Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL313376962M
Compliance #: HL313371521C

Date Concluded: December 31, 2024

Name, Address, and County of Licensee Investigated:
Highland GW LLC
1925 Graham Avenue
St. Paul, MN 55116
Ramsey County

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

Evaluator's Name: Willette Shafer, RN
Special Investigator

Finding: Substantiated, facility and individual responsibility

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

Initial Investigation Allegation(s):
The facility neglected the resident when the facility failed to provide supervision during a meal and the resident choked and died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility and alleged perpetrator (AP) #1 and AP #2 were responsible for the maltreatment. Multiple unlicensed personnel (ULP), AP #1 and AP #2 (both registered nurses) failed to perform lifesaving medical care during an emergency after resident #1 choked during a meal in the dining room. Resident #1 required a pureed diet with honey thick liquids. Resident started to convulse in the dining room and ULP #1 lowered him to the floor. While resident #1 was on the floor in the dining room, resident #2 told multiple staff resident #1 stuffed another resident's food in his mouth. The staff failed to provide abdominal thrusts (Heimlich Maneuver), or call emergency medical services and resident #1 died.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the hospice provider. The investigation included review of resident records, death record, facility internal investigation, facility incident report, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator toured the facility and observed interactions between residents and staff during a meal.

Resident #1 resided in an assisted living memory care unit. Resident #1's diagnoses included dementia, depression, and difficulty walking. Resident #1's service plan included assistance with bathing, grooming, mobility, transfers, and meals. Resident #1 received a puree diet with honey thickened liquids. Resident #1's assessment indicated he required supervision at meals.

The day before the incident, AP #1 completed resident #1's assessment. AP #1 assessed resident #1 vital signs were within normal limits, he had a regular rhythm heart beat and his lungs sounds were cleared with non-labored breathing.

Resident #1's progress notes, on the date of the incident, time stamped just before dinner, indicated resident #1's vital signs were all stable and within normal limits. AP #1 documented she sat and talked with resident #1 and he was comfortable.

According to the incident report, while resident #1 was in the dining room he stood up and was having difficulty breathing. ULP lowered resident #1 to the floor and notified the nurses. Resident #1's vital signs recorded a temperature of 97.5, pulse of 46 beats per minute (bpm) (normal between 60-100 bpm) and oxygen saturation was 35% (normal above 90%). There was no recorded blood pressure or respirations.

A progress note documented by AP #1, written at 6:49 p.m., indicated ULP reported resident #1 was unresponsive. AP #1 documented, upon arrival to the dining room resident #1's was lying on the floor and his pupils were non-dilated. AP #1 documented the same vitals as the incident report. AP #1 called hospice and left a voice message. After speaking to the hospice nurse, they moved resident #1 to his room. Upon investigation, it was reported resident #1 had finished eating his own food (puree and honey thickened liquids) and another resident at the table gave resident #1 a sandwich.

Resident #1's death record he died the day of the choking incident. The death record indicated the cause of death was asphyxia (deprived of oxygen) due to choking on a food bolus.

During an interview, ULP #1 said he assisted resident #1 with eating in the dining room. After he assisted resident #1, ULP #1 assisted a different resident. While feeding the other resident, he observed resident #1 stand up. Resident #1 appeared like he was going to vomit. ULP #1 assisted resident #1 to the floor and ULP #2 went to get help. ULP #1 said resident #2 reported another resident at their table gave resident #1 something to eat. Resident #2 said this while he

assisted resident #1 to the floor and again when other staff were present, including AP #1 and AP #2. He said AP #1 and AP #2 tried to see if resident #1 was choking by looking in his mouth. Resident #2 also reported which resident gave resident #1 food during the incident. He said AP #1 and AP #2 arrived quickly after he lowered resident #1 to the floor and assessed vital signs, but he denied anyone performed the Heimlich Maneuver. ULP #1 said the facility never provided him with training on how to perform the Heimlich Maneuver.

During an interview, resident #2 said she sat at the same table resident #1 sat at during dinner. She said she observed another resident give resident #1 half of his sandwich. Resident #1 shoved the whole sandwich in his mouth. Resident #1 tried to get it [the sandwich] down, but he choked. He started to convulse, and staff lowered him to the floor. She said staff tried to get the food out of his mouth, but nobody performed the Heimlich Maneuver. She said she told everyone resident #1 ate another resident's food while resident #1 was on the dining room floor. She said all the staff including AP #1 and AP #2 were present when she reported it. She identified which resident gave him food. Resident #2 said AP #1 asked her again later about the incident, and she told her the same thing, that another resident gave him their food.

During an interview, ULP #2 said he observed resident #1 shaking and ULP #1 lowered him to the ground. ULP #2 said he went to get the nurses and ULP #3 who was administering medications. He said ULP #3 took the residents vitals. ULP #2 said did not hear anyone say resident #1 choked.

During an interview, ULP #3 said he was passing medication during the incident. He saw resident #1 on the floor with ULP #1 and ran to get help. When the AP #1 and AP #2 arrived, they assessed resident #1's vitals. While resident #1 was on the dining room floor resident #2 told everyone, resident #1 ate another resident's food. He said AP #1 and AP #2 looked in resident #1's mouth but could not see anything. He said the Heimlich Maneuver was not performed during the emergency. They contacted hospice and moved resident #1 out of the dining room. He said the facility provided training on the Heimlich Maneuver after the incident.

During an interview, AP #1 said ULP #3 alerted her of the incident. When she arrived resident #1 was laying on the dining room floor, unresponsive, not breathing. She assessed vital signs and called hospice. She said she never assessed resident #1's mouth for an airway obstruction. She said she was aware resident #1 had a history of eating other resident's food. AP #1 completed the internal investigation. She said she never heard about resident #1 eating another resident's food until after the incident.

During an interview, AP #2 said staff reported resident #1 was unresponsive in the dining room. When she arrived, resident #1 was on the floor not breathing. She said they assessed vitals and listened for heart and lung sounds. She denied she looked in resident #1's mouth for an airway obstruction. The Heimlich Maneuver/chest thrusts were not performed. She never heard resident #2 report resident #1 ate something until after the incident. The incident shocked her because resident #1 was not sick. She said if she knew resident #1 choked, she would have

performed chest thrusts and called emergency services. She said caregivers are trained through a video on the Heimlich Maneuver but there was no demonstration or competency completed.

During an interview, resident #1's guardian said he received a phone call from AP #1 informing him resident #1 died the day before. He said AP #1 said he collapsed in the dining room and died. The next day hospice told the guardian she heard from residents and staff at that facility, resident #1 choked and died. Hospice encouraged the guardian to request a copy of the incident report. He called the facility and sent emails requesting a copy of the incident report but never received anything. He said the death certificate identified choking as the cause of death, but staff never administered aid to the resident.

During an interview, a member of management said ULP are not trained on how to perform the Heimlich Maneuver or trained on cardiopulmonary resuscitation. The nurses are expected to perform those procedures if needed and if nurses are unavailable, ULP are instructed to call emergency services.

ULP #1's training record indicated ULP #1 received training on the Heimlich Maneuver. The training record is signed by a registered nurse who is no longer identified on the licensee's staff roster.

ULP-2's training record lacked documented training specific to the Heimlich Maneuver. ULP #2'sctraining record was dated, two weeks after the incident. Also, the handling of various emergencies box was not marked as completed in the boxed titled "Observation of Competency" or "Training Completed".

ULP #3's training record lacked documented training on the Heimlich Maneuver.

The facility's emergency response policy included choking as an example of a significant emergency to call 911, however, the policy directed staff to call hospice if a resident who was hospice experienced an emergency and not 911.

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) AP #1 and AP #2 followed an erroneous order, direction or care plan with awareness and failure to take action.

The facility directed an erroneous order, direction, or care plan.

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

The facility failed to provide proper training and/or supervision of staff.

The facility provided adequate staffing levels.

The facility and AP #1 and AP #2 followed the facility directive and/or policies and procedures.

(3) The facility and AP #1 and AP #2 failed to follow professional standards and/or exercise professional judgement.

The facility and AP #1 and AP #2 failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes, both AP #1 and AP #2.

Action taken by facility:
The facility conducted an internal investigation and reported the incident to the licensed assisted living director.

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

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the

Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Ramsey County Attorney
St. Paul City Attorney
St. Paul 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
	31337	A. BUILDING: _____ B. WING _____	C 12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND GW LLC	1925 GRAHAM AVENUE SAINT PAUL, MN 55116

(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: HL313379485C/HL313376343M HL313371521C/HL313376962M On December 3, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 24 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for HL313379485C/HL313376343M, tag identification 0470, 1760, and 2360. The following correction orders are issued for HL313371521C/HL313376962M, tag identification 620, 2320, and 2360.	0 000	The Minnesota Department of Health documents the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule number out of compliance are listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule 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/RULES.	
0 470 SS=G	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 facility had sufficient staffing 24 hours per day to meet the scheduled and reasonably foreseeable unscheduled needs for 5 of 6 residents (R1, R3, R4, R6, R7) reviewed. The facility had insufficient staffing for at least one shift 12 out of 30 days in September. Additionally, the facility had insufficient staffing for at least one shift eight out of 31 days in the month	0 470		

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0 470	Continued From page 2 of October. On one day the facility was critically understaffed and without unlicensed personnel (ULP) trained to provide all services, R1 was physically restrained to his wheelchair. The assisted living residents, R3, R4, R6, R7 went without all morning medications. 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: The licensee's Staffing Plan last reviewed December 6, 2024, indicated the staffing pattern is assessed every six months and staffing numbers are based on acuity assessed by the registered nurse and determined by the Uniform Assessment Tool. The licensee will ensure sufficient staffing 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. In addition, a minimum of two trained staff are needed to administer medications and two direct-care staff must be scheduled to provide other services on both day and evening shift. The night shift must have one trained staff to administer medications and two direct-care staff. The licensee time and attendance and timecard report for agency staff records reviewed September 1, 2024, through September 30, 2024,	0 470		

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0 470	Continued From page 3 indicated the following dates and shifts where licensee's staffing plan minimum staffing requirements were not met, less than four unlicensed personnel (ULP) on days (6:30 a.m. to 2:30 p.m.) and evening shifts (2:30 p.m. to 10:30 p.m.) and less than three ULP on overnight shift (10:30 p.m. to 6:30 a.m.): September 1, 2024: three ULP worked on day shift. September 3, 2024: two ULP worked on evening shift, 2 additional ULP did not arrive until 7:15 p.m. and 8:15 p.m. September 5, 2024: three ULP worked on day shift; there was one ULP in training on day shift. September 6, 2024: three ULP worked on day shift; there was one ULP in training on day shift; two ULP worked on overnight shift. September 7, 2024, three ULP worked on day shift; there was one ULP in training on day shift. September 9, 2024, two ULP worked on overnight shift. September 18, 2024, three ULP worked on day shift; a fourth ULP did not arrive until 10:00 a.m. September 20, 2024, three ULP worked on day shift; three ULP worked on evening shift. September 21, 2024, two ULP worked the full hours of day shift, a third ULP worked from 11:15 a.m. to 2:30 p.m. September 27, 2024, two ULP worked on overnight shift. September 29, 2024, two ULP worked on day shift; one ULP arrived an hour early from evening shift at 1:30 p.m., two ULP worked on overnight shift. September 30, 2024, three ULP worked on day shift, two ULP worked on overnight shift. The licensee time and attendance records reviewed September 1, 2024, through September	0 470		

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0 470	Continued From page 4 30, 2024, indicated the following dates and shifts where licensee's staffing plan minimum staffing requirements were not met, less than four unlicensed personnel (ULP) on days (6:30 a.m. to 2:30 p.m.) and evening shifts (2:30 p.m. to 10:30 p.m.) and less than three ULP on overnight shift (10:30 p.m. to 6:30 a.m.): According to the licensee's census dated September 29, 2024, 29 residents received services at the facility; 17 residents resided on the first-floor assisted living area while 12 residents resided on the second-floor secured memory care. The licensee's Daily Schedule dated September 29, 2024 (a Sunday), indicated one staff worked on each unit on the day shift from 6:30 a.m. to 2:30 p.m. ULP-F worked as a caregiver in the assisted living unit, while ULP-A administered medications in the secured memory care unit. The licensee time and attendance records indicated on September 29, 2024, ULP-H arrived at 1:30 p.m., an hour earlier than her shift to assist. R1 R1 admitted August 14, 2024, and resided in the secured memory care unit. R1's diagnoses included dementia, frequent falls, and diabetes. R1's service plan dated October 10, 2024, indicated R1 received assistance with medication administration, behavioral interventions, feeding assistance, bathing, grooming, repositioning every two hours, and he used a mechanical full body (Hoyer) lift with two staff assistance to transfer.	0 470		

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0 470	Continued From page 5 A licensee internal investigation dated October 4, 2024, indicated on September 29, 2024, R1's family came to visit him and found him in his chair, facing the window with a sling strapped around him. The day shift was shorted staff and ULP-A worked the floor by himself passing medications and providing cares. R1 kept getting up from his chair at every interval. ULP-A noted attempts to re-direct were ineffective and was concerned about R1 falling. ULP-A said he took R1 to his room to relax in his wheelchair and pinned the hook to the wheelchair so it would not move. ULP-A offered R1 a snack and went to attend to other residents. When the family member found R1, the evening shift had started, and the family inquired about R1 being tied in his chair. ULP-H went to R1's room to check on the family member's concern and found R1 tied to his chair with his sling. ULP-H untied the sling from R1. R3 R3 admitted January 25, 2024, and resided in assisted living. R3's diagnoses included Parkinson's disease, back pain, abdominal pain, bipolar disorder, hemiplegia, recurrent falls, depression, and obsessive-compulsive disorder. R3's service plan dated December 11, 2024, indicated R3 received assistance with medication management, behavioral interventions, safety checks and housekeeping. R3's medication administration record dated September 29, 2024, indicated R3 never received her morning medications or treatments scheduled at 8:00 a.m. and 10:00 a.m., including an antibiotic, anticonvulsant, Parkinson's medication and pain medication.	0 470		

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0 470	Continued From page 6 R4 R4 admitted February 29, 2024, and resided in assisted living. R4's diagnoses included transient paralysis, adult failure to thrive, and diabetes. R4's service plan dated December 11, 2024, indicated R4 received services including transfer assistance with a mechanical full body lift that required two staff assist, medication management, and assist of two staff for bathing, dressing, and grooming. R4's medication administration record dated September 29, 2024, indicated R4 never received his morning medications or treatments scheduled at 8:00 a.m., including heart and blood pressure medications, a water pill, a blood thinner, anti-diabetic medication, anticonvulsant, and creams for various skin rashes. R6 R6 admitted February 15, 2018, and resided in assisted living. R6's diagnosis included type II diabetes with diabetic neuropathy, chronic pain, fibromyalgia, and schizoaffective disorder. R6's service plan dated July 5, 2024, indicated R6 received services including medication management, glucose monitoring, dressing, grooming, mobility, transfers, and toileting. R6's medication administration record dated September 29, 2024, indicated R6 never received her 8:00 a.m. or 12:00 p.m. medications or treatments, including blood sugar monitoring and anti-diabetic medication, antidepressant, anti-anxiety, an inhaler, blood pressure medication, and a patch for pain relief. R7	0 470		

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0 470	Continued From page 7 R7 admitted September 22, 2022, and resided in assisted living. R7's diagnosis included type II diabetes with diabetic chronic kidney disease. R7's service plan dated July 26, 2024, indicated R7 received services including medication management, blood glucose monitoring, dressing, ostomy bag cares, turn and reposition every two hours with assist of two staff, grooming, meal set-up, and assist of two staff for bathing. R7 also transferred with assistance from two staff with a mechanical full body (Hoyer) lift. R7's medication administration record dated September 29, 2024, indicated R7 never received his morning medications or treatments including blood sugar checks and sliding scale insulin scheduled at 7:30 a.m. and 11:00 a.m. R7 never received medication scheduled at 8:00 a.m., including a blood pressure check and blood pressure medication, anticonvulsant and various creams for skin concerns. The licensee time and attendance and timecard report for agency staff records reviewed October 1, 2024, through October 31, 2024, indicated the following dates and shifts where licensee's staffing plan minimum staffing requirements were not met, less than four ULP on days and evening shifts and less than three ULP on overnight shift: October 6, 2024, two ULP worked on overnight shift. October 9, 2024, two ULP worked on overnight shift. October 10, 2024, one ULP worked for 30 minutes in the building when one of the two overnight ULPs left at 6:00 a.m. and the first day shift ULP, who was in training, did not arrive until 6:30 a.m. The second day shift ULP did not arrive	0 470		

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0 470	Continued From page 8 until 6:45 a.m. and the third- and fourth-day shift ULP arrived at 7:00 a.m. October 17, 2024, three ULP worked on day shift. October 18, 2024, three ULP worked on day shift. October 19, 2024, two ULP worked on overnight shift. October 26, 2024, three ULP worked on evening shift, a fourth ULP worked until 5:00 p.m. October 30, 2024, three ULP worked on evening shift; there was one ULP in training on evening shift. On December 3, 2024, at 12:25 p.m., ULP-F stated she worked alone in the assisted living unit on the first floor. She was not trained on medication administration. She stated ULP-A worked alone in the secured memory care on the second floor. ULP-A was trained to administer medications. ULP-A administered medications and provided services to the residents in the memory care unit. The residents in assisted living did not receive their morning medications on September 29, 2024, because she was the only staff working and she was not certified to administer medications. ULP-F asked ULP-A to administer R3's medications because R3 complained of pain and had Parkinson's disease with medications that are needed at specific times. ULP-A declined to administer any medications to residents on the first floor. She said ULP-A was overwhelmed administering medications and providing services to all the residents in memory care. She said more staff came in around lunch time to assist. On December 3, 2024, at 11:30 a.m., clinical nurse supervisor (CNS)-D said ULP-A worked alone in the memory care unit. ULP-A administered medications and provided care to those residents. ULP-F worked alone in the	0 470		

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0 470	Continued From page 9 assisted living, first floor and provided care to those residents. ULP-F was not trained on medication administration. There were no staff available to administer medications to the residents in assisted living. A family member reported she found R1 tied to his wheelchair with his sling. The incident was later investigated, and ULP-A was terminated for restraining R1. R1 was at an increased risk for falls. ULP-A restrained R1 to his wheelchair to prevent the resident from falling after other interventions were ineffective. CNS-D said the facility required four to five staff on the day shift to complete all resident services. On December 3, 2024, at 12:05 p.m., assistant manager (AM)-D said the day shift required four to five staff to provide care and to ensure resident safety. Three staff to complete all services and ensure safety would be "questionable", two staff in the entire building is unsafe. If staff are unable to make it to work, they should find their own coverage. If the building is short staffed the director, nursing staff, and AM-D need to cover the shift. On December 12, 2024, at 11:05 a.m., licensed assisted living director (LALD)-B said four staff are scheduled on day shift, two on each floor for memory care and assisted living. One staff on each unit administered medication while the second assisted with other services. This day only two staff worked in the building which was unsafe. R1's wife observed R1 stuck in his wheelchair with his sling wrapped around him and hooked onto the back of his wheelchair. LALD-B said ULP-A restrained the resident to prevent him from standing and potentially falling. Several residents required two person transfers with a full body mechanical (Hoyer) lift and at least one staff member must always be in the secured memory	0 470		

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0 470	Continued From page 10 care. The Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated March 11, 2023, indicated the licensee typically scheduled the following number of ULPs for each shift: Day shift: Four or more depending on census/ level of acuity. Evening shift: Four or more depending on census/ level of acuity. Night shift: Two plus In addition, the UDALSA indicated mechanical lift: assist of two (staff) transfers were available. The licensee's Transfer Assistance policy dated April 1, 2024, indicated two staff are needed to complete a transfer using a full body "Hoyer" lift. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 620 SS=F	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	0 620		

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0 620	Continued From page 11 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. (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	0 620		

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0 620	Continued From page 12 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 facility failed to report an incident of suspected abuse to the Minnesota Adult Abuse Reporting Center (MAARC) within 24 hours and concluded not to report for a witnessed incident of choking and failure to provide emergency aid resulting in death for one of two residents (R2) reviewed. This deficient practice had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is 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: R2's diagnoses included dementia, depression, and difficulty walking. R2's service plan dated September 3, 2023, included assistance with bathing, grooming, mobility, transfers, and meals. The resident received a pureed diet with honey thickened liquids. R2's Uniform Assessment Tool dated August 22, 2024, indicated R2 required supervision at meals.	0 620		

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0 620	Continued From page 13 A facility incident report dated October 24, 2024, indicated R2 was in the dining room when he stood up and was having difficulty breathing. An unlicensed personnel (ULP) lowered R2 to the floor and notified the nurses. R2's vital signs were temperature 97.5, pulse 46 bpm (normal between 60-100 bpm) and oxygen saturation was 35% (normal above 90%). There was no recorded blood pressure or respirations. R2's progress note dated October 24, 2024, at 6:49 p.m., written by registered nurse (RN)-A indicated at 4:13 p.m., ULP reported R2 was unresponsive. Upon arrival to the dining area, RN-A observed R2 lying down with a pillow under his head and pupils non-dilating. RN-A documented the same vitals as the incident report. RN-A called hospice and left a voicemail. RN-A documented staff had spoken with the hospice nurse who instructed to move R2 to his room. RN-A documented upon investigation it was reported R2 had finished eating his own food (puree and honey thickened liquids) and another resident at his same table gave R2 a sandwich. R2's death record dated October 24, 2024, indicated the cause of death was asphyxia (deprived of oxygen) due to choking on a food bolus. The facility internal investigation dated October 25, 2024, completed by RN-A, indicated upon investigation it was reported R2 had finished eating his food and was offered a sandwich by another resident who was sitting at his same table. The action plan was to have all resident who require feeding assistance to be at the same table. The internal investigation form had been marked "no" to the question of a report made to MAARC.	0 620		

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0 620	Continued From page 14 December 27, 2024, at 10:30 a.m., ULP-C said he assisted R2 with eating in the dining room. After he assisted R2, he assisted a different resident. While feeding the other resident, ULP-C observed R2 stand up. R2 appeared like he was going to vomit. ULP-C assisted R2 to the floor and ULP-D went to get help. ULP-C said R8 reported another resident at their table gave R2 food. R8 said this while R2 was assisted to the dining room floor. R8 repeated the same information, that another resident gave R2 something to eat again when the nurses and other staff were present. He said RN-A and RN-I tried to see if R2 was choking by looking in his mouth. He said the nurses assessed vital signs, but he denied anyone performed the Heimlich Maneuver. ULP-C said the facility never provided him with training on how to perform the Heimlich Maneuver. December 27, 2024 at 12:00 p.m., R8 said she observed another resident give R2 half of his sandwich. R2 shoved the whole sandwich in his mouth. R2 tried to swallow the food, but he choked. R2 started to convulse, and staff lowered him to the floor. She said staff tried to get the food out of his mouth, but nobody performed the Heimlich Maneuver. While R2 was laying on the dining room floor, R8 she told everyone R2 ate another resident's food. She said all the staff including the nurses were present when she reported it. December 27, 2024, at 11:00 a.m., RN-A said ULP-H alerted her of the incident. When she arrived R2 was laying on the dining room floor, unresponsive, not breathing. She assessed vital signs and called hospice. RN-A said she never assessed R2's mouth for an airway obstruction.	0 620		

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0 620	Continued From page 15 RN-A said she was aware R2 had a history of eating other resident's food. During interview on December 27, 2024, at 11:30 a.m., licensed assisted living director (LALD)-B stated R2 lived in memory care and ate a purred diet. It was reported to her R2 choked on food another resident gave him during a meal. The Heimlich Maneuver was not performed and R2 died. She denied she filed a report with the MAARC. The facility's policy titled Vulnerable Adult Maltreatment-Prevention & Reporting, dated April 1, 2024, indicated the LALD will contact the Regional Director with findings of an investigation and contact MAARC for suspicion of maltreatment. A report must be made no later than 24 hours after the maltreatment was first suspected. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not	01760		

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01760	Continued From page 16 administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to administer medications as prescribed for four of six residents (R3, R4, R6, and R7) reviewed. This had the potential to affect all residents currently receiving medication management services from the licensee. 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 is 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: The licensee's Daily Schedule dated September 29, 2024 (a Sunday), indicated one staff worked on each unit on the day shift from 6:30 a.m. to 2:30 p.m. Unlicensed personnel (ULP)-F worked as a caregiver in the assisted living unit, while ULP-A administered medications in the secured memory care unit. The licensee time and attendance records indicated on September 29, 2024, ULP-H arrived at 1:30 p.m., an hour earlier than her shift to assist. R3 R3 admitted January 25, 2024, and resided in assisted living. R3's diagnoses included	01760		

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01760	Continued From page 17 Parkinson's disease, back pain, abdominal pain, bipolar disorder, hemiplegia, recurrent falls, depression, and obsessive-compulsive disorder. R3's service plan dated December 11, 2024, indicated R3 received assistance with medication management, behavioral interventions, safety checks and housekeeping. R3's medication administration record (MAR) dated September 29, 2024, indicated R3 never received her morning medications or treatments. R3's missed medication doses included: - Carbidopa-Levodopa 25 milligrams (mg) for Parkinson's disease, 8:00 a.m. and 10:00 a.m. doses - Acetaminophen 325 mg for pain, 8:00 am. - Depakote 500 mg for anticonvulsants, 8:00 a.m. - Macrobid 100 mg antibiotic for urinary tract infection, 8:00 a.m. - Senna 8.6 mg for constipation, 8:00 a.m. - Vitamin D3 25 micrograms (mcg), 8:00 a.m. R3's MAR Dated October 2024, indicated R3 did not receive Macrobid 100 mg on the following dates: October 4, 2024, at 8:00 p.m., reason "refused" October 5, 2024, at 8:00 p.m., reason "held" October 6, 2024, at 8:00 p.m., reasone "refused" R4 R4 admitted February 29, 2024, and resided in assisted living on the first floor. R4's diagnoses included transient paralysis, adult failure to thrive, and diabetes. R4's service plan dated December 11, 2024, indicated R4 received services including transfer	01760		

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01760	Continued From page 18 assistance with a mechanical full body lift that required two staff assist, medication management, and assist of two staff for bathing, dressing, and grooming. R4's MAR dated September 29, 2024, indicated R4 never received his morning medications or treatments. R4's missed medication doses and treatments included: - Amlodipine Besylate 10 mg daily for blood pressure, 8:00 am. - Aquaphor 41% ointment daily to both heels for skin irritation, 8:00 a.m. - Atorvastatin Calcium 40 mg daily for hyperlipidemia, 8:00 a.m. - Clotrimazole 1% cream twice daily for rash, 8:00 a.m. - Diclofenac Sodium 1% gel to right knee three times daily for swollen, 8:00 a.m. - Eliquis 5 mg, a blood thinner to prevent stroke, 8:00 a.m. - Furosemide 40 mg for excessive fluid, 8:00 a.m. - Jardiance 25 mg daily for diabetes, 8:00 a.m. - Magnesium Oxide 420 mg for supplement, 8:00 a.m. - Metoprolol Tartrate 100 mg for atrial fibrillation, 8:00 a.m. - Nystop 100000 U/G powder for skin irritation/yeast, 8:00 a.m. - Lyrica 20 mg (anticonvulsant) for pain, 8:00 a.m. - Senna 8.6 mg daily for constipation, 8:00 a.m. - Spironolactone 25 mg half tab for heart failure, 8:00 a.m. - Tamsulosin HCL 0.4 mg daily for prostate, 8:00 a.m. - Terbinafine 250 mg daily for antifungal, 8:00 a.m.	01760		

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01760	Continued From page 19 R6 R6 admitted February 15, 2018, and resided in assisted living. R6's diagnosis included type II diabetes with diabetic neuropathy, chronic pain, fibromyalgia, and schizoaffective disorder. R6's service plan dated July 5, 2024, indicated R6 received services including medication management, glucose monitoring, dressing, grooming, mobility, transfers, and toileting. R6's MAR dated September 29, 2024, indicated R6 never received her 8:00 a.m. or 12:00 p.m. medications or treatments. R6's missed medication doses and treatments included: - Blood Sugar monitoring at 7:30 a.m. - Lidocaine Patch 4%, apply one patch application, 8:00 a.m. - Aspirin EC 81 mg daily for post operation, 8:00 a.m. - Breyna 160- 4.5 mcg inhaler for COPD/ Asthma, 8:00 a.m. - Bupropion XL 150 mg for major depressive disorder, 8:00 a.m. - Escitalopram Oxalate 20 mg daily for anxiety, 8:00 a.m. - Gabapentin 300 mg daily for pain, 8:00 a.m. - Metformin HCL 500 mg daily for diabetes, 8:00 a.m. - Vitamin D3 2000 units/ 50 mcg two tabs for supplement, 8:00 a.m. - Safety check at 12 p.m. - Lisinopril 2.5 mg daily for hypertension, 12:00 p.m. R7 R7 admitted September 22, 2022, and resided in assisted living. R7's diagnosis included type II	01760		

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01760	Continued From page 20 diabetes with diabetic chronic kidney disease. R7's service plan dated July 26, 2024, indicated R7 received services including medication management, blood glucose monitoring, dressing, ostomy bag cares, turn and reposition every two hours with assist of two staff, grooming, meal set-up, and assist of two staff for bathing. R7 also transferred with assistance from two staff with a mechanical full body (Hoyer) lift. R7's MAR dated September 29, 2024, indicated R7 never received his morning medications or treatments. R7's missed medication doses and treatments included: - Humalog Kwik injectable 100/ml, inject before meals. Insulin dosage was based on a sliding scale, 7:30 a.m. - Blood sugar monitoring 7:30 a.m. - Calmoseptine 0.44-20.6% ointment apply to buttock wound, 8:00 a.m. - Gabapentin 400 mg three capsules for anticonvulsant, 8:00 a.m. - Hydrophilic ointment for skin protection daily, 8:00 a.m. - Losartan 50 mg for systolic blood pressure. Hold if blood pressure is less than 130 for hypertension, 8:00 a.m. - Miconazole cream to affected area for skin irritation, 8:00 a.m. - Silver Sulfadiazine to legs for skin irritation, 8:00 a.m. - Blood glucose check daily at 11:00 a.m. - Humalog Kwik injectable 100/ml, inject before meals. Insulin dosage was based on a sliding scale, 11:30 a.m. On December 3, 2024, at 12:25 p.m., ULP-F stated she worked alone on the assisted living unit. She was not trained on medication	01760		

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(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
01760	Continued From page 21 administration. ULP-A worked alone in the secured memory care. ULP-A was trained to administer medications and administered medications to the memory care residents. The residents in assisted living did not receive their morning medications as no trained staff worked in assisted living. ULP-F asked ULP-A to administer R3's medications because R3 complained of pain and had Parkinson's disease with medications that were time sensitive. ULP-A declined to administer any medications to residents on in assisted living. ULP-A was overwhelmed with administering medications and providing services to all the residents in memory care. She said more staff came in around lunch time to assist. On December 3, 2024, at 11:30 a.m., clinical nurse supervisor (CNS)-D said ULP-A worked alone in the memory care unit. ULP-A was the only staff available to administered medications and provided services to those residents. ULP-F worked alone in the assisted living and was not trained on medication administration. Medications were not administered to residents in assisted living as staff were not available. The licensee's Medications and Treatments policy dated April 1, 2024, indicated documentation of a medication administration must be completed after the task is performed. Medication administration will be documented on the Medication Administration Record (MAR) by entering the staff's initials under the date the medication was administered. The staff member will document in each resident's MAR problems with medication administration, including refusals. Staff will also document reasons why administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when	01760		

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	31337	A. BUILDING: _____ B. WING _____	C 12/03/2024

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01760	Continued From page 22 medication was not administered as prescribed and in compliance with the resident's medication management plan. Time period for correction: Seven (7) days	01760		
02320 SS=J	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with 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 interview and record review, the licensee failed to ensure staff were properly trained and competent to provide necessary medical care, Heimlich Maneuver, to one of one resident (R2). R2 choked in the dining room with multiple licensee's staff present. The licensee's staff failed to perform chest thrusts (Heimlich Maneuver) or contact emergency medical services and R2 died. This practice resulted in a level four violation (a violation that results in 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:	02320		

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02320	Continued From page 23 Minnesota Statute 604A.01, subdivision 1, Good Samaritan Law, duty to assist, indicates a person at the scene of an emergency who knows that another person is exposed to or has suffered grave physical harm shall give reasonable assistance to the exposed person, which may include obtaining or attempting to obtain aid from law enforcement or medical personnel. R2 resided in the secured memory care unit and was on hospice. R2's diagnoses included dementia, depression, and difficulty walking. R2's service plan dated September 3, 2024, indicated R2's received services including assistance with bathing, grooming, mobility, transfers, and meals. R2 received a pureed diet with honey thickened liquids. R2's Vulnerability Risk Reduction Plan dated August 2, 2024, indicated R2 was unable to recognize hazards in his environment. R2's Uniform Assessment Tool dated August 22, 2024, indicated R2 required supervision at meals. R2's late entry progress note documented October 24, 2024, at 12:19 p.m., for October 23, 2024, at 3:00 p.m., indicated registered nurse (RN)-A completed R2's comprehensive assessment. R2's vital signs were within normal limits. R2's heart rate was normal and regular rhythm. R2's lungs were clear and non-labored breathing. R2's progress note dated October 24, 2024, at 4:04 p.m., R2's weekly vital signs documented blood pressure was 122/68, pulse was 69 beats per minute (bpm), temperature was 97.6 and respirations was 18 breaths per minute. RN-A	02320		

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02320	Continued From page 24 documented R2 was comfortable and she sat and talked with him. A facility incident report dated October 24, 2024, indicated R2 was in the dining room when he stood up and was having difficulty breathing. An unlicensed personnel (ULP) lowered R2 to the floor and notified the nurses. R2's vital signs were temperature 97.5, pulse 46 bpm (normal between 60-100 bpm) and oxygen saturation was 35% (normal above 90%). There was no recorded blood pressure or respirations. R2's progress note dated October 24, 2024, at 6:49 p.m., written by RN-A indicated at 4:13 p.m., ULP reported R2 was unresponsive. Upon arrival to the dining area, RN-A observed R2 lying down with a pillow under his head and pupils non-dilating. RN-A documented the same vitals as the incident report. RN-A called hospice and left a voicemail. RN-A documented staff had spoken with the hospice nurse who instructed to move R2 to his room. RN-A documented upon investigation it was reported R2 had finished eating his own food (puree and honey thickened liquids) and another resident at his same table gave R2 a sandwich. R2's death record dated October 24, 2024, indicated the cause of death was asphyxia (deprived of oxygen) due to choking on a food bolus. December 27, 2024, at 10:30 a.m., ULP-C said he assisted R2 with eating in the dining room. After he assisted R2, he assisted a different resident. While feeding the other resident, ULP-C observed R2 stand up. R2 appeared like he was going to vomit. ULP-C assisted R2 to the floor and ULP-D went to get help. ULP-C said R8	02320		

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02320	Continued From page 25 reported another resident at their table gave R2 food. R8 said this while R2 was assisted to the dining room floor. R8 repeated the same information, that another resident gave R2 something to eat again when the nurses and other staff were present. He said RN-A and RN-I tried to see if R2 was choking by looking in his mouth. He said the nurses assessed vital signs, but he denied anyone performed the Heimlich Maneuver. ULP-C said the facility never provided him with training on how to perform the Heimlich Maneuver. December 27, 2024 at 12:00 p.m., R8 said she observed another resident give R2 half of his sandwich. R2 shoved the whole sandwich in his mouth. R2 tried to swallow the food, but he choked. R2 started to convulse, and staff lowered him to the floor. She said staff tried to get the food out of his mouth, but nobody performed the Heimlich Maneuver. While R2 was laying on the dining room floor, R8 she told everyone R2 ate another resident's food. She said all the staff including the nurses were present when she reported it. December 27, 2024, at 11:00 a.m., RN-A said ULP-H alerted her of the incident. When she arrived R2 was laying on the dining room floor, unresponsive, not breathing. She assessed vital signs and called hospice. RN-A said she never assessed R2's mouth for an airway obstruction. RN-A said she was aware R2 had a history of eating other resident's food. December 30, 2024, at 11:40 a.m., RN-I said staff reported R2 was unresponsive in the dining room. When she arrived, R2 was on the floor not breathing. She said they assessed vitals and listened for heart and lung sounds. RN-I denied	02320		

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02320	Continued From page 26 she looked in R2's mouth for an airway obstruction. The Heimlich Maneuver/chest thrusts were not performed. RN-I never heard R8 report R2 ate something until after the incident. RN-I said caregivers are trained on the Heimlich Maneuver through a video in Educare but there is no demonstration or competency completed. RN-I said RN-A was present during the incident and several other ULP's. December 27, 2024, 1:00 p.m., R2's guardian (G)-E said he received a phone call from RN-A informing him R2 died the day before. G-E said RN-A said R2 collapsed in the dining room and died. The next day hospice said residents and staff at that facility, reported to her R2 choked and died. Hospice encouraged the G-E to request a copy of the incident report. G-E inquired the licensee about the claim and requested a copy of the incident report. The licensee never provided G-E a copy of the incident report. G-E said the death certificate identified choking as the cause of death, but staff never administered aid to R2. December 27, 2024, at 11:30 a.m., licensed assisted living director (LALD)-B said ULP's are not trained on the the Heimlich Maneuver or trained on cardiopulmonary resuscitation (CPR). The nurses are expected to perform those procedures if assessed as necessary. If nurses are unavailable, ULP's are instructed to call emergency services. ULP-C's Employee Core Training record dated July 26, 2024, indicated ULP-C received training on the Heimlich Maneuver. The training record was signed by a RN who is no longer identified on the licensee's staff roster. ULP-D's training record lacked an Employee	02320		

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02320	Continued From page 27 Core Training record and lacked documented training specific to the Heimlich Maneuver. The record included a Practical Skills Test for ULP Core Training dated November 7, 2024, two weeks after the date of the incident. Also, the handling of various emergencies box was not marked as completed in the boxed titled "Observation of Competency" or "Training Completed". ULP-H's training record lacked an Employee Core Training record and lacked documented training specific to the Heimlich Maneuver. The licensee's Emergency/ 911 policy dated April 1, 2024, indicated if a resident is found unresponisve without a pulse or breathing and is "NOT" on hospice, call 911 immediately. The policy directed for residents who are on hospice experiencing an emergency, hospice should be called immediately. Examples of significant emergencies for staff to call 911 included choking. 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 two of two resident(s) reviewed (R1 and R2) were free from maltreatment.	02360		

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02360	Continued From page 28 Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment of R1. The facility and two individual persons were responsible for the maltreatment of R2. Both, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		