Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL297197023M
Compliance #: HL297191700C

Date Concluded: March 7, 2025

Name, Address, and County of Licensee Investigated:
The Legacy of St Anthony
2540 Kenzie Ter
St Anthony, MN 55418
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lori Pokela R.N.
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 safety checks were not completed in accordance with the service plan and the resident was later found in a locked kitchen on the floor with injuries.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. It was unable to be determined whether staff's failure to complete a safety check at the scheduled time resulted in the resident's fall. When staff discovered the resident missing from his room, staff contacted facility administration, the police, and the resident's family. The resident was located and sent to the hospital for evaluation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident's medical records, facility internal investigation documentation, facility incident reports, personnel files, staff schedules, law enforcement

report, and related facility policy and procedures. Also, the investigator observed the facility environment and staff to resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included Alzheimer's Disease, hypertension (high blood pressure), diabetes mellitus, and anxiety. The resident's service plan included staff assistance with activities of daily living including medication management, staff escorts to the dining room, and hourly safety checks. The resident's assessment indicated the resident was alert, but confused and forgetful with impaired decision-making skills. The resident was independent with ambulation.

During a night shift safety check, staff discovered the resident was missing from his room. Facility documentation indicated unlicensed personnel (ULP) called the on-call nurse at approximately 4:12 a.m. while another unlicensed personnel called 911. ULP searched the facility for the resident while making the phone calls. The on-call nurse called both the administrative nurse and executive personnel to report the resident missing from his room who came to the facility to assist with the search. At 5:50 a.m. executive personnel found the resident in the facility's unlocked dining room kitchen on the floor with a skin tear on the right arm and no visible head injury.

A law enforcement report indicated facility night shift staff called law enforcement at 4:43 a.m. to report the resident missing. The facility night staff informed law enforcement the resident was last seen at 2:30 a.m. The law enforcement report indicated they were contacted later by facility staff saying that the resident was found with injuries and law enforcement responded to assist ambulance personnel. While the ambulance personnel assessed the resident, the resident's family arrived at the facility and the resident was transported to the hospital.

Hospital records indicated the resident sustained a bruise to the right shoulder and a skin tear to the right elbow. X-rays were negative for fracture and a CT scan showed no signs of traumatic injury. Left-sided facial drooping was noted upon examination in the emergency room and the resident was admitted to the hospital. The resident did not return to the facility and discharged to a transitional care unit.

During investigative interviews, ULP stated they checked on the resident at 12:30 a.m. and the resident was asleep. ULP could not recall the specific time, but at 2:30 a.m. or 3:30 a.m. when they went to check on the resident again, the resident was not in his room. The ULP immediately searched the facility, including the dining room area and kitchen, but did not initially see the resident. One ULP stated while they completed a long search for the resident outside the facility they received a call from administrative staff that the resident was found.

During an interview, the resident's family member stated a facility nurse called her landline and cell phone at 4:49 a.m. and informed the family member that her "auntie" or "grannie" was missing. The family informed the facility staff nurse that she does not have an "auntie" or "grannie" and that she must have the wrong number. The staff nurse told the family member to

go back to sleep. At 5:02 a.m. law enforcement called the family member and informed that the resident was reported missing. The family member stated approximately fifteen minutes later the resident's family member was at the facility and found the facility dining room doors locked. The resident's family member then started searching outside the facility and returned to the facility at 6:00 a.m. and was informed the resident had been found in the facility's kitchen. The family member observed the resident was lying on his right side, he was moving and there was a lot of blood on the floor. The family member was told one of the night ULPs searched the dining area, and may not have looked into the kitchen area, then locked the dining room door after not seeing the resident.

During an interview, the on-call nurse stated the resident was noted missing at 3:30 a.m. and it was reported to her via phone at 3:40 a.m. by ULP. The nurse instructed the ULP to search the facility while she called administrative staff, executive personnel and law enforcement to report the resident missing. The on-call nurse also stated she called the resident's family and left a voice mail to report the resident was missing from his room. The nurse denied calling the family to report a missing person and then indicating they called the wrong number.

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, per family request.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
When the resident was discovered missing, staff contacted 911 and searched for the resident.

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
	29719	A. BUILDING: _____ B. WING _____	C 01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LEGACY OF ST ANTHONY	2540 KENZIE TERRACE SAINT ANTHONY, MN 55418

(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: #HL297191700C/#HL297197023M On January 7, 2025 through January 14,2025, 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 45 residents receiving services under the provider's Assisted Living Care license. The following correction order is issued/orders are issued for #HL297191700C/#HL297197023M, tag identification 0500, 0650, 0730.	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.	
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following	0 500		

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0 500	Continued From page 1 and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel	0 500		

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0 500	Continued From page 2 performing delegated tasks. This MN Requirement is not met as evidenced by: Based on observation and record review, the licensee failed to ensure they had met the requirements for licensure by attesting the managerial officials in charge of day-to-day operations had assisted living licensure facility policies and procedures in place as required and keep them current. This had the potential to affect all three 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) and was 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). Findings include: The licensee currently had an assisted living license effective May 1, 2024 to April 30, 2025. The licensee lacked policies to include the new Assisted Living Licensure effective August 1, 2021. On January 7, 2025, the investigator initiated a maltreatment on-site complaint investigation visit. While touring the licensee on January 7, 2024, at 1:55 p.m., the investigator observed the Emergency Preparedness Policy and Grievance Forms posted on the main level of the licensee. Neither posting contained effective dates of the policies.	0 500		

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0 500	Continued From page 3 On January 8, 2025, at 10:06 a.m., the investigator requested licensee policies via email to the licensed assisted director, (LALD)-A. On January 8, 2025, at 2:47 p.m., LALD-A sent licensee's policies. On January 15, 2025, at 6:12 a.m., LALD-A sent an email to the investigator that indicated the licensee needed to get the updated policies that reflected the new assisted living regulations of August 1, 2021. The licensee failed to have the following policies and procedures in place and kept current as the following policies were dated July 1, 2021: -Vulnerable Adult Policy -Protecting the Resident's Rights -Resident Bill of Rights -Medication Management Policy -Supervision of Staff and Delegated Services No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) Days	0 500		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules;	0 650		

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0 650	Continued From page 4 (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure current employee records were maintained to include the required content of a background study clearance letter for three of six employees (ULP-C, RN-F and ULP-G) with records reviewed. 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 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: ULP-C: Unlicensed personnel, (ULP)-C's job description	0 650		

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0 650	Continued From page 5 and date of hire were not provided by the licensee. ULP-C's, required payroll information form, dated March 22, 2022 and ULP-C's signed licensee background check consent form was dated March 17, 2022. ULP-C's background application was completed on March 17, 2022. An email provided by the licensee's licensed assisted living director, (LALD)-A, dated January 13, 2025, at 8:15 a.m., indicated ULP-C's background clearance was missing from ULP-C's personnel file. ULP-C completed orientation competencies on October 3, 2022. The licensee provided schedule for November 3, 2024 to November 16, 2024. ULP-C was providing cares to resident's during this time period provided. RN-F: Registered nurse, director of nursing, (RN)-F's, job description was signed on July 17, 2024. RN-F's signed licensee background check consent form was dated July 17, 2022 and signed by LALD-A on January 17, 2024. RN-F's payroll paperwork, including the I-9 Form was signed and dated by RN-F on July 17, 2024 and signed by LALD-A on January 17, 2024. RN-F's background study application was completed on July 17, 2024. An email provided by the licensee's licensed	0 650		

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0 650	Continued From page 6 assisted living director, (LALD)-A, dated January 13, 2025, at 8:15 a.m., indicated RN-F's background clearance was missing from RN-F's personnel file. An email provided to the investigator on January 13, 2025 at 9:39 a.m., indicated licensee staff submitted a background study application on January 19, 2024. RN-F's background study application, dated July 17, 2024, sent by LALD-A to the investigator on January 13, 2025 at 9:39 a.m., indicated in a handwritten note on RN-F's background study application, that this application was submitted on January 19, 2024 and re-submitted on January 2025. (no day indicated). After the investigation was initiated, LALD-A provided a completed background clearance letter for RN-F, dated January 13, 2025. ULP-G: Unlicensed personnel (ULP)-G provided cares to the residents according to the licensee's schedule on the dates of November 3, 2025, November 4, 2025, November 5, 2025, November 8, 2025, November 9, 2025, November 11, 2025 and November 16, 2025. During an interview dated January 13, 2024 at 3:03 p.m., ULP-G stated she had been working full-time at the licensee and was employed at the licensee for fourteen years. The investigator requested unlicensed personnel's background clearance letter on January 13, 2025 at 8:02 a.m. via email to LALD-A.	0 650		

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0 650	Continued From page 7 No background study clearance letter was provided. Policy: The licensee's provided Criminal Background Check Form, (undated), indicated a criminal background check will be completed on all employees. A criminal record may be ground for ineligible hire or grounds to terminate employment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (21) days	0 650		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives,	0 730		

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0 730	Continued From page 8 guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee staff failed to ensure the content of the resident record included documentation of services identified in the service plan when scheduled night shift safety checks were not documented for one of two residents (R1) with records reviewed. This practice resulted in a level two violation (a	0 730		

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0 730	Continued From page 9 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 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: R1's record was reviewed. R1 was admitted to the licensee on August 5, 2016. R1's diagnoses included Alzheimer's Disease without behavioral disturbance, diabetes mellitus, hypertension and anxiety. R1 was receiving hospice services for Alzheimer's Disease, malnutrition and other co-morbidities from September 1, 2022 until March 23, 2023 when R1 was discharged from hospice services. R1's service plan dated March 4, 2022, indicated R1 to receive hourly safety checks twenty-four hours every day. The service plan indicated R1 received staff assistance with activities of daily living, (ADLs), such as, dressing, grooming, toileting on the day and evening shifts. The resident also received services for medication management and escort to and from the licensee's dining room. R1's individual abuse prevention plan, (IAPP), dated April 22, 2024, indicated R1 had a history of frequent falls and required staff safety checks. R1's service delivery records reviewed for August 1, 2024 through August 31, 2024, indicated licensee night staff completed twenty-one night	0 730		

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0 730	Continued From page 10 shift safety checks out of the one-hundred eighty night shift safety checks that were on scheduled on R1's plan of care. R1's service delivery records reviewed for September 1, 2024 through September 30, 2024, indicated licensee night staff completed only twenty-three night shift safety checks out of the one-hundred eighty night shift safety checks that were scheduled on R1's plan of care. R1's service delivery records reviewed for October 1, 2024 through October 31, 2024, indicated licensee night staff did not document that any night shif, hourly safety checks were completed per R1's plan of care. R1's service delivery records reviewed for November 1, 2024 through November 9, 2024, indicated licensee night staff completed three night shift safety checks out of the sixty-three night shift safety checks that were scheduled on R1's plan of care. An incident report dated November 9, 2024, at 4:30 a.m., indicated R1 was found on the licensee's kitchen, tile, floor at 5:50 a.m. The incident report indicated unlicensed personnel, (ULP)-C, called LPN-B at 4:12 a.m., to report R1 was not in his room. Unlicensed personnel, (ULP)-G, called emergency medical services, (EMS), (911), at that same time and both ULP-C and ULP-G were searching the licensee for R1. LPN-B called the director of nursing, RN-F and LALD-A to report R1 was missing. The report indicated someone called FM-E at 4:00 a.m. to report R1 was missing. When R1 was found in the unlocked kitchen at 5:50 a.m., R1 was breathing, continent, had a skin tear on his right arm, was alert and had no visible head injury. R1	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29719	A. BUILDING: _____ B. WING _____	C 01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 730	Continued From page 11 told licensee staff that he had been on the floor for approximately fifteen minutes. During an interview dated January 9, 2025 at 4:23 p.m., FM-E stated she felt there was not enough staff on the schedule, R1 was neglected and R1 did not receive good care from the licensee. During an interview dated January 9, 2025 at 12:51 p.m., RN-F stated she had not been aware of the lack of documentation regarding R1's safety checks. A licensee provided email dated January 10, 2025 at 11:10 a.m., from RN-F, indicated that RN-F followed-up on January 11, 2025,with night shift staff regarding the missing documentation of night time safety checks for R1. RN-F informed the investigator that she was told night staff had issues with documentation of R1's night shift safety checks and had reported the concerns to administrative staff. RN-F's email indicated she did not know why some documentation was indicated and some was not. RN-F informed the investigator that licensee administrative staff had resolved the issue with the electronic charting agency, all staff shift was updated and administrative staff would be completing audits of the documentation moving forward. No Further Information Provided. TIME PERIOD TO CORRECT: Seven (7) days	0 730		