DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H5255125M **Date Concluded:** April 22, 2022

Name, Address, and County of Licensee Investigated:
Cerenity Care Center on Humboldt
512 Humboldt Avenue
St. Paul, MN 55107
Ramsey County

Facility Type: Nursing Home **Evaluator's Name:** Peggy Boeck, RN
Special Investigator

Finding: Substantiated, individual responsibility

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

Allegation(s):
The Alleged Perpetrator (AP) abused a resident when the AP roughly handled the resident during cares and did not stop when the resident stated the AP was hurting the resident. The AP also threatened the resident with a raised fist as if to hit him.

Investigative Findings and Conclusion:
Abuse is substantiated. The AP is responsible for the maltreatment. The resident feared for his safety as he could not defend himself. The facility received multiple concerns about the AP before the incident from a nurse manager, including verbal aggression towards the nurse manager. The AP had an expired nursing license, prior allegations of abuse/neglect/ drug diversion in another state, and a history of disciplinary action on his nursing license in Minnesota. Psychological harm occurred when the resident required counseling after the incident.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator reviewed facility documents, resident records, policies and procedures related to abuse prevention, as well as personnel records. The investigator reviewed the licensing board public documents.

The resident moved into the facility due to a stroke with resulting right sided weakness, difficulty swallowing, diabetes, and heart disease. The resident received speech therapy, occupational therapy, physical therapy, and assistance with incontinence cares, transfers, and medication administration.

The AP worked at the facility for approximately nine months. The AP was employed by an agency that provided licensed staff to facilities. The AP worked for the agency for less than one year.

According to a facility report, the resident became agitated one day while working with occupational therapy. The AP had entered the room to ask a routine question of the resident. The resident became agitated and angry. A certified occupational therapy assistant (COTA), who was providing therapy spoke with the resident. The resident stated the AP had been intentionally rough with the resident earlier in the day while changing him. The resident told the COTA he never wanted the AP in his room again. The COTA calmed the resident and reassured the resident that he was safe.

During an interview, the COTA stated he had never seen the resident so agitated. The resident told the COTA the AP would go out of his way to "manhandle" the resident. The resident told the COTA the AP physically intimidated him by raising a fist to the resident as if to hit him. The COTA stated after the session with the resident he reported the concerns regarding the AP to a nurse manager (NM #1).

During an interview, NM #1 stated she talked with the resident, who was visibly upset about the incident with the AP. The resident told the nurse manager to not let the AP back in his room again. The nurse manager reported the incident to the administrator.

During an interview, the administrator stated when she heard of the incident, she had the AP removed from the facility and notified the employment agency to not send the AP to the facility. The administrator stated several months before the incident she became aware of some concerns a nurse manager (NM #2) had regarding the AP's performance at the facility, but thought it was a personality conflict between NM #2 and the AP. The administrator stated the facility did not provide feedback to the agency regarding the AP's performance. The administrator stated the facility had no documentation of NM #2's concerns and no documentation of an investigation.

During an interview, NM #2 stated she had multiple concerns about the AP's performance (such as verbal aggression, lack of documentation, failure to assess residents, lying about medication

orders, document privacy, falsification of blood sugars, giving a narcotic without appropriate orders, and possible missing narcotics). NM #2 stated each time she found a concern with the AP's job performance, she met with the AP and attempted to provide coaching and education. NM #2 stated the meetings always ended with the AP yelling at her. NM #2 stated she made a list of her concerns and gave them to the administrator three months before the incident with the resident. NM #2 stated the AP did not work on her floor for a while and the administrator told her she investigated the AP but brought him back to work on another floor because no residents had made complaints. NM #2 stated the administrator directed her to send a copy of her concerns to the employment agency after the incident with the resident.

During interview the owner of the employment agency stated the AP's background study did not indicate any issues with the AP's license, but the agency did not review the attached public documents on the licensing board website. The owner stated he had not received negative feedback from the facility regarding the AP until after the incident. The owner stated the agency did not reach out to facilities for feedback on the AP's performance, as the AP had not worked at the agency for a year.

During an interview, the director of nursing (DON) stated the administrator informed her of the NM #2's concerns about the AP. The DON stated she investigated the concerns about the AP giving medications without an order, and concerns about the AP's inaccurate narcotic counts. The DON stated she did not inform the employment agency about the concerns with the AP. The DON stated the facility would not monitor the performance of agency staff unless there was a resident complaint.

During an interview, the resident stated the AP was rough with cares every time he was in the resident's room. The resident stated he feared the AP, as the resident recently had a stroke and "could not defend" himself. The resident stated he talked about his concerns with the COTA and insisted he report it to someone.

During an interview, the AP stated he would never hurt any of his residents and if anyone said he did, he would give up his license. The AP stated a group of staff with similar citizenship constructed the allegations. The AP verified that he currently had an expired nursing license but attributed that to the actions of another group of persons with similar nationality that worked at the employment agency.

A review of public documents on the licensing board website indicated the AP had multiple complaints related to abuse of residents, neglect of cares, and possible drug diversion dating back several years from more than one state. The AP's license had been suspended, but the order was stayed (discipline not imposed so long as the AP complied with specific requirements). The AP's license expired two months before the incident with the resident. The AP continued to work at the facility as though licensed.

In conclusion, abuse 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.

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;
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and
(4) use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.
(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

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

Action taken by facility:

The AP no longer works at the facility or for the employment agency.
The facility referred the resident for counseling services.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

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
Minnesota Board of Nursing

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00538	A. BUILDING: ______ B. WING ______	C **04/22/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER ON HUMBOLDT	**512 HUMBOLDT AVENUE SAINT PAUL, MN 55107**

(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
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H5255125M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued for	2 000	The Minnesota Department of Health documents the State Licensing 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	

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2 000	Continued From page 1 #H5255125M, tag identification __1850____. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "reviewed" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000	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 are the Suggested Method of Correction and 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.	
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a	21850		4/28/22

Minnesota Department of Health

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21850	Continued From page 2 resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on interviews and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was abused. Findings include: On April 22, 2022, the Minnesota Department of Health (MDH) issued a determination that abuse occurred, and that an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	21850	Corrections not needed	