Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL219471700M
Compliance #: HL219476660C

Date Concluded: June 9, 2026

Name, Address, and County of Licensee Investigated:
Cerenity Residence Marian of St. Paul
225 Frank Street
St. Paul, MN 55106
Ramsey County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Maerin Renee, RN
Special Investigator

Finding: Inconclusive

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 a delay in starting an antibiotic for treatment of the resident's urinary tract infection (UTI) resulted in confusion and agitation. Staff found the resident crawling on the floor of her apartment. The resident was sent to the hospital where she was diagnosed with a subdural hematoma (a life-threatening collection of blood between the brain surface and its outer lining (dura mater) usually caused by head trauma tearing veins).

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although there was a delay in initiating prescribed antibiotic therapy, it was unable to be determined if the delay in medication resulted in the resident's fall.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family. The investigation included review of the resident record, hospital records, clinic records, pharmacy records, facility internal

investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed medication administration and resident interactions with staff.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes, cellulitis, lymphedema, and kidney disease. The resident's services included assistance with medication management, meals, and daily safety checks. The resident's assessment indicated she was independent or required minimal care with most activities of daily living.

The facility internal investigation indicated the resident had been experiencing symptoms of a UTI, including confusion. The resident's family members took the resident to her clinic where she was diagnosed with a UTI and received a prescription for an antibiotic (cephalexin). The family member assumed the facility was notified of the new prescription. After the resident returned from her appointment, she was visited by a therapist from an outside home health agency, and a family member gave the clinic after-visit summary with the new medication order to him. The family member said the therapist told them he would give it to nursing staff on his way out. The nursing team did not receive documentation of the after-visit summary, so were unaware of the cephalexin prescription.

The pharmacy received the order for the cephalexin and delivered the medication to the facility late that Friday evening. The medication was placed in the nursing office. However, the on-call nurse was not notified of the medication delivery, so the cephalexin was not entered into the resident's medication administration record (MAR). Subsequently, the resident did not receive any doses of the cephalexin on Saturday or Sunday. Late on Sunday evening, staff found the resident crawling on the floor in her apartment in a confused, agitated state. The resident was unable to report to staff what had happened. The resident was taken to the hospital where she was diagnosed with a subdural hematoma and a urinary tract infection (UTI).

Facility leadership interviewed the staff members who were on duty the night the cephalexin was delivered, and all denied accepting the medication delivery. Staff said the delivery was left with the security guard at the entrance, who placed it in the nursing office without notifying staff or the on-call nurse. Facility leadership called the pharmacy, but pharmacy staff said the delivery driver did not record the time of the delivery or who accepted the delivery, so they were unable to provide that information. The security agent on duty the night stated he did not sign for medication delivery, and that the task was outside the scope of his job. The agent said a staff member asked him if the medical courier had arrived, but the agent had been patrolling and had not seen anyone. The following night, the agent recalled seeing the medication delivery outside the nurse's office.

The outside agency home care therapist said he did visit the resident the day she returned from the clinic. The resident's family member had two copies of the after-visit summary. The family member told the therapist one copy was for the family and the other copy was for the

therapist. The therapist reviewed the paperwork, noted relevant information, and shredded it. The therapist said he was not told to give the documentation to the facility's nursing staff.

The resident's clinic visit form obtained by the investigator indicated she was seen for an ingrown toenail of her left foot. The resident was diagnosed with cellulitis and abscess of her foot. The cellulitis was previously treated, but not fully resolved, so the provider prescribed cephalexin (an antibiotic) twice a day for seven days. The resident also complained of forgetfulness and auditory hallucinations, with cognitive changes noted. These symptoms were possibly related to side effects of her gabapentin medication, and discontinuing gabapentin was discussed. The visit note indicated the resident was experiencing urinary frequency, so a urinalysis and urine culture were ordered. Lab tests returned positive for a UTI.

A copy of the cephalexin prescription from the pharmacy obtained by the investigator indicated the resident was prescribed one capsule of cephalexin 500mg (an antibiotic) per mouth to be taken twice a day for seven days. A total of 14 capsules were dispensed. The indication for the cephalexin was L03119-(ICD-10): cellulitis of an unspecified part of a limb (not a UTI).

The resident's progress notes indicated the night she fell, the resident was found crawling around on the floor in her apartment. The resident was combative and confused, which was not her baseline status. Staff called 911 and the resident was transported to the hospital.

The resident's hospital records indicated she was admitted with a diagnosis of subdural hematoma. Facility staff reported the resident had been more confused the past couple of days and had complained of a headache. The resident was seen by neurosurgery, but the team decided against surgical intervention. The resident completed a 5-day course of antibiotics for treatment of the UTI, a palliative care consult was ordered, and the resident was discharged to a transitional care unit (TCU).

When interviewed, a supervisor said facility nurses did not receive a copy of the clinic visit form, so they were unaware of the new prescription. The clinic faxed the prescription to the pharmacy, and the pharmacy delivered the medication to the facility sometime late Friday or early Saturday morning. Whoever accepted the medication delivery did not notify the after-hours on-call nurse, so the medication was not entered into the resident's MAR for administration. The delivery driver did not collect the signature of the individual who accepted the medication delivery, nor did the driver record the time of the delivery. So, the pharmacy was unable to provide the facility with the identity of who accepted the medication delivery. The staff members working Friday evening and overnight denied accepting the medication delivery. The staff members suggested the security guard may have accepted the medication delivery, but leadership verified the security guard did not accept the medication delivery. Facility leadership reviewed camera footage but did not see evidence of the medication delivery. On Sunday, after missing four doses of her antibiotic, the resident fell and went to the hospital.

When interviewed, a nurse said a family member called and let her know the resident was to begin an antibiotic, cephalexin. The nurse tried to call the pharmacy to get a copy of the prescription but was unable to get through. The nurse did not call the clinic because she did not know which clinic the resident went to. The nurse said she had already left when the resident returned, so she did not receive an after-visit clinic summary, nor did she transcribe the cephalexin onto the resident's MAR. The nurse believed the cephalexin was delivered late Friday evening, but staff did not notify the on-call nurse about the new medication. The nurse returned to work on Monday morning and found the medication sitting in the nurse office, but by then the resident was admitted to the hospital.

When interviewed, a staff member said he did not recall seeing a delivery person deliver the resident's antibiotic. The staff member said the standard protocol was for the delivery person to find a staff member to accept the delivery or go to the front desk to find someone. As far as he knew, no medication was delivered to staff that evening.

When interviewed a family member said the family was disappointed, overall, by the care the resident received at the facility. The family member said she and another family took the resident to her clinic, where she was diagnosed with a UTI and prescribed cephalexin. The family member brought the after-visit documentation and prescription to the facility nurse who said they would fill the antibiotic. However, after the resident fell, the family member talked with a facility nurse on Monday, and the nurse said the cephalexin was not filled. The family member said an after-visit clinic summary was provided to both facility nurses and the resident's home health nurse. After the resident's hospital stay, she moved to a different facility for a higher level of care.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

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.

Vulnerable Adult interviewed: No, due to cognitive status.
Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility completed an internal investigation, reviewed medication delivery protocols with the pharmacy and staff and completed staff education.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

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
	21947	A. BUILDING: _____ B. WING _____	C 04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY RESIDENCE - MARIAN OF	225 FRANK STREET SAINT PAUL, MN 55106

(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 On April 7, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL219476660C/#HL219471700M. No correction orders are issued.	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.	