Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL301334085M
Compliance #: HL301336896C

Date Concluded: March 29, 2023

Name, Address, and County of Licensee Investigated:
Augustana Apartments of Minneapolis
1510 11th Ave South
Minneapolis, MN 55404
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brandon Martfeld, RN
Special Investigator
Carrie Euerle, MPH, MSN, RN, CNP Special Investigator

Finding: Substantiated, facility responsibility

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

Initial Investigation Allegation(s):
The facility neglected a resident after the resident was found outside of the facility and brought to the hospital.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Neglect occurred when the facility failed to take action on their awareness and knowledge of identified risks, safety concerns and a need for increased supervision of the resident. The facility did not assess, provided an increase in services or supervision, attempt to find new placement, and did not develop or implement new interventions to protect the resident's safety.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a paramedic, county case manager, mental health practitioner and the resident's responsible party. The investigation included review of resident records, staff schedules, safety checks, facility incidents, facility policies and procedures and hospital records. Also, the investigator observed the facility, resident's room, and common areas.

Minnesota Statute section 144G.08 subdivision 59, defines "Resident" as an adult living in an assisted living facility who has executed an assisted living contract.

The resident resided in an assisted living facility. The resident had a signed service agreement with the facility that indicated the resident received services that included weekly housekeeping and laundry. The resident also received county services and had a county case manager and a community mental health treatment team involved in his care.

An unknown community member observed the resident walking in a neighborhood several blocks away from the facility in December 2022. The resident fell in the snow several times and appeared confused and lost. When the community member approached the resident, he ran away. The community member contacted emergency medical services (EMS). EMS found the resident walking about in the community and transported the resident to the hospital for an evaluation.

Hospital discharge paperwork indicated the resident was confused and informed his responsible party the resident was to remain under supervision and monitored for the next twenty-four hours. The resident went home with his responsible party and returned to his apartment at the facility the next day.

No report was provided to the facility nursing or administrative staff upon the resident's return to the facility. However, ten days later the Assistant Director of Housing (ADH) received an email from the community mental health practitioner involved with the resident's care. The email detailed safety concerns and the resident should not be outside by himself. The email included a request for an assessment to be completed on the resident and a need for increased supervision. Attached to the email was the resident's recent hospital discharge summary that identified diagnoses of confusion, dementia, and bipolar disorder and included instructions for the resident to avoid unsupervised walks outside due to concerns of falling, getting lost, and not being able to find his way back home.

Twelve days later (one month after the resident's hospitalization), the ADH forwarded the email to the interim regional nurse with a note to bring this to her attention as she was sure the facility nurse or the licensed assisted living director (LALD) had never responded.

The resident's progress notes identified two days after the mental health practitioner's email was forwarded to the regional nurse, a facility staff member found the resident outside in the

snow and the resident could not recall the correct number of his apartment. The staff member included in the progress note she was “concerned” because of an incident that occurred three days earlier when she observed the resident trying to get into an apartment that was not his. There was no follow-up response, documentation, incident report, or assessment completed after the staff member’s report of this incident or entry of the progress note.

Eight days after receipt of the email from the ADH, the regional nurse forwarded the mental health practitioner’s email to the interim nursing consultant.

The interim nursing consultant replied the next day questioning if it was safe for the resident to continue [living] at the facility. The interim regional nurse responded with a request for the resident to be assessed.

No assessment was completed. The facility attempted to complete daily “I’m ok” checks. However, the LALD detailed in an email the resident was not able to remember to consistently complete the requirements of the check. In addition, the facility had no system in place to monitor or audit completion of the checks and the checks were not added to the resident’s service plan.

Over the course of the next three weeks, several emails were circulated between the interim nursing consultant, the resident’s county case manager, and the LALD. The emails all detailed concerns of identified safety risks and the resident’s need for increased supervision. The county case manager made a request for an assessment be completed and for an increase in services to be provided by the facility for the resident’s safety. The facility refused to increase the resident’s services citing staffing concerns, the resident’s need for a secured dementia care unit, and indicated they were unable to provide the resident’s required amount of supervision.

The LALD detailed in an email and in the resident’s progress notes attempts to contact the resident’s responsible party. The emails indicated the facility was aware the resident’s responsible party did not want the resident moved and wanted the facility to increase services provided to the resident.

The resident’s record lacked a discharge notice, efforts to seek alternative placement by the facility and interim safety interventions or services during the almost two-month period when facility staff were first notified of concerns regarding the resident’s decline in cognitive status and need for increased supervision.

During the onsite investigation, the investigator observed the resident outside of the building [in winter] attempting to open a door that required a key fob entry. The key fob temporarily unlocked the door and required the door to be open within a short period of time. After several minutes struggling to open the door before it relocked, the resident turned around and entered through the facility automatic sliding doors. However, the observation was during business hours, while the sliding doors remained open.

During an interview with the interim nursing consultant, regional director of clinical services, the LALD and the AHD, identified the resident as “independent” and stated he did not receive any nursing services. They denied knowledge of the December 2022 hospitalization. However, when email dates, times, and further information was discussed, they acknowledged documented awareness of safety concerns but suggested the lack of action was due to previous administration who did not fulfill their job responsibilities. Despite acknowledgement of identified safety concerns, services were not increased. They also confirmed the resident currently resided at the facility (two months after the hospitalization), but the facility could not meet the increased safety and supervision needs of the resident and that he required placement in a secured dementia unit. However, no additional services or supervision had been implemented.

During an interview with the resident’s county case manager, identified concerns of the resident’s decline in cognitive status and need for additional assistance. The case manager said the facility also identified and informed her of safety concerns. The facility felt the resident was not safe and required an increase in supervision and level of care. The case manager said although the facility had been informed of current and ongoing concerns of the resident’s safety, no assessment had been completed despite multiple requests and the facility refused to provide additional services. In addition, the case manager stated no termination letter or discharge process had been initiated and the facility had not attempted to assist with finding alternative placement for the resident.

The interim nursing consultant was interviewed a second time and indicated she had discussions with facility upper management of the responsibility the facility had due to their awareness of concerns with the resident’s safety. She went on to say that some of the management did not understand the resident did not reside in independent living and was identified as a resident.

During an interview, resident’s responsible party stated when safety concerns were first identified and discussed with her, she was told by the previous facility management the resident’s services would be increased to meet his needs. However, when management changed in mid-December, these services were not available to the resident. She was told the facility could not meet the resident’s needs, he needed more supervision than they could provide, and identified the resident as a liability. The responsible party felt the resident could remain safe in the facility if they increased services as previously suggested.

The resident was interviewed and could not provide the current date or year. The resident did not recall sustaining a fall outside in December and was unable to provide the name of the building or the apartment number in which he resided.

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:
None.

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

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

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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
Minneapolis City Attorney
Minneapolis 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
	30133	A. BUILDING: _____ B. WING _____	C 02/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA APARTMENTS OF MPLS	1509 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: HL301334085M / HL301336896C HL301331861M / HL301333476C On February 14, 2023, through February 15, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 315 total residents with 84 receiving services under the provider's Assisted Living license. The following correction orders are issued for HL301334085M / HL301336896C, tag identification 2320, 2360.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of th 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.	
02320 SS=G	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with	02320		

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02320	Continued From page 1 continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the resident's right to receive health care and other assisted living services with continuity from people who were properly trained and competent to perform their duties and adequately provide services for one of two residents (R2) reviewed. The facility failed to act on their knowledge of identified safety concerns for a resident (R2) with observed and documented cognitive decline who had a need for increased supervision, needs and services. 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: Minnesota Statute, section 144G.08 subdivision 5 defines "Assisted living contract" as the legal agreement between a resident and an assisted living facility for housing and, if applicable, assisted living services. Minnesota Statute, section 144G.08 subdivision 7	02320		

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02320	Continued From page 2 defines an "Assisted living facility" as a facility that provides sleeping accommodations and assisted living services to one or more adults. Minnesota Statute section 144G.08 subdivision 59, defines "Resident" as an adult living in an assisted living facility who has executed an assisted living contract. The licensee had attested they read and understood the Assisted Living licensing statutes under Minnesota Statutes section 144G upon application for Assisted Living licensure on May 31, 2021. The licensee began providing Assisted Living services on August 1, 2021. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated May 31, 2022, indicated the licensee offered the service of daily safety checks and daily "I'm ok" checks. The UDALSA further indicated the licensee offered to residents who resided in the care suites, hourly and every two-hour safety checks, daily safety checks, daily "I'm ok" checks, and emergency and non-emergency call system services. The UDALSA also identified the licensee provided assistance in accessing community resources and social services. R2's facesheet indicated an admission date of July 18, 2022. R2's Assisted Living Contract identifed R2 as a resident of the assisted living facility. The contract was signed by R2, identified as the responsible party, on July 18, 2022. R2's county waiver authorization plan indicated R2 received housekeeping and laundry services from the licensee, however the waiver did not	02320		

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02320	Continued From page 3 identify the date services were initiated. R2's Individual Abuse Prevention Plan (IAPP) dated July 14, 2022, indicated R2 did not have behaviors that posed a risk to self. The IAPP indicated if R2 had behaviors, R2 would seek services. R2's plan of care dated February 12, 2023, indicated R2 received housekeeping and laundry services once a week. A facility email dated December 29, 2022, indicated R2's community mental health practitioner (MHP)-I, sent an email to the assistant director of housing (AHD)-D regarding R2. The email notified the licensee of concerns that R2 was not able to keep himself safe. The email also indicated MHP-I requested the licensee to complete a nursing assessment on R2. Attachments within the email included an after visit summary from an emergency room visit dated 12/16/22. R2's after visit summary from the emergency room, dated December 16, 2022, attached to the December 29, 2022, email to the facility, indicated R2 had psychiatric problems. The after visit summary also indicated R2 had diagnoses of dementia, confusion, and bipolar disorder. The after visit summary instructions indicated R2 was to avoid unsupervised walks outside because of concerns of falling, getting lost and not being able to find his way back home. The facility email dated December 29, 2022, was forwarded from AHD-D to the Regional Director of Clinical Services-(RDCS)-J on January 10, 2023, that included a statement that AHD-D was concerned the licensed assisted living director	02320		

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02320	Continued From page 4 (LALD)-C did not respond [to the email] last week and neither did the registered nurse. There was no documentation of follow-up completed by RDCS-J upon receiving this email. On January 12, 2023, R2's progress notes identified R2 was found outside on his knees stuck in the snow. Staffing Coordinator (SC)-A asked R2 if he needed help getting up, which R2 replied yes. The progress note identified R2's pants were "very wet" and R2 had been outside for a length of time. R2 stated he lived in apartment 221, which was the wrong apartment number. Upon entering the apartment complex, R2 "saw some friends" and had left the writer [SC-A]. The progress note further detailed SC-A "was concerned" about R2 and included detail of an incident that occurred on January 9, 2023,(3 days prior) in which R2 was found attempting to get into apartment 522, which was the incorrect apartment. R2 was told it was the wrong apartment and had left the area. RDCS-J forwarded the December 29, 2022, email she recieved from AHD-D, to registered nurse consultant (RNC)-B on January 18, 2023 (eight days after receiving the email). On January 19, 2023, RNC-B then replied to the email indicating to RDCS-J of safety concerns she had for R2 of going outside. In the email, RNC-B also detailed that the licensee cannot stop the resident from coming and going unless R2 was in a secured memory unit. RDCS-J responded to RNC-B, asking if an assessment can be completed on R2 to determine what R2 needed for services. On January 20, 2023, RNC-B responded to RDCS-J and the newly hired Licensed Assisted	02320		

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02320	Continued From page 5 Living Director (LALD)-C. The email indicated R2's case manager requested the licensee to implement safety checks to increase supervision of R2 because the case manager felt R2 was not safe to go outside alone. RNC-B had called MHP-I who indicated R2 would be closed to their services [assertive community treatment] for medication setup in 60 days because R2 required a higher level of care. The email further indicated MHP-I had concerns of R2 wandering, not being safe to go outside due to cognitive decline and that R2 needed a memory care unit. RNC-B also indicated R2 was not appropriate for assisted living services due to cognitive decline. On January 27, 2023, an email from R2's case manager to RNC-B questioned if R2 had an assessment completed. RNC-B responded to R2's case manager indicating R2 was not appropriate to be placed at the licensee due to cognitive decline. The email further indicated a secured memory care unit was recommended for R2. R2's case manager responded to RNC-B with an email questioning if RNC-B was asking R2 to move out and requested if additional services could be added. RNC-B responded via email to the case manager and included the LALD-C, indicating that R2 could stay because of fair housing but that R2 should seek placement in another facility with a memory care unit due to safety awareness. On February 7, 2023, multiple emails between the case manager, RNC-B, and LALD-C, indicated R2's power of attorney thought the licensee had a memory care unit. The emails then indicated the licensee did not have a memory care unit, and LALD-C had made multiple attempts to speak with R2's power of attorney with no success. The email explained	02320		

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02320	Continued From page 6 that a meeting with R2, the power of attorney, case manager and RNC-B could take place February 16, 2023. R2's record did not include acknowledgement of R2 being found outside and being transported to the hospital on December 16, 2022, or any changes to R2's care. R2's record contained no follow-up or additional safety interventions following the witnessed incident identified in R2's January 12, 2023 progress note, or any detail of the January 9th, 2023 incident. R2's IAPP was not updated following the identified safety concerns and incidents the facility was aware of regarding R2 being found in the community. R2's record did not include indication that the licensee attempted to assist in finding alternative placement, despite their identified safety concerns. During an observation on February 15, 2023, at 10:05 a.m., the investigator observed R2 outside in a courtyard attempting to get in the facility through a dining room door. The dining room door could be heard unlocking after R2 made multiple attempts to unlock the door with a key fob. However, R2 could not unlock the door and pull the door open to get inside. After several attempts, R2 turned away, walked across the courtyard and into the licensee's automatic opening doors. During an interview on February 15, 2023, at 10:16 a.m., R2 stated he had enough services from the licensee to keep him safe. R2 stated he fell in the springtime of 2022, but did not have any memory of falling outside of the licensee in December. During the interview R2 could not recall the name of the apartment he resided in and provided the investigator with the wrong	02320		

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02320	Continued From page 7 apartment number that he resided in. During an interview on February 15, 2023, at 1:05 p.m., R2's case manager stated a county assessment was completed on R2 prior to his admission to the facility. The case manager stated the assessment identified R2 had dementia, however she identified that since the assessment last March 2022, the safety issues and R2's dementia have magnified. The case manager stated she had awareness of safety concerns for R2 to remain unsupervised at the licensee and within the community. The case manager stated she had informed the licensee of these concerns multiple times, which the licensee acknowledged, however refused to increase services for R2. The case manager questioned this as the licensee had been billing R2 for assisted living services for laundry and housekeeping but refused to increase services when safety concerns had been identified. The case manager acknowledged that R2's responsible party did not feel R2 was unsafe, however there were documented incidents of R2 found wandering and confused throughout the community. The case manager stated the licensee was also aware of these incidents and concerns, but had not issued a termination letter, or attempted to assist with finding other placement for R2. The licensee only declined to increase services, despite their acknowledgement of R2's decline in cognition and the licensee indicating R2 required a secured memory unit. During an interview on February 15, 2023, at 1:17 p.m., SC-A stated on January 12, 2023, she found R2 outside kneeling in the snow. SC-A stated R2 said he needed help getting up. R2 appeared to have been outside for a while	02320		

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02320	Continued From page 8 because his pants were "really wet." SC-A escorted R2 inside of the building and down to the business office. R2 remembered where he lived once they got to the business office. SC-A stated she wrote a progress note about the incident and told an RN. The RN no longer worked at the facility. SC-A also stated R2 was found on a different date, on the wrong floor, attempting to get into another resident's apartment. SC-A told R2 he was at the wrong apartment. R2 left the area and went downstairs to have a cigarette. SC-A stated she did not fill out an incident report when she found R2 outside in the snow. During an interview on February 15, 2023, at 1:58 p.m., RNC-B, LALD-C, AHD-D and Regional Director of Operations (RDO)-E identified R2 as independent and that R2 received no nursing services. The team acknowledged R2 was found outside on January 12, 2023. However, the team stated there was no documentation and denied acknowledgement that R2 was found outside and transported to the hospital on December 16, 2022. The team acknowledged R2's case manager had brought forward concerns of R2 needing more supervision because of not being safe to be outside independently. The team stated they were not able to add services to keep R2 safe because of staffing concerns. LALD-C stated R2 was on okay checks. LALD-C went on to say that okay checks were a voluntary program for residents in which the resident would slides a plaque back and forth at the beginning of the day indicating they were okay. R2's okay check was to be completed every 24 hours. If R2 did not move the plaque, then staff would knock on the door, if no answer at the door, then a phone call would be completed. If R2 did not answer the phone, then a staff member would key into R2's	02320		

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	30133	A. BUILDING: _____ B. WING _____	C 02/15/2023

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02320	Continued From page 9 apartment. R2, at times, did not remember to move the plaque. LALD-C identified the " I'm Ok check" as an informal process informal. LALD-C was questioned regarding the documentation process of the "I'm OK checks" as some checks were documented and some were left blank with no follow up. LALD-C confirmed staff were not utilizing a consistent process for the checks. The team also acknowledged no reports had been filed with the state agency regarding R2. During an interview on February 23, 2023, at 8:20 a.m., paramedic-H stated he answered the call of R2 being found outside confused and repeatedly falling on December 16, 2022. Upon arrival, R2 was found cold, and confused. R2 thought the year was 1980. The paramedic had concerns R2 was self-neglecting and unsafe. During an interview on February 23, 2023, at 9:20 a.m., RDCS-J indicated her role at the licensee was to help the nursing team with compliance and training. RDCS-J further stated she was aware of R2's safety concerns, however stated an increase in services would not keep R2 safe. RDCS-J indicated R2's family was responsible for keeping R2 safe because R2 was not on clinical services. RDCS-J stated R2 could not be moved out of the licensee because R2 was not on clinical services. RDCS-J acknowledged and confirmed R2 lived at the assisted living facility and received laundry and housekeeping services. RDCS-J indicated the extended dates between the email response from December 29, 2022, until January 10, 2023 was because the previous LALD had not completed her job responsibilities and was terminated. During an interview on February 24, 2023, at 12:24 p.m,. MHP-I stated R2's cognition had	02320		

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02320	Continued From page 10 significantly declined since the fall of 2022. MHP-I was aware of R2 falling multiple times while outside of the licensee and being transported to the hospital on December 16, 2022. The MHP-I was told about a nursing assessment that was to be completed on R2 in December to increase services. However, when MHP-I reached out to the licensee, the licensee did not respond. During an interview on February 27, 2023, at 12:52 p.m., R2's responsible party (RP)-L indicated a previous director of nursing (DON) told her the licensee would increase services for R2 between November 15, 2022 and December 15, 2022. Then the DON quit in December and R2 did not get upgraded on his services. Then on February 16, 2023, there was a meeting with R2, RP-L and the licensee. LALD-C explained to R2 that he could no longer live at the licensee because he was a liability and a safety risk. During an interview on February 28, 2023, at 12:20 p.m., RNC-B stated conversations with R2's case manager and MHP-I informed R2 needed more supervision due to cognitive decline and required placement in a secured unit. RNC-B stated both RDCS-J and RDO-E were aware of R2's situation and that recommendations were to find R2 a secured memory care unit. RNC-B stated a termination notice or assistance to find new placement had not been completed. RNC-B then stated regulation changed as of August 2021, and that all resident's were now overseen by the licensee. RNC-B stated some staff at the licensee did not understand that regulation change and continued saying R2 was independent without services. RNC-B stated R2 was the responsibility of the licensee because he was a resident of the building.	02320		

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02320	Continued From page 11 R2's record lacked documentation of follow-up or the requested assessment(s) indicated in emails to the licensee. The licensee's Behavior Management policy dated October 10, 2022, indicated examples of behaviors included wandering. The policy further indicated behaviors would be identified, assessed, and interventions would be coordinated with the resident, family, and staff. The licensee's Abuse Prohibition policy dated February 21, 2019, indicated neglect included self-neglect. The policy defined neglect as 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. The policy further indicated all residents were considered vulnerable adults and the RN is to evaluate the vulnerability of each vulnerable adult and develop interventions as part of the individual abuse prevention plan. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
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 two residents reviewed (R2) was free from maltreatment. Findings include:	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	

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02360	Continued From page 12 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		