Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL318816302M
Compliance #: HL318819447C

Date Concluded: January 28, 2025

Name, Address, and County of Licensee Investigated:
Morning Glory Homes
4328 Williston Road
Minnetonka, MN 55345
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Holly German, 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 alleged perpetrator (AP) financially exploited the resident when he acted as the resident's rep payee, used, and spent the resident's money without permission.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was substantiated. The facility and AP were responsible for the maltreatment. The AP, who was the facility owner and licensed assisted living director (LALD), acted as the resident's rep payee. The AP opened a bank account listing himself and the resident as account owners, had the resident's social security income automatically deposited into the business account of the facility, failed to account for the resident's money, and failed to provide monthly statements and receipts to the resident. The AP made unauthorized purchases and withdrawals from a bank account shared with the resident.

The investigator conducted interviews with facility administrative staff, bank staff and the resident's legal guardian. The investigator contacted law enforcement. The investigation included review of the resident records, personnel files, staff schedules, law enforcement report, banking records, and related facility policy and procedures.

The resident resided in an assisted living facility for over eight years. The resident's diagnoses included paranoid schizophrenia and cognitive impairment. The resident's service plan included assistance with financial decisions, shopping services and transportation. The resident's assessment indicated the resident walked with a walker, was alert and had impaired decision making. The resident had a guardian in place to help with decision making.

Three months after admission, the AP sent an email to the resident's guardian to update her on the resident's care and adjustment to the facility. The AP indicated the facility was assisting the resident to manage her funds and locked up her cash, with every receipt tracked. The email indicated staff were going to assist the resident with opening a bank account because she had over $500. The AP also indicated, if the resident's bank account were to drop below $500, the facility would keep her cashed locked up with the nurses and give her cash per request.

A cash ledger log indicated the facility received $57.55 in cash to account for the resident upon her admission to the facility. The ledger logged various withdrawals for restaurants, stores, and cash. The ledger logged various deposits that included social security allowances and renter's refunds. The transactions were dated but did not indicate who documented the transactions or had any documented signatures of staff or the resident. The last transaction in the ledger documented a balance of $315.09 and had no further transactions documented for over six years.

The resident's bank savings account application, opened approximately 10 months after admission, indicated the resident was the sole owner of a checking account. Bank statements over seven years' time indicated there were no deposits of the resident's social security benefit payments. The statements indicated the resident was charged a monthly fee for most of the months due to not meeting the minimum account balance required for the account, totaling a loss of $670 due to fees by the AP's mismanagement of maintaining the $500 minimum balance. The resident's savings account had $3,135 of ATM (automated tell machine) and check withdrawals.

The resident's records at the facility did not contain any monthly statements or accounting records of the bank account opened by the AP with the resident's money. The resident's record did not contain any receipts of transactions.

During an interview, the resident stated she receives $129 a month for spending money from her monthly social security benefits. The resident stated her rent was paid directly to the facility and she had no other bills. The resident stated she did not have a bank account prior to admitting to the facility, but one was set up for her and the AP took care of it. The resident

stated she did not know the initial deposit amount placed in the bank account when it was opened. The resident stated she had not received any statements or receipts, did not know how much her social security income was, or how much her rent was. The resident stated she assumed her rent had been paid but had not spoken to the AP about money. The resident stated she was not aware of any amount of money missing from her account and thought she had about $8,000 in the bank.

During an interview, the resident's legal guardian stated the resident had multiple guardians prior to her taking on the role, and the guardians did not do what they were supposed to do. The guardian stated the AP had always been the one taking care of the resident's finances, including all the money that came in from social security and the money in the resident's checking account. The guardian stated she and the resident requested statements from the AP, but never received any. The guardian stated all the resident's money went directly into the business account of the facility. The guardian stated the resident was charged service fees due to the account not meeting the minimum amount required in the account. The guardian stated she and the resident went to the bank to figure out what was going on, and they discovered the account was in the negative $10. The guardian stated the bank was alerted of her concern with the management of the account by the AP. The guardian stated once she voiced her concern to the AP, he attempted to give her two cashier's checks totaling about $8,000 because that was how much the AP thought he had in his account that was actually the resident's money. The guardian stated she then became the resident's representative payee. Both she and the resident now have a new debit card for the resident's bank account. The guardian stated the AP no longer has access to the resident's bank account. The guardian stated the AP never gave the resident her full spending amounts each month. The guardian stated she felt the AP still owed the resident approximately $11,000 for the services fees charged on the resident's bank account due to his mismanagement of the account, for the renter's rebates the resident should have received, and for the full amount of the monthly spending money the resident was allowed.

During an interview, the bank manager stated he first met the resident and her guardian when they came to the bank with questions about transactions on the resident's checking account where the resident was the sole account owner. The manager stated his staff noted several ATM withdrawals from the account and debit card swipes at stores in the area that the resident was unsure of what the charges were for. The manager stated the resident told him the AP had her debit card. The manager stated the guardian told him she believed the AP was stealing money from the resident and had control over the resident's debit card. The manager stated they realized those transactions were not benefiting the resident and filed a fraud claim. The manager stated he called the AP and asked him if he was the representative payee for the resident's social security income benefit, and the AP stated he was. The manager stated the AP told him the social security money went into an account there at the bank, but the manager told the AP there was no such account. The manager stated the AP then stated he was doing the resident's money wrong, and it was in fact being deposited into his own account. The manager stated he reminded the AP of the process he was supposed to go through as

representative payee and the AP stated he was helping the resident as a favor. The manager stated he told the AP he was breaking the law and instructed the AP to return the debit card.

During an interview, the AP stated he was “guilty.” The AP stated he let the resident’s money go in the business account of the facility and he should not have because the resident did not have her own account. The AP stated he gave the resident her spending money, but he mismanaged her money. The AP stated he got a bank account set up for the resident and mismanaged it. The AP stated it got out of hand and he did not have receipts. The AP stated the resident’s previous guardian was difficult do get ahold of, did not do the things she needed to get done for the resident, so by default he had to take it over. The AP stated he had also previously been the representative payee for another resident, who no longer resided at the facility. The AP stated that was his first failure as he knew better. The AP stated once the current guardian was in place, he attempted to give her a cashier’s check for the amount he believed was owed to the resident based off the amount noted in the cash ledger, but she would not take it. The AP stated he had made an appointment for the resident and her guardian to go to the bank and open an account, but at the last minute the guardian could not go. The AP said he made the mistake of going with the resident alone as he wanted to keep the process moving along. The AP stated the guardian was then supposed to go with the resident to the bank and have it signed over to her and have his name removed, but that did not happen. The AP stated he made withdrawals from the account for the resident to go shopping, and he did not track it. The AP stated he processed the paperwork for the resident to receive a renter’s rebate and that check was held in the business account of the facility. The AP stated he was trying to keep track of that but could not find the log of the renter’s rebates. The AP stated he mismanaged the resident’s money, it was not right, he knew better and failed. The AP stated he was responsible and needed to make it right. The AP stated he should have called the Ombudsman for direction when the guardian was not doing the things they should have for the resident from the beginning.

In conclusion, the Minnesota Department of Health determined financial exploitation 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.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means:
(b) In the absence of legal authority a person:
(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;
(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud;

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

(1) The AP did not follow an erroneous order, direction, or care plan.

The AP directed 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 provided adequate staffing levels.

The AP failed to follow the facility directive and/or policies and procedures.

The AP had the authority to direct and implement operational regulatory requirements or make operational changes.

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

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

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility ensured the resident's physical care needs were met.

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
Hennepin County Attorney
Minnetonka City Attorney
Minnetonka Police Department
Minnesota Board of Executives for Long Term Services and Supports

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31881	A. BUILDING: _____ B. WING _____	C 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING GLORY HOMES INCORPORATED	4328 WILLISTON ROAD MINNETONKA, MN 55345

(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: HL318819447C/HL318816302M On January 9, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 4 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for HL318819447C/HL318816302M, tag identification 590, 600, 2360.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.OC text-	
0 590 SS=F	144G.42 Subd. 3 Facility restrictions (a) This subdivision does not apply to licensees	0 590		

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0 590	Continued From page 1 that are Minnesota counties or other units of government. (b) A facility or staff person may not: (1) accept a power-of-attorney from residents for any purpose, and may not accept appointments as guardians or conservators of residents; or (2) borrow a resident's funds or personal or real property, nor in any way convert a resident's property to the possession of the facility or staff person. (c) A facility may not serve as a resident's legal, designated, or other representative. (d) Nothing in this subdivision precludes a facility or staff person from accepting gifts of minimal value or precludes acceptance of donations or bequests made to a facility that are exempt from section 501(c)(3) of the Internal Revenue Code. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to properly receive, manage and uphold professional boundaries of resident finances, as required for 1 of 1 residents (R1) reviewed. The licensee acted as representative payee, had R1's social security checks deposited into the licensee bank account and mismanaged the finances of R1. 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).	0 590		

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0 590	Continued From page 2 The findings include: R1's diagnosis includes paranoid schizophrenia and cognitive impairment. R1's service plan dated April 11, 2024, indicated R1 received assistance with mobility, finances, and care decisions. R1's monthly bank savings account statements dated June 26, 2017, through December 24, 2024, lacked documentation of any deposit transactions of R1's monthly social security income. During an interview on January 9, 2025, at 10:41 a.m., R1 stated her monthly rent goes directly to the licensee every month. R1 stated she did not have anything to do with setting up a bank account, that licensed assisted living director (LALD)-C took care of it. R1 stated she did not know the initial deposit amount into the bank account. R1 stated she did not know how much her rent cost, or how much she received every month from social security. R1 stated she never received statements or receipts from LALD-C. During an interview on January 15, 2025, at 3:00 p.m., R1's guardian (G)-B stated LALD-C always took care of R1's finances. G-B stated she requested LALD-C give R1 her bank statements and that did not happen. G-B stated she found out R1's social security was going directly into the bank account of the licensee. G-B stated all R1's money went into the bank account of the licensee. G-B stated LALD-C's use of R1's funds was unauthorized. During an interview on January 16, 2025, at 11:30 a.m., LALD-C stated he was guilty for the mismanagement of R1's finances. LALD-C stated he unofficially acted as R1's representative payee	0 590		

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0 590	Continued From page 3 and R1's social security income went to the bank account of the facility. LALD-C stated that was his failure and he knew better. LALD-C stated he made the mistake of opening a bank account listing himself and R1 as the account owners. LALD-C stated he made withdrawals from the account and did not do a proper job of tracking it well. LALD-C stated he failed to give R1 any statements. LALD-C stated he failed and was responsible for the mismanagement of R1's finances. LALD-C stated had previously been the representative payee for another resident who longer lives at the facility. The licensee-provided policy titled "Billing" dated July 22, 2021, indicated monthly bills would be generated by the licensee and provided to the resident or the resident's designated representative. The licensee-provided policy titled "Handling of Resident Finances and Property" dated August 1, 2021, indicated if resident funds are deposited with the licensee, the licensee will assume fiduciary and custodial responsibility for the funds, and will be directly accountable to the resident for the funds. The policy further indicated the licensee will not convert a resident's property to their possession. TIME PERIOD FOR CORRECTION: Seven (7) days	0 590		
0 600 SS=F	144G.42 Subd. 4 Handling residents' finances and property (a) A facility may assist residents with household budgeting, including paying bills and purchasing household goods, but may not otherwise manage	0 600		

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0 600	Continued From page 4 a resident's property. (b) Where funds are deposited with the facility by the resident, the licensee: (1) retains fiduciary and custodial responsibility for the funds; (2) is directly accountable to the resident for the funds; and (3) must maintain records of and provide a resident with receipts for all transactions and purchases made with the resident's funds. When receipts are not available, the transaction or purchase must be documented. (c) Subject to paragraph (d), if responsibilities for day-to-day management of the resident funds are delegated to the manager, the manager must: (1) provide the licensee with a monthly accounting of the resident funds; and (2) meet all legal requirements related to holding and accounting for resident funds. (d) The facility must ensure any party responsible for holding or managing residents' personal funds is bonded or obtains insurance in sufficient amounts to specifically cover losses of resident funds and provides proof of the bond or insurance. This MN Requirement is not met as evidenced by: Based on interview and document review the licensee failed to maintain records and receipts for purchases with resident funds, as required for 1 of 1 resident's (R1) reviewed. The 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 was issued at a widespread scope (when	0 600	Assisted Living Provider 144G. 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	

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0 600	Continued From page 5 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's diagnosis includes paranoid schizophrenia and cognitive impairment. R1's service plan dated April 11, 2024, indicated R1 received assistance with mobility, finances, and care decisions. A log titled "(Name of R1) Cash Account" with an initial dated entry of September 15, 2016, indicated the facility recorded a cash amount of $57.55 that belonged to R1. The log included documented entries of withdrawals and deposits and lacked documentation of who made the entry and lacked signature acknowledgment of the transactions by R1. The final documented entry dated May 2, 2019, indicated R1 had $157.27 cash on hand. The licensee failed to produce receipts for transactions made as documented in the log. An email dated November 3, 2016, from licensed assisted living director (LALD)-C to R1's previous guardian indicated the facility was helping R1 manage her funds and locked up her cash. Every receipt was tracked. The email indicated a staff member was going to assist R1 with opening a bank account because she had over $500. If R1's account were to drop below $500, the facility would keep her cash locked up with the nurses and give her cash per request. R1's bank application indicated her savings account was opened June 26, 2017 and she was sole owner of the account. R1's monthly bank statements dated June 26, 2017, through December 24, 2024, after the first month	0 600	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.OC text-	

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0 600	Continued From page 6 statement of the account, no withdrawals until January 2019. The June and July 2017 statements indicated the first two months waived the minimum of $1500 balance fee. November 2020 statement indicated the bank changed to minimum balance to $500. The fee for going below the monthly minimum balance was $10 each month. R1's savings bank statements dated June 26, 2017, through December 24, 2024, indicated the licensee, who managed R1's account, allowed the account to go below the minimum monthly balance 67 times, resulting in $670 lost to bank fees. ATM (automated teller machine) and check withdrawals without documented receipt of expense included: October 23, 2023, amount $2000. November 23, 2023, amount $400. September 18, 2024, amount $80. November 7, 2024, amount $655. Transactions without documented receipts included: December 20, 2024, amount $70.58 to Amazon. December 23, 2024, amount $36.07 to Amazon. A forwarded email from R1's guardian (G)-B to LALD-C dated September 23, 2024, at 10:13 a.m., from R1's Bank received on September 23, 2024, at 10:03 a.m., indicated a confirmed appointment for October 1, 2024, at 2:00 p.m., to discuss account and services for R1 and to update savings account with appropriate changes. G-B and LALD-C managed the account. During an interview on January 9, 2025, at 10:41 a.m., R1 stated her monthly rent goes directly to the licensee every month. R1 stated she did not know how much her rent cost, or how much she	0 600		

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0 600	Continued From page 7 received every month from social security. R1 stated she never received statements or receipts from LALD-C. During an interview on January 15, 2025, at 3:00 p.m., G-B stated LALD-C always took care of R1's finances. G-B stated she requested LALD-C give R1 her bank statements and that did not happen. G-B stated she found out R1's social security was going directly into the bank account of the licensee. G-B stated all R1's money went into the bank account of the licensee. G-B stated she discovered R1's bank account was negative $10 due to LALD-C mismanaging the account. G-B stated LALD-C's use of R1's funds was unauthorized. During an interview on January 16, 2025, at 11:30 a.m., LALD-C stated he was "guilty" for the mismanagement of R1's finances. LALD-C stated he made withdrawals from R1's bank account and did not do a proper job of tracking it well. LALD-C stated he failed to give R1 any statements. LALD-C stated he gave R1 receipts for her monthly spending money but could not locate them because they are scattered. LALD-C stated he failed and was responsible for the mismanagement of R1's finances. An email dated January 16, 2025, at 12:30 p.m., sent by LALD-C to the surveyor, LALD-C wrote he would scan and send receipts right away. An email dated January 17, 2025, at 12:42 p.m., sent by LALD-C, LALD-C wrote he was gathering receipts. Surveyor never received requested receipts from LALD-C.	0 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31881	A. BUILDING: _____ B. WING _____	C 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 600	Continued From page 8 During an interview on January 16, 2025, at 1:00 p.m., R1's bank manager (BM)-D stated R1 and G-B came to the bank with questions about transactions on R1's bank account where she was the sole owner of the account. BM-D stated bank staff noted several ATM withdrawals and debit card swipes at local stores that R1 did not recognize. BM-D stated R1 told him that LALD-C had her debit card. BM-D stated a claim of fraud was filed on the account, and BM-D contacted LALD-C and directed him to return the debit card. BM-D stated the account had to be closed due to the fraud. The licensee-provided policy titled "Handling of Resident Finances and Property" dated August 1, 2021, indicated the licensee will maintain record of and provide the resident with receipts for all transactions and purchases made with resident funds. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 600		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH)	02360	No plan of correction is required for this tag.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02360	Continued From page 9 issued a determination maltreatment occurred, and the facility and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		