Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304629042M
Compliance #: HL304622423C

Date Concluded: April 15, 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):
An alleged perpetrator (AP), an agency staff member, neglected a resident when they failed to respond to the resident's pendant call for assistance to the bathroom. The resident fell after she attempted to walk herself to the bathroom. The resident was transported to the emergency department.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. There was not a preponderance of evidence to suggest maltreatment occurred. The AP was responding to another resident emergency at the time the resident fell. Although the resident was evaluated at the emergency department, she returned to the facility a few hours later at her baseline health status.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator interviewed the resident. The investigation

included review of the resident's facility record including her call pendant report and fall incident report, internal investigation, hospital record, facility incident reports, AP employee file, staff schedules, and related facility policy and procedures. Also, the investigator observed resident interactions with staff while onsite at the facility.

The resident resided in an assisted living facility. The resident's diagnoses included but were not limited to unsteadiness on feet and repeated falls. The resident's services included assistance with activities of daily living, medications, meals, housekeeping, laundry and toileting assistance every three hours. The resident's assessment indicated the resident had moderate cognitive impairment but was able to make her needs known, was independent with the use of her call light, used a manual wheelchair and walker for mobility and required a gait belt for transfers.

Staff responded to the resident's call light and found the resident on the floor. The resident was unable to report how she fell but assumed she was trying to go to the bathroom since her walker was next to her. Staff contacted 911 and had the resident transported to the emergency department for further evaluation.

Hospital records indicated the resident reported to hospital staff she fell while walking to the bathroom. The resident was diagnosed with a closed head injury and returned to the facility a few hours later at her normal baseline status.

Facility leadership initiated an internal investigation into the fall and found the resident's call pendant was on for one hour prior to staff finding her on the floor. Staff interviewed during the investigation reported they were responding to another resident emergency at the time of the fall and answered the call light as soon as they could. The AP stated she rushed to the resident's apartment after she saw the resident's call pendant alert and immediately called the on-call nurse who advised her to call 911. The AP stated she remained with the resident until she was transported to the emergency department. The AP stated the resident got up to use the bathroom by herself and pushed her call pendant because she noticed her wheelchair was not in her room. The AP reported she had taken the resident's wheelchair out of her room to assist with the resident emergency in the common area because the storage unit wheelchair was not in proper working order.

Review of the facility staff schedule at the time of the incident indicated the AP was the only staff member scheduled to work and provide cares and medications for almost 30 residents.

During interview with facility leadership, leadership acknowledged the AP should not have removed the resident's wheelchair from her room, but the AP did not know where to find extra wheelchairs, so she used the resident's wheelchair to respond to another resident emergency. Following the incident, all staff were educated about where to find extra medical equipment, including wheelchairs.

When interviewed, the resident stated she felt guilty asking for assistance because staff felt overloaded every time she called. The resident also stated she loved living at the facility and had no concerns with the care provided by staff.

When interviewed, the AP stated when she was alerted to the resident fall in the common area she looked around for a wheelchair and found one in a storage room, but it was unusable but recalled the resident had a wheelchair, so she borrowed the resident's wheelchair. The AP stated the resident told her she tried to use her walker to go to the bathroom after the AP did not respond when she pressed her call pendant. The AP indicated as soon as she was able, she responded to the resident's call light and found her on the floor and stayed with her until the ambulance arrived. The AP stated as an agency staff person she picked up a lot of shifts at the facility and stated it was "overwhelming" at times, answering call lights, administering medications, and insulin.

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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility educated staff following the incident. The facility received leadership approval for an additional shift from 5:00 p.m. until 9:00 p.m. to assist with resident cares in the assisted living facility.

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
	30462	A. BUILDING: _____ B. WING _____	C 01/08/2026

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 January 8, 2026, the Minnesota Department of Health conducted a complaint investigation of #HL304622423C/#HL304629042M. 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.	