Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL354094221M
Compliance #: HL354095052C

Date Concluded: December 31, 2024

Name, Address, and County of Licensee Investigated:
Relief Homecare LLC
700 14th street
Farmington, MN 55024
Dakota County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Erin Johnson-Crosby, RN
Special Investigator

Finding: Not Substantiated

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), an unlicensed facility staff member, abused a resident when the AP called the resident names, then stood up and threated to hit the resident with their shoe.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. While the AP's actions were disrespectful and unprofessional, the actions of the AP did not meet the definition of abuse.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident's medical record, video footage, personnel files, and facility policies and procedures. At the time of the onsite visit, the investigator toured the facility and observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included schizoaffective disorder, mood dysregulation disorder, anxiety, and post-traumatic stress disorder. The resident's service plan included assistance with medication administration and behavior management. The resident's assessment indicated the resident was cognitively intact and impulsive behaviors.

Review of video footage identified the resident and AP sitting in chairs in a facility commons area. The AP was heard calling the resident names, and the resident took a remote and threw it at the AP. The AP removed her shoe, stood up, and raised her hand with her shoe in it in a threatening manner towards the resident. However, another unlicensed staff member immediately intervened and separated the AP and resident.

During an interview, the resident's guardian stated if the other staff member did not intervene, the AP may have hit the resident. The guardian stated the AP interacted and responded to the resident was not appropriate.

During an interview, facility management stated when he became aware of the incident, he sent the video footage to the resident's guardian and county case worker. Facility management indicated that they felt that the AP was not going to hit the resident but stated there was additional re-training provided following the incident to prevent reoccurrence.

During an interview, the AP denied abusing the resident. The AP stated she was fearful of the resident due to the resident's violent and aggressive behaviors.

In conclusion, the Minnesota Department of Health determined abuse was not substantiated.

"Not Substantiated" means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.

(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

Vulnerable Adult interviewed: No, per guardian request.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
Training was completed following the incident.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35409	A. BUILDING: _____ B. WING _____	C 12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RELIEF HOMECARE LLC	700 14TH STREET FARMINGTON, MN 55024

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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: #HL354095052C/#HL354094221M On December 4, 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 three residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for ##HL354095052C/#HL354094221M, tag identification 0495, 0780, 1290, 2350.	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	

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0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3	
0 495 SS=F	144G.41 Subdivision. 1 (13) Minimum Requirements (13) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to provide staff access to an on-call registered nurse (RN) 24 hours per day, seven days per week. This had the potential to affect all residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated May 14, 2023, indicated the licensee had a part time registered nurse (RN) in addition to a RN who was required to be accessible to the staff at all times. On December 4, 2024, at 12:55 p.m., licensed assisted living director (LALD)-C stated he was	0 495	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 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	

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0 495	Continued From page 2 onsite full time and was the LALD for one other site. LALD-C stated registered nurse (RN)-F was on site once a week and on call 24 hours a day. On December 4, 2024, RN-F stated she worked overnights at a hospital three nights a week. RN-F stated staff could contact the LALD if there was an emergency if she did not answer the phone. RN-F stated during the day staff will call and she answers. During the nights she worked at the hospital staff will call and leave a message and she would return their call on her break. On December 4, 2024, at 3:20 p.m., LALD-C stated RN-F would call the facility back when she was on break during the nights she worked. LALD-C stated there was not another nurse available when RN-F worked at the hospital. At 3:40 p.m., LALD-C stated if there was a concern at night staff would call 911. LALD-C stated it would be difficult to hire a nurse to work 24 hours a day. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 495	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.	
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate	0 780		

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0 780	Continued From page 3 sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to comply with the State Fire Code in Minnesota Rules, chapter 7511 regarding burning candles and smoking in the facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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:	0 780		

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0 780	Continued From page 4 R2 was admitted on April 24, 2024, with diagnoses including Schizoaffective personality disorder, depression and substance abuse. R2's service plan dated August 28, 2024, indicated R2 required assistance with dressing, medication administration, and behavior management of agitation, irritability, anxiety, orientation, aggression, and wandering. R2's assessment dated September 4, 2024, indicated R2 was alert and oriented and was able smoke safely. The assessment did not include an assessment regarding candle safety. The assessment also indicated R2 had diagnoses including paranoia and delusions. An assessment dated December 4, 2024, (same date as onsite visit) indicated staff have noticed the smell of cigarette smoke coming from R2's room occasionally, even though R2 denies smoking in her room. Staff continue to encourage R2 to smoke outside. The assessment also indicated R2 had diagnoses including paranoia and delusions. The assessment did not identify alternative interventions to prevent R2 from smoking in her room. R2's progress note dated, July 11, 2024, written by unlicensed personnel (ULP)-G indicated R2 and other residents were lighting cigarettes inside the building before going out to smoke. Staff reminded residents not to light cigarettes in the house. R2's progress note dated, October 17, 2024, written by an ULP-G indicated R2 was caught smoking in her room tonight. The hallways and the bathroom were filled with cigarette smoke. The staff informed R2 smoking was not allowed indoors.	0 780		

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0 780	Continued From page 5 R2's progress note dated, October 26, 2024, written by an ULP-G indicated R2 was caught smoking in her bed room. R2 asked for a cigarette from another resident and went upstairs instead of outside. Staff walked to the bedroom door and cigarette smoke filled the air coming from under the door. R2's progress notes dated, November 5, 2024, written by registered nurse (RN)-F indicated R2 was alert and oriented and staff should continue to monitor the resident and remind her not to smoke in her room. R2's medical record did not include interventions to attempt to prevent R2 from lighting candles or smoking in her room. R2's medical record also did not include an updated assessment following incidents. On December 4, 2024, at 12:00 p.m., the investigator entered R2's room and observed three candles burning. R2 stated she was allowed to have candles in her room. On December 4, 2024, at 12:15 p.m., ULP-G stated R2 was not oriented at times and was dependent on the day shift staff. ULP-G stated R2 was not supposed to have candles in her room and had also been caught smoking in her room. ULP-G thought R2 probably lit the candles to try to cover up the cigarette smell. ULP-G stated she had found cigarette butts in the bathroom garbage. At 12:30 p.m.,ULP-G stated she went to R2's room and R2 still had the candles lit. ULP-G told R2 candles were not allowed in the facility. On December 4, 2024, at 3:00 p.m., RN-F stated	0 780		

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0 780	Continued From page 6 she was on site yesterday and R2 had candles lit in her room and it smelled like smoke in R2's room. RN-F stated that staff tell R2 to not smoke in her room. RN-C stated R2 was alert and oriented but occasionally has visual hallucinations. On December 4, 2024, at 1:55 p.m., licensed assisted living director (LALD)-C stated R2 started smoking in her room when the weather became colder. LALD-C stated he talked to R2 about smoking safety, but R2 did not care and continued to smoke in her room. LALD-C stated candles were not allowed in resident rooms due to safety and was not aware R2 had candles in her room. LALD-C stated maybe the facility should set up safety checks. LALD-C stated the nurse smelled smoke in R2's room yesterday but didn't chart it. LALD-C stated an assessment should have been updated when R2 was found smoking in her room with additional interventions to prevent R2 from smoking in her room. The licensee's Smoking use policy dated July 21, 2021, indicated smoking was strictly prohibited in all indoor areas of the premises. An employee/resident who observed a policy violation should report it to the supervisor. No further information was provided. Time period to correct: Two (2) days	0 780		
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	01290		

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01290	Continued From page 7 144.057 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 remove two of two unlicensed personnel (ULP)-D and ULP-E from working unsupervised with residents after a Notice of Background Study Disqualification was sent by the Department of Human Services (DHS) indicating ULP-D and ULP-E were disqualified from providing direct patient care in the DHS NETStudy 2.0 system. This had the ability 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 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-E	01290		

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01290	Continued From page 8 ULP-E was hired on June 18, 2021, to provide direct care and services to the licensee's residents. The licensee's list of current employees indicated ULP-E was currently employed by the licensee as an ULP. On December 12, 2024, the investigator emailed the licensee requesting a background study. The same day licensed assisted living director (LALD)-C sent back ULP-E's background study clearance dated June 11, 2021. The background study indicated the study was not affiliated with this licensee but had been completed for another facility with the same name and under the same ownership; not for the current licensee's health facility identification (HFID) number. A Department of Human Services background study status dated September 21, 2022, indicated the licensee requested a background study status of ULP-E and ULP-D A review of ULP-E's NETStudy 2.0 portal indicated on October 6, 2022, ULP-E required supervision while providing direct care. The NETStudy 2.0 portal website indicated that on October 6, 2024, the licensee removed ULP-E's affiliation from the facility, despite ULP-E remaining as an employee. The licensee's schedule dated December 4, 2024, indicated ULP-E worked from 10:00 p.m., to 6:00 a.m. ULP-D ULP-D was hired on September 21, 2022, to provide direct care and services to the licensee's	01290		

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01290	Continued From page 9 residents. On December 12, 2024, the investigator emailed the licensee requesting a background study for ULP-D. The same day the licensee sent a background study clearance dated June 11, 2021. The background study had the incorrect licensee information listed and was not associated with the current licensee HFID number. A review of ULP-D in the NETStudy 2.0 portal indicated on November 20, 2023, a letter was sent to ULP-D and the licensee/LALD-C which indicated background study fingerprints and photo were not provided in the time required and the entity must immediately remove you from your position. The letter indicated ULP-D could not provide direct contact services, however ULP-D remained working at the facility. The licensee's June 2024, schedule indicated ULP-D worked on June 1, June 2, June 4, June 5, June 6, June 7, June 8, June 9, June 10, June 12, June 13, June 14, June 15, June 16, June 17, June 18, June 19, June 20, June 21, June 22, June 23, June 24, June 25, June 26, June 27, June 29, and June 30. A facility incident report dated June 14, 2024, indicated R1 told staff they were slow, so unlicensed personnel (ULP)-D told R1 she was slow. The report indicated R1 took a laptop and facility phone and threw them at ULP-D. The laptop hit ULP-D's right arm so she stood up but another staff got in the middle of R1 and ULP-D to stop her. The other ULP removed R1 from the situation. The incident report indicated more training and redirection was required following the incident but did not include specific information.	01290		

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01290	Continued From page 10 Video footage on June 14, 2024, identified R1 and ULP-D sitting in the living room chairs. ULP-D looked at R1 and stated, "you are slow, you are." R1 then took the remote and threw it at ULP-D. ULP-D removed her shoe, stood up, and with her shoe in her hand raised her hand like she was going to hit R1 with her shoe. Another ULP intervened at that time separating ULP-D from R1. ULP-D stated, "do that again, you are slow." Review of ULP-D's employee file indicated on November 20, 2023, ULP-D received training on the assisted living bill of rights, person centered care and reporting maltreatment. The investigator requested disciplinary records, coaching, and performance reviews, but records were not provided. ULP-D's employee file did not not include an updated background study. On December 4, 2024, at 12:55 p.m., LALD-C stated the licensee scheduled one ULP at all times. LALD-C stated background studies were completed on all employees prior to providing services. On December 12, 2024, at 12:00 p.m., LALD-C confirmed ULP-D provided direct care to residents until around October 2024. On December 12, 2024, the investigator emailed LALD-C requesting the most recent background study for ULP-D and ULP-E. LALD-C replied the back ground checks were completed at the time of hire and the information was from NETStudy. The investigator questioned LALD-C regarding the most recent background study for ULP-D which was dated November 20, 2023, indicating the licensee must immediately remove ULP-D	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35409	A. BUILDING: _____ B. WING _____	C 12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RELIEF HOMECARE LLC	700 14TH STREET FARMINGTON, MN 55024

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01290	Continued From page 11 from providing direct care. LALD-C did not respond to the emailed question. On December 20, 2024, ULP-D stated she was not aware she was disqualified from providing direct care due to not completing the requirements for the background study. ULP-D stated she had never been finger printed as required to complete the background study. The licensee's application for assisted living license renewal dated and signed by LALD-C on April 3, 2024, indicated the licensee read and understood Minnesota statute Chapter 144G, which included information regarding background studies. No further information was provided. TIME PERIOD OF CORRECTION: Two (2) days	01290		
02350 SS=G	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the licensee failed to ensure one of one resident (R1) was treated in a courteous, respectful, and dignified manner. 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	02350		

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02350	Continued From page 12 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). Findings include: R1 was admitted to the licensee on May 12, 2024, with diagnoses including fetal alcohol syndrome, schizoaffective disorder, mood dysregulation disorder, anxiety, and post-traumatic stress disorder. R1's admission assessment dated May 17, 2024, indicated R1 was at risk for verbal, emotional, and financial abuse and staff were educated on R1's boundaries and asking triggering questions. R1 was alert and oriented. R1's Service plan dated May 28, 2024, indicated R1 require assistance with behavioral management and medication management and was independent with other activities of daily living R1's progress notes dated May 27, 2024, written on June 20, 2024, indicated R1 was easily irritated and agitated and could become abusive by calling staff names and standing in their face. Staff should continue to redirect and respect R1's privacy. R1's individual abuse prevention plan dated May 31, 2024, indicated staff should not engage in arguments with R1 and encourage better communication techniques. R1's incident report dated June 14, 2024, indicated R1 told staff they were slow, so unlicensed personnel (ULP)-D told R1 she was	02350		

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02350	Continued From page 13 slow. The report indicated R1 took a laptop and facility phone and threw them at ULP-D. The laptop hit ULP-D's right arm so she stood up but another staff got in the middle of R1 and ULP-D to stop her. The other ULP removed R1 from the situation. The incident report indicated more training and redirection was required following the incident but did not include specific information. Video footage on June 14, 2024, identified R1 and ULP-D sitting in the living room chairs. ULP-D looked at R1 and stated, "you are slow, you are." R1 then took the remote and threw it at ULP-D. ULP-D removed her shoe, stood up, and with her shoe in her hand raised her hand like she was going to hit R1 with her shoe. Another ULP intervened at that time separating ULP-D from R1. ULP-D stated, "do that again, you are slow." Review of ULP-D's employee file indicated on November 20, 2023, ULP-D received training on the assisted living bill of rights, person centered care and reporting maltreatment. The investigator requested disciplinary records, coaching, and performance reviews, but records were not provided. ULP-D's employee file did not not include an updated background study. On December 5, 2024, at 12:00 p.m., R1's guardian-C stated she received the video from LALD-C and the way staff interacted and responded to R1 was not appropriate. Guardian-C stated R1 did not like to be disrespected and that was what staff were doing. On December 12, 2024, at 12:00 p.m., licensed assisted living director (LALD)-C stated he heard R1 hit ULP-D with a phone. LALD-C stated they reviewed the video footage and did not think	02350		

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02350	Continued From page 14 ULP-D acted like she was going to hit R1 and did not see ULP-D lift up her shoe. LALD-C stated staff were not trained to react that way and should have attempted to de-escalate R1's behaviors. On December 20, 2024, at 11:00 a.m., ULP-D stated R1 was violent, abusive and would throw things. ULP-D stated on June 14, 2024, R1 called her slow, so she called R1 slow. R1 then took a laptop and threw it at her. ULP-D she took off her shoe to scare R1 a little bit but did not want to hit her. ULP-D stated R1 was very strong. ULP-D stated the staff did not have adequate training to care for someone with behaviors like R1. ULP-D stated she was scared of R1. ULP-D stated that was not how she should have reacted. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days.	02350		