staff would be expected to call the manager who lived nearby and she would come in and give medications if needed and she was not sure why the ULP failed to notify the nurse or manager that the resident had requested pain medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		

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0 495	Continued From page 5	0 495		
0 495 SS=F	144G.41 Subdivision. 1 (13) Minimum Requirements (13) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide staff access to an on-call registered nurse (RN) 24 hours per day, seven days per week. This had the potential to affect all residents receiving assisted living services. 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 potential to affect a large portion or all of the residents). The findings include: On August 18, 2025, at the investigator arrived at the facility to initiate a maltreatment investigation. Staff working at the facility stated the RN was not on site that day and she could be reached by calling the on-call phone. On August 18, 2025, at 12:55 p.m., unlicensed personnel (ULP)-D stated clinical nurse supervisor (CNS)-B didn't really have a schedule, it was just whenever she wanted to come in but she would try to come in every day during the week. ULP-D stated she was not sure why	0 495		

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0 495	Continued From page 6 CNS-B was not there that day as she would usually call in the morning to check in and she hadn't done that today. ULP-D stated there was usually a licensed practical nurse but she hadn't been there lately and she was not sure where she was. ULP-D stated licensed assisted living director in residence (LALDIR)-A did not have a schedule of when she would come in and she was not in the facility often. On August 18, 2025, at 1:36 p.m., the investigator called the number for the on-call phone. The phone was off and went straight to voicemail. The investigator left a voicemail requesting a call back. The RN did not call back. On August 18, 2025, at 1:40 p.m., the investigator asked staff to try calling the nurse on-call phone. The phone was off and went straight to voicemail. A staff member stated it was possible the RN did not charge the phone and it had died. The investigator asked how they would reach a nurse and staff stated they would have to contact the assisted living director, who was not a nurse. On August 20, 2025, at 9:46 a.m., the investigator called the number for the on-call phone. The phone rang out and went to voicemail. The investigator left a voicemail requesting a call back. On August 20, 2025, at 10:08 a.m., the investigator called the facility. The phone rang out and went to voicemail. The investigator left a voicemail requesting a call back. On August 20, 2025, at 10:30 a.m., the investigator called CNS-B's personal phone	0 495		

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0 495	Continued From page 7 number and she stated that she was currently on the road heading to the facility. On August 20, 2025, at 11:15 a.m., CNS-B stated the number for the on-call nurse would change depending on who was on call but that staff should know where to find the number and who to call. CNS-B stated they had tried to get staff to use the on-call RN phone number but they wouldn't use it and that staff should have known to call the nurse's personal phone number, not the on call number. On August 20, 2025, at 11:35 a.m., licensed practical nurse (LPN)-C stated it was "typical" for the RN phone to be off or not answered and that there was a phone number posted for the RN but "it doesn't mean she has the phone on or she answers it." LPN-C stated the CNS did not have a set schedule and would come and go when she wanted and they did not know when she would be at the facility. On August 21, 2025, at 3:30 p.m. owner (O)-F stated that facility staff knew to contact the nurse directly and not with the on-call number and that the nurse's phone number would be written on a white board. O-F stated the on-call nurse number wasn't really used and after checking the phone log on that phone, she saw that there had not been any calls from facility staff as the facility would call the nurse's personal number. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 495		

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0 620	Continued From page 8	0 620		
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.	0 620		

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0 620	Continued From page 9 (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one residents (R1) after she did not receive pain medication due to staff not being trained to give medications. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	0 620		

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0 620	Continued From page 10 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included adult failure to thrive and anxiety. R1's assessment dated June 30, 2025, indicated the resident was going to have her teeth extracted and get dentures next month. All medications were managed by the facility nurse and administered by trained staff per physician order and facility policy and procedure. R1's progress notes indicated on July 8, 2025, the resident had an appointment for dental extractions. A note entered by licensed practical nurse (LPN)-C the next day indicated the resident was given an order for Motrin 800 milligrams (mg) and hydrocodone/acetaminophen (Norco) 5/325 mg. The medication was noted to have been filled and onsite. On July 10, 2025, the resident underwent cataract surgery on her left eye. R1's medication administration record (MAR) for July 2025 included the following: Ibuprofen (Motrin) 800 mg tablet by mouth twice daily as needed starting on July 10th and ending on July 16th Another order was entered for "IBU" 800 mg one tablet by mouth every six hours for pain starting on July 8th and ending on July 16th Hydro-Apap 5-325 (Norco) mg take one to two tablets every six hours as needed for pain starting on July 8th and ending on July 24th. The Norco was given on July 10th at 9:56 a.m. due to her mouth hurTing and again on July 11th	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36902	A. BUILDING: _____ B. WING _____	C 08/18/2025

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0 620	Continued From page 11 at 10:53 a.m. for pain in her mouth and it was documented the LPN was aware. Later that day at 8:59 p.m., the resident was given another dose due to mouth pain rated at a 6. The on-call nurse was messaged. The Motrin was given on July 11th at 6:10 a.m. and 3:13 p.m. due to mouth pain. The licensee's complaint log indicated on July 11, 2025, the resident asked for pain medication due to having all her teeth removed on July 8, 2025. "Night staff are NOT med trained and did not contact the manager [LALDIR-A] to come to the facility and administer said pain medication. [R1] waited until 6 a.m. when morning staff arrived to get any sort of pain medicine..." The complaint was reviewed by licensed practical nurse (LPN)-C who took the following action, "Talked with resident about this. Will talk to employees about this. Employee was contacted was very apologizing for not contacting nursing or management." On August 18, 2025, at 1:05 p.m., R1 stated the staff couldn't give her medications because the staff member wasn't qualified to give them. R1 stated, "what could I say, ok I'll suffer?...she couldn't give out meds, they should have someone on call that could." R1 stated she was in a lot of pain so she went back to sleep until the morning shift came and could give her medication. On August 20, 2025, at 11:15 a.m., clinical nurse supervisor (CNS)-B stated the incident was not reported to MAARC as the resident herself had not filed the grievance and the resident said she was ok to wait. CNS-B stated she didn't think	0 620		

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0 620	Continued From page 12 there were concerns for neglect and it was more of a reeducation moment and she had trained three staff members who were not previously medication trained. On August 20, 2025, at 4:41 p.m., owner (O)-F wrote via email, "we truly did not see this as a MAARC report as it truly is/was that the caregiver said she would get the med person and the resident said no, I can wait." The licensee's Vulnerable Adult Maltreatment - Prevention & Reporting policy dated August 2021, indicated if staff suspected maltreatment of a vulnerable adult, they would notify the assisted living director and clinical nurse supervisor. If the Assisted Living Director or Clinical Nurse Supervisor confirmed the suspicion of maltreatment, they would contact the Minnesota Adult Abuse Reporting Center (MAARC). Such report would be made no later than 24 hours after the maltreatment was first suspected. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
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 13 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. 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 potential to affect a large portion or all of the residents). The findings include: On August 18, 2025, at 12:45 p.m., the investigator observed fly tape hanging from the ceiling in the communal living room and the facility dining room. Five fly tapes were hanging from the communal living room ceiling. Most of the tape was covered in dark insects. Four fly tapes were hanging from the facility dining room ceiling, including near areas where residents would eat. Most of the tape was covered in dark insects. On August 20, 2025, at 11:15 a.m., clinical nurse supervisor (CNS)-B stated she had not observed the fly tape recently and was not aware how	0 800		

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0 800	Continued From page 14 many insects were on it and she would reach out to maintenance to take care of it. No further information waas provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
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 required for this tag.	