DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL336132022M
Compliance #: HL336133428C

Date Concluded: July 29, 2025
Date Amended: February 23, 2026

Name, Address, and County of Licensee Investigated:
The Sanctuary at St. Cloud
2410 20th Avenue Southeast
Saint Cloud, MN 56304
Sherburne County

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

Evaluator's Name: Lena Gangestad, RN
Special Investigator
Amended By: Matt Heffron, JD
Operations Manager

Finding: Substantiated, individual responsibility

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 alleged perpetrators (AP) #1 and AP #2 verbally abused the resident by threatening to call the police and evict the resident from the facility.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was substantiated. ~~AP#1 and~~ AP#2 <u>was</u> ~~were~~ responsible for the maltreatment. ~~AP #1 and AP #2~~ <u>Facility staff members</u> attempted to stop the resident from speaking with a community staff person. At the time the resident was waiting for the meeting with the community staff, ~~both AP #1 and~~ AP #2 threatened to call the police and evict the resident if he did not move away from the door.

The investigator conducted interviews with facility staff members, including administrative staffs. The investigation included review of the resident's records, personnel files, staff schedules, policies, and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included generalized anxiety disorder. The resident's service plan included assistance with wound care and medication administration.

One day, the resident was waiting outside a room for a scheduled meeting with a community staff member conducting field interviews with residents. While he waited, AP #1 approached and asked him to move away from the door, expressing concern that he was blocking access and might overhear private conversations. AP #1 reportedly told the resident he could not talk with the community staff member. ~~AP #1 told the resident, the community staff did not want to talk to him and if he was going to continue to cause problems, AP #1 would issue him a lease violation to have the resident "kicked out."~~ AP #2 then threatened to call the police to have the resident kicked out.

During an interview, the resident stated he wanted to speak with the community staff, so he requested for an interview and waited outside her door. He said AP #1 was unaware he had an arrangement with the community staff, so she asked him to move away from the door. When he refused, AP #1 went to get AP #2~~, and together they moved his scooter 15–20 feet away from where he had been waiting~~. He stated they told him he would receive a lease violation, and they would call the police and kick him out of the facility if he did not move away from the door.

During an interview, the community staff member stated the resident had requested a meeting with her, so she asked him to wait outside the room while she prepared. She said she was standing about one foot inside the door, while the resident was about one foot outside. She clearly heard AP #1 holler at the resident and threaten to call the police, falsely telling him the community staff member did not want to speak with him and he would be evicted if he did not comply. She also reported hearing a different voice, identified as AP #2 saying they would call the police if necessary and asking the resident if he wanted to be evicted from the facility. She said AP #1 and AP #2 were unaware she was in the room, and as soon as she opened the door, both of them left quickly.

During an interview, AP #1 stated the resident had parked his scooter outside the door, and she was concerned the community staff member would not be able to open the door, so she asked him to move away from the room. Additionally, she did not want him to overhear the conversation taking place inside. She said the resident refused to move, so she asked AP #2 for help in persuading him. She stated she did not threaten to call the police or evict him from the facility.

During an interview, AP #2 stated the community staff member was in the private dining room with the door closed. The resident had parked his scooter close to the door, which could have prevented them from opening it when they were ready to leave. She said she heard AP #1 ask the resident to move, but he began raising his voice, so she stepped in. AP #2 told him the staff knew he wanted to talk with them and they would call him when it was his turn. She told him he needed to move because the person inside the room had the same right to confidentiality as he did. She said when he refused to move, they left him alone. She also stated she did not hear AP #1 threaten to call the police or evict him from the facility, and she herself did not say anything like that to him either.

In conclusion, the Minnesota Department of Health determined abuse was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening; or
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.
(c) Any sexual contact or penetration as defined in section 609.341, between a facility staff person or a person providing services in the facility and a resident, patient, or client of that facility.

(d) The act of forcing, compelling, coercing, or enticing a vulnerable adult against the vulnerable adult's will to perform services for the advantage of another.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Not Applicable.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
No action taken.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

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

You may also call 651-201-4200 to receive a copy via mail or email.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Sherburne County Attorney
Saint Cloud City Attorney
Saint Cloud Police Department
Board of Executives for Long-Term Services and Supports

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33613	A. BUILDING: _____ B. WING _____	C 05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SANCTUARY AT ST CLOUD	2410 20TH AVENUE SE SAINT CLOUD, MN 56304

(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: HL336132022M/HL336133428C On May 13, 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 131 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for HL336132022M/HL336133428C, tag identification 2360.	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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and individual persons were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction is required for this tag.	