Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL325871680M
Compliance #: HL325876583C

Date Concluded: June 8, 2026

Name, Address, and County of Licensee Investigated:
The Sanctuary at West St. Paul
1746 Oakdale Avenue
West St. Paul, MN 55118
Dakota County

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

Evaluator's Name: Maerin Renee, 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):
The facility neglected the resident when she fell out of bed and became entangled in her wheelchair overnight. At the hospital, the resident was diagnosed with rhabdomyolysis, a potentially life-threatening syndrome involving the rapid breakdown of damaged skeletal muscle, releasing toxic intracellular contents into the bloodstream. The resident was treated and moved to a transitional care unit (TCU) for rehabilitation.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident's care plan was followed at the time of the incident. When staff became aware of the fall, the resident was assessed and sent to the hospital for further evaluation. The resident was treated and returned to her baseline health status.

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

The resident resided in an assisted living facility. The resident's diagnoses included left-sided weakness, type 2 diabetes, and atrial fibrillation. The resident's services included assistance with medication management, wound care, meals, housekeeping, and laundry. The resident's assessment indicated she used a wheelchair and had an unsteady or shuffling gate. The resident's service plan indicated the resident was independent with transfers and ambulation and safety checks were scheduled for 11:00 a.m. and 5:00 p.m. The resident had no scheduled overnight checks.

Facility documentation indicated staff found the resident lying on the floor of her room. The resident was lying on her left side, and her left leg was crossed over her right leg. The resident's left foot was trapped beneath the footrest of her wheelchair. The resident reported to staff that she believed she fell around 10:30 p.m. The resident denied hitting her head but complained of pain in her left leg. Staff called 911 and the resident was transported to the hospital. The resident was hospitalized and treated for rhabdomyolysis. The resident transferred to a transitional care unit (TCU) for further recovery before returning to the facility.

Review of the fall indicated the resident did not have scheduled safety checks during the overnight shift, and the call pendant was not within the resident's reach at the time of the fall. Nursing updated the resident's service plan to have staff assist with transfers and a safety check was added for the overnight shift.

When interviewed, a supervisor said at the time of the fall, the resident received standard safety checks, which occurred at 11:00 a.m. and 5:00 p.m. daily. Staff found the resident in the morning, with her left leg wedged under the foot pedal of her wheelchair. Staff called 911 and the resident was taken to the hospital. After a brief hospital stay, the resident went to a TCU for further recovery. She later returned to the facility and returned to her baseline condition. After the resident returned, an overnight safety check at 2:00 a.m. was added to her services.

When interviewed, the resident said she was using her power wheelchair to get her call pendant, because she had left it on her nightstand. The resident said, "The chair got away from me." The resident managed her power wheelchair independently, and said when she turned it on, she was following it to the nightstand. She said the chair then "took" off, causing her to lose her balance and fall. The resident had not yet reached her pendant, so she was unable to call for help. The resident said she was hospitalized for a couple days, then spent a couple weeks in a TCU, but was fine now. The resident thought it was nice that her service plan was updated to include an overnight safety check and felt that staff were very good to her. The resident said the nurses are great and the staff take good care of her.

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: No, declined a formal interview.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility responded to the resident’s fall per protocol and updated her service plan to include an overnight safety check.

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
	32587	A. BUILDING: _____ B. WING _____	C 05/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SANCTUARY AT WEST ST PAUL	1746 OAKDALE AVENUE WEST SAINT PAUL, MN 55118

(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 May 5, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL325876583C/#HL325871680M. 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.	