Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304627423M
Compliance #: HL304627185C

Date Concluded: April 14, 2026

Name, Address, and County of Licensee Investigated:
Cerenity Residence on Humboldt
514 Humboldt Avenue
Saint Paul, MN 55101
Ramsey County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Michele Larson, 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):
A facility staff member/alleged perpetrator (AP) neglected the resident when the plan of care was not followed, and the resident fell and sustained a hip fracture.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident fell and was hospitalized, there was not a preponderance of evidence to support the fall was caused by the failure of facility staff to provide necessary care or services.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff and unlicensed staff. The investigator interviewed the resident's family member. The investigation included review of the resident record, the resident's hospital record, facility internal investigation, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed direct staff care during her onsite investigation.

The resident resided in an assisted living memory care unit. The resident's diagnoses included but were not limited to dementia and unsteadiness on feet. The resident's admission assessment indicated the resident was alert and oriented to self only. The assessment identified the resident was independent with toileting and the resident was able to toilet self without issue. The assessment further indicated the resident required stand by assistance with dressing and grooming due to balance issues. The assessment included under the mobility section the resident was SBA (stand by assist) or assist of one staff to meals and activities up to three times or more per day; use of assistive device (wheelchair, walker, etc). The mobility section included the use of a walker for ambulation; staff are to remind resident to use when they see him without. The resident's admission service plan indicated the resident required standby assistance to meals or activities up to three or more times per day.

The day the fall occurred, the resident was seen by staff walking to his room. The resident did not have his walker. A short time after he returned to his room, the resident called for help. The resident was found on the floor. The incident report indicated the resident slipped and fell on spilled coffee in his bathroom after returning from breakfast. Staff contacted 911 and the resident was sent to the hospital for further evaluation.

The resident's hospital record indicated the resident was diagnosed with a closed fracture of the right hip bone (femur).

Facility administration investigated the fall. The staff member/alleged perpetrator(AP) was assisting another resident when she saw the resident walk past her without his walker. The AP provided conflicting reports on if she reminded the resident to use his walker prior to the fall. The resident was already inside his apartment when he fell. The AP immediately responded to the resident's cry for help and staff called 911.

Following nursing staff's evaluation of the incident all memory care service plans were reviewed for accuracy in mobility status and staff were educated on resident safety, fall prevention, durable medical equipment, and reporting resident changes in condition.

When interviewed, the AP stated she was with another resident in the dining area getting their insulin and medications ready to bring the other resident back to their apartment. The AP stated she saw the resident without his walker and reminded the resident he needed to use it. The AP stated shortly after she heard the resident yell for help, she immediately ran to his apartment where she found the resident on the floor. The AP stated she called the nurse and took the resident's vitals.

When interviewed, a staff member stated the AP told her the resident refused to use his walker. The staff member stated the resident was easy to direct but sometimes the resident did not want to use his walker even when you redirected him. The staff member stated the incident would not have happened if they had another staff member working.

When interviewed, a facility nurse stated the resident was a high fall risk demonstrated by his shuffling gait and stiff way he walked. The nurse stated the resident was forgetful and needed a lot of reminders to use his walker, but the resident usually complied when asked. The nurse stated she was unsure what the resident's initial service plan indicated, stating it was difficult for her to understand and read it.

When interviewed, the resident's family member stated the resident was outgoing and enjoyed going to the dining area, stating he never liked to stay in his apartment. The family member stated it was staff's responsibility to ensure the resident had his walker and used it.

When interviewed, facility leadership stated the facility met the minimum staffing levels but following the incident the facility added a morning float shift from 6:30 a.m. to 1:00 p.m., to work between the memory care unit and the assisted living side.

In conclusion, the Minnesota Department of Health determined neglect 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.

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. Unable to interview due to the resident's cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility re-educated staff on the importance of reminding and assisting residents who require the use of durable medical equipment (DME) for walking and transfers, and all resident's service plans in memory care were reviewed and updated on mobility status. In addition, a float shift was added to the morning shift to assist residents in the memory care unit and assisted living.

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
	30462	A. BUILDING: _____ B. WING _____	C 12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY RESIDENCE ON HUMBOLDT	514 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
0 000	Initial Comments On December 30, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL304627185C/#HL304627423M. No correction orders are issued.	0 000	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 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.	