Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL402878742M
Compliance #: HL402876401C

Date Concluded: March 26, 2025

Name, Address, and County of Licensee Investigated:
Shekky Care Services Professional Corporation
1160 Chicago Avenue
Saint Paul Park, Minnesota 55071
Washington County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Nicole Myslicki, RN
Special Investigator
Rhylee Gilb, 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 resident 1 and resident 2 when staff failed to supervise resident 1 who started a fire at the facility.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility knew resident 1 smoked in his room and had continued mental health and drug induced psychosis issues. Four days prior, resident 1 left the facility and went to a location suspected of where he typically obtains methamphetamine. The facility failed to adequately assess resident 1 and did not have specific interventions in place to reduce the risk of a fire starting. Resident 1 started a fire in his room and drug paraphernalia with drug substance was found. The day of the fire the scheduled unlicensed personnel (ULP) called into work and the AP worked alone. The AP worked intermittently at the facility as an

unpaid volunteer and was not normally at the facility alone. The AP received proper emergency training and responding to the fire incident appropriately, putting out the fire and evacuating the residents, while resident 2 called 911. The AP was not responsible for the maltreatment involving the fire.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted resident 1's guardian, law enforcement, and resident 2's case manager. The investigation included review of the resident records, facility incident reports, personnel files, staff schedules, law enforcement reports, fire department report, and related facility policy and procedures. Also, the investigator observed resident 1's bedroom, food, and cleanliness of the facility.

Resident 1 resided in an assisted living facility. Resident 1's diagnoses included several mental health diagnoses and substance abuse. Resident 1's service plan included medication management. The service plan identified goals including assuring safety but did not include safety interventions. Resident 1's assessment indicated resident 1 smoked in his room and chose not to go to the designated smoking area. The assessment indicated resident 1 previously burnt the side of his bedsheet with a cigarette. The assessment identified resident 1 as able to safely use a lighter or matches and smoking materials but did misuse it when smoking in his room.

Facility incident reports included incidents during the month prior to the fire when staff presumed resident 1 was under influence of drugs. Resident 1 threatened to hit staff and others with a metal iron and had delusions and paranoia about the FBI (Federal Bureau of Investigations). Resident 1 had another incident of experiencing auditory and visual hallucinations the FBI had surrounded the house. Resident 1 was yelling and barricading the doors. The incident report indicated resident 1's behaviors were concerning and to continue monitoring closely his mental state and medication compliance for safety of himself and others.

A facility incident report four days prior to the fire indicated staff presumed he was heading to a location where he typically acquired methamphetamine. Staff reminded resident 1 he was not permitted to leave facility and use drugs. Resident 1 chose to leave anyway. The facility initiated a missing resident when he failed to return. The report indicated there was concern about resident 1's mental health in the days prior with erratic behavior involving need to contact law enforcement. When law enforcement did locate resident 1, he fled. Later he showed up to a homeless shelter and the director contacted the facility. The director recommended to the facility resident 1 needed a mental health worker and intensive residential treatment program for 90 days to address substance abuse.

Resident 1's vulnerability assessment completed four days prior to the fire incident, indicated resident 1 had confusion, disorientation, inability to understand or follow instructions related to mental health diagnoses. Resident 1 had substance abuse issues with drug induced psychosis. The assessment section to evaluate current safety measures indicated resident 1 had

medication management, shower reminders and assistance with laundry. The assessment section to check mark identified goals and interventions was incomplete with nothing checked. Resident 1's individual abuse prevention plan (IAPP) indicated his only vulnerability was risk for physical abuse towards others. The IAPP section for self-abuse, including engaging in self-injurious behaviors was left blank. Resident 1's record failed to include interventions to help reduce the risk for fires or to ensure safety due to resident 1 smoking in his room.

Resident 1's service delivery record included behavior monitoring but failed to include specific direction of interventions for staff to take when resident 1 experienced behaviors. The service delivery record indicated for about one week leading up to the fire incident, resident 1 engaged daily in smoking in his room, property destruction, and yelling and banging on walls. He also experienced hallucinations daily during that time.

A facility incident report indicated smoke detectors went off early in the morning. Smoke came from resident 1's room and filled the entire common area. Staff responded and went to resident 1's room. The staff member instructed resident 1 to open his door, but he refused and had barricaded the entrance to his room. Resident 1 became increasingly agitated and stated it was not a big deal and he was okay. The staff member proceeded to use an extra key to gain access. Due to the extent of the smoke and potential fire hazard, staff forced entry into the room. Resident 1 had been smoking in his room and staff found drug paraphernalia and what appeared to be illegal drugs. Resident 1 appeared confused, restless, and disoriented. Resident 1 stated the FBI started the fire. Staff called 911 and resident 2 evacuated from the facility.

A fire department's fire report indicated although they received an initial notice of smoke at the facility, but it had been cancelled. They were then called by law enforcement to come to the facility due to a resident knocking over a candle in his room. The candle ignited a plastic laundry basket filled with mail. This burned into the wood floor and caused smoke. The burn extended into the flooring, which the fire department extinguished.

A law enforcement report indicated resident 1 started a fire in his room which posed a significant risk to all residents and staff at the facility. The report indicated the nurse stated resident 1 had been a danger to himself and others due to a series of alarming incidents. There were concerns regarding his mental state and overall safety. Staff members reported resident 1 appeared confused and possibly under the influence of illegal drugs, as evidenced by erratic behavior. Law enforcement observed several burned items in resident 1's room.

During an interview, the nurse stated resident 1 had a history of smoking in his room. Resident 1 had already received a warning and a thirty (30) day notice. The morning of the incident, the nurse received a call from the AP, stating resident 1 started a fire. He had been trying to get residents 1 and 2 out of the facility and put out the fire. Resident 1 also had a history at the facility of removing the smoke detector from his room, as well as locking and barricading his door closed. Interventions in place included informing resident 1 he could not smoke in his room, giving a warning, placing him on a probationary period, and calling law enforcement

when they thought he appeared to be under the influence of illegal drugs. The facility staff also tried to perform safety checks when they thought he had been using drugs. The nurse also stated they tried to keep his lighter, but he purchased more when he left the facility.

During an interview, resident 2 stated she woke up to the fire alarm sounding. Resident 2 went upstairs, saw smoke and called 911. Resident 2 stated several drug paraphernalia items were observed in resident 1's room and thought it looked like staff never checked on him.

During an interview, the AP stated worked at the facility as an unpaid volunteer. Normally, the AP worked with a staff member, lifting, helping in the kitchen, and cleaning. For the shift on which the fire incident occurred, another staff member should have been at the facility, but they called in. The nurse informed the AP of the call in and that he would be alone for the shift. The AP stated he received training on fires and emergencies. He followed the procedure he observed during a fire drill at the facility, which included assessing the situation and intensity of the fire and calling the fire department if necessary. Early in the morning, the AP smelled the fire before the alarms went off. The AP went to resident 1's room to check on him, but resident 1 responded everything had been fine. The smoke detectors then went off, and resident 2 came upstairs. The AP requested resident 2 evacuate the facility and went to resident 1's room with a key. After gaining entry, the AP observed fire, smoke, and resident 1 standing in his room. Resident 1 told the AP everything was fine, and the AP should not come close to him. The AP got water from the kitchen and put out the fire. Resident 2 called 911. After law enforcement arrived, resident 2 agreed to evacuate the facility. The AP showed them resident 1's room, and they observed smoldering fire coming from under the flooring. Law enforcement called the fire department who came and pulled up flooring to see if there was a threat to reignite, then they left. The AP then helped resident 1 clean his room, and the nurse arrived.

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.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):

(1) The AP did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The facility did not direct an erroneous order, direction, or care plan.

(2) The facility was not in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility failed to provide adequate staffing levels.

The facility did not follow the facility directive and/or policies and procedures.

(3) The facility failed to follow professional standards and/or exercise professional judgement.

The facility failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: Resident 1: No, resident 1 declined to interview. Resident 2: Yes.
Family/Responsible Party interviewed: Resident 1: Yes. Resident 2: No. No family available and resident 2 is her own responsible party.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility completed incident reports and complied with law enforcement.

Action taken by the Minnesota Department of Health:
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
Washington County Attorney
Saint Paul Park City Attorney
Saint Paul Park 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
	40287	A. BUILDING: _____ B. WING _____	C 02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEKKY CARE SERVICES PROFESSIONAL C(	1160 CHICAGO AVENUE ST PAUL PARK, MN 55071

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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: HL402876401C/HL402878742M HL402871800C/HL402871240M On February 4, 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 was 1 resident receiving services under the provider's Assisted Living license. The following correction orders are issued for HL402876401C/HL402878742M, tag identification 630, 1290, 2360. The following correction orders are issued for HL402871800C/HL402871240M, tag identification 630, 1290.	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.	
0 630 SS=G	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to adequately assess and develop individual abuse prevention plans (IAPP) with specific interventions in place to reduce risks and vulnerabilities three of three residents (R1 R2, R3) reviewed. R1 started a fire in his room. 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 R1 admitted to the licensee February 1, 2024. R1's diagnoses included bipolar disorder and substance abuse. R1's service plan dated January 31, 2024, indicated R1 received	0 630		

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0 630	Continued From page 2 medication management. R1's service plan identified goals including assuring safety but did not include safety interventions. R1's assessment dated August 14, 2024, indicated R1 had a history of smoking in his room and chose not to use the designated smoking area, and previously burned his bed sheet with a cigarette. The assessment identified R1 as able to safely use a lighter or matches and smoking materials but did misuse it when smoking in his room. An incident report dated December 5, 2024, indicated R1 had an episode of experiencing auditory and visual hallucinations the Federal Bureau of Investigations (FBI) had surrounded the house. R1 was yelling and barricading the doors. The incident report identified R1's behaviors as concerning and indicated staff would continue closely monitoring his mental state and medication compliance for safety of himself and others. An incident report dated December 10, 2024, indicated R1 threatened to hit staff and others with a metal iron and had delusions and paranoia about the FBI. An incident report dated January 15, 2025, indicated R1 left the licensee, informing staff he was going to the mall. The report indicted staff presumed R1 was heading to a location he typically acquired methamphetamine. R1 did not return to the licensee. The licensee notified law enforcement and filed a missing person report. R1 fled from law enforcement when he was found. Later, R1 showed up at homeless shelter and the director contacted the licensee. The director recommended to the licensee R1 needed a mental health worker and intensive residential treatment program for 90 days to address	0 630		

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0 630	Continued From page 3 substance abuse. R1's IAPP dated January 15, 2025, indicated R1 had a history of abusive behavior towards others and risk factors including mental health conditions and drug-induced psychosis. The IAPP indicated R1 sometimes did not have insight to his mental illness when experiencing drug-induced psychosis and not mentally stable. The IAPP section for self-abuse, including engaging in self-injurious behaviors was left blank. R1's record failed to include interventions to help reduce the risk for fires or to ensure safety due to R1 smoking in his room. R1's service delivery record dated January 2025, included behavior monitoring. Behavior monitoring included for aggression, destructive property, yelling, banging on walls, hallucinations, signs of drug induced paranoia, and concerns of smoking in his room. However, the service delivery record and IAPP failed to include specific direction of interventions for unlicensed personnel (ULP) to take when R1 experienced behaviors. An incident report dated January 19, 2025, indicated smoke detectors went off early in the morning. Smoke came from R1's room and filled the entire common area. Staff responded and went to R1's room. The staff member instructed R1 to open his door, but he refused and had barricaded the entrance to his room. R1 became increasingly agitated and stated it was not a big deal and he was okay. The staff member proceeded to use an extra key to gain access. Due to the extent of the smoke and potential fire hazard, staff forced entry into the room. R1 had been smoking in his room and staff found drug paraphernalia and what appeared to be illegal drugs. R1 appeared confused, restless, and	0 630		

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0 630	Continued From page 4 disoriented. R1 stated the FBI started the fire. Staff put out the fire, and resident 2 called 911 and evacuated from the building. A fire department's fire report dated January 19, 2025, indicated although they received an initial notice of smoke at the facility, but it had been canceled. They were then called by law enforcement to come to the facility due to a resident knocking over a candle in his room. The candle ignited a plastic laundry basket filled with mail. This burned into the wood floor and caused smoke. The burn extended into the flooring, which the fire department extinguished. During an interview February 5, 2025, at 9:34 a.m., registered nurse (RN)-A stated R1 had a history of smoking in his room. R1 had already received a warning and a thirty (30) day notice. The morning of the incident, RN-A received a call from ULP-C, stating R1 started a fire. He had been trying to get R1 and R2 out of the facility and put out the fire. R1 also had a history at the facility of removing the smoke detector from his room, as well as locking and barricading his door closed. Interventions in place included informing R1 he could not smoke in his room, giving a warning, placing him on a probationary period, and calling law enforcement when they thought he appeared to be under the influence of illegal drugs. The licensee also tried to perform safety checks when they thought he had been using drugs. RN-A stated they tried to keep R1's lighter, but he purchased more when he left the facility. R2 R2 admitted to the licensee November 26, 2024. R2's diagnoses included anxiety. R2's service plan dated November 26, 2024, indicated she received assistance with monitoring for	0 630		

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0 630	Continued From page 5 heightened anxiety. R2's service plan identified goals including assuring safety but did not include safety interventions. R2's IAPP dated November 26, 2024, indicated R2 had a history of abusive behaviors towards others. The IAPP did not identify any specific goals or interventions to address R2's vulnerabilities and minimize the risk of abuse. R3 R3 admitted to the licensee December 2, 2024. R3's diagnoses included schizoaffective disorder. R3's service plan dated December 2, 2024, indicated he received assistance with monitoring for heightened anxiety. R3's service plan identified goals including assuring safety but did not include safety interventions. R3's IAPP dated December 2, 2024, included a section titled Physical Abuse. Within the section, RN-A answered "no" to the question asked if R3 was susceptible to physical abuse. The IAPP did not identify R3 as having inappropriate interactions with others or as being verbally/physically abusive to others. The IAPP did not identify any specific goals or interventions to address R3's vulnerabilities and minimize the risk of abuse. The IAPP indicated the licensee did not have knowledge of R3 committing a violent crime or act of physical aggression toward others. An incident report dated January 13, 2025, indicated R3 verbally threaten to physically assault other residents. R3 contacted law enforcement to complain about his peers. Law enforcement talked with residents and left. Immediately after law enforcement left, R3 threatened to physically harm a female peer [R2], approaching her closely, displaying anger and	0 630		

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0 630	Continued From page 6 irritability. R2 said she would defend herself. R3 called law enforcement again. R3 was arrested and taken to jail, determined to be the aggressor. A law enforcement report dated January 13, 2025, indicated law enforcement responded to reports of verbal dispute. R2 threatened R3 with use of pepper spray. R3 confronted R2 who was sitting on the couch, gesturing towards R2 while yelling and using profanity. R2 warned R3 if he did not move away she would pepper spray him. R3 told R2 he would "break her in half" before she could spray him. The facility owner (OW)-B, onsite, told law enforcement R3 had exhibited verbal aggression towards other residents and pushed a male resident at one time. Law enforcement took R3 into custody. R2 stated because of R3's verbal outbursts, she carried pepper spray. During an interview on February 4, 2025, at 12:06 p.m., R2 stated when law enforcement first arrived, R3 complained about R1. R2 stated she told law enforcement R1 was not the problem, R3 was. R3 told R2 to shut her mouth and law enforcement told R3 not to talk to her that way. After law enforcement left, R3 told R2 he did not care what law enforcement said, he would snap her in half before she could spray him with pepper spray. R2 stated OW-B was present and just sat there and said nothing. During an interview on February 5, 2025, at 9:34 a.m., RN-A stated R3 had anger issues and could be triggered easily. After the incident, she completed education with staff on how to redirect residents during verbal altercation and how to de-escalate situations. During an interview on February 5, 2025, at 10:56	0 630		

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0 630	Continued From page 7 a.m., OW-B stated during the altercation with R2 and R3, he instructed R2 to go downstairs and take a nap. He told R3 to take his medications. During an interview on February 21, 2025, at 10:03 a.m., R3 confirmed the same information as the law enforcement report and his verbal threat to R2. He stated they had a loud verbal confrontation. R3 stated OW-B had been there the whole interaction and did nothing. R3 stated OW-B was careless, negligent, lacked supervision and lacked protection from an attempt of assault upon him. R3 stated when law enforcement arrived, OW-B did not interact with them, sat in a chair and did nothing. R2 and R3's IAPPs failed to be updated after the incident on January 13, 2025. During an interview March 25, 2025, at 10:00 a.m. RN-A stated she completed IAPPs upon admission, then with 14 day assessments, 90-day assessments, and as needed. "As needed" meant when any incident happened, causing a need to update the IAPP. RN-A stated if a vulnerability was identified, interventions would be identified to help reduce the risk. The licensee's policy Individual Abuse Prevention Plan dated January 1, 2024, indicated the licensee would develop and implement an IAPP for each vulnerable adult. The plan would contain an individualized review or assessment, including specific measures to be taken to minimize the risk of abuse to that person or other vulnerable adults. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		

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01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of three employees (volunteer (VOL)-C) had a cleared background study before having access to residents. This had the ability to affect all residents (R1, R2). 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 admitted to the licensee February 1, 2024.	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40287	A. BUILDING: _____ B. WING _____	C 02/04/2025

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01290	Continued From page 9 R1's diagnoses included bipolar disorder and substance abuse. R1's service plan dated January 31, 2024, indicated R1 received assistance with reminders to perform grooming and dressing and medication administration. R1's service plan identified goals including assuring safety. R1's assessment dated August 14, 2024, indicated R1 had a history of smoking in his room and once burnt his bedsheet with a cigarette. R2 admitted to the licensee November 26, 2024. R2's diagnoses included anxiety. R2's service plan dated November 26, 2024, indicated she received assistance with monitoring for heightened anxiety. R1's service plan identified goals including assuring safety. During an onsite visit February 4, 2025, at 2:47 p.m., the investigator requested VOL-C's personnel file from registered nurse (RN)-A. During an interview February 4, 2025, at 3:29 p.m., RN-A stated she could not find VOL-C's file and needed to check her office. During email correspondence February 10, 2025, at 11:20 a.m., RN-A indicated owner (OW)-B hired VOL-C to volunteer on October 10, 2024. RN-A indicated she could not locate VOL-C's background study clearance results, so she ran a background check February 7, 2025. The licensee's staff roster, undated, indicated VOL-C started working as a volunteer at the licensee December 25, 2024. The licensee's staff schedule for January 2025, indicated VOL-C had been scheduled January 4, 2025, and January 19, 2025.	01290		

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01290	Continued From page 10 During an interview February 12, 2025, at 9:33 a.m. VOL-C stated he started working as an unpaid volunteer around November 2024. He helped with mostly everything except signing documentation and medications. VOL-C stated he normally worked with a staff member, but on January 19, 2025, the staff member called in. VOL-C stated he was not supposed to be alone that shift. The licensee-provided policy Background Studies, dated January 20, 2024, indicated the licensee would conduct a Minnesota Department of Human Services (DHS) background study on all employees and volunteers. The policy also indicated no employee could provide direct services and have independent direct contact with any residents until acceptable result of the background study had been received. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
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 three resident(s) reviewed (R1) was free from maltreatment. Findings include:	02360	No plan of correction is required for this tag.	

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02360	Continued From page 11 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(s) for details.	02360		