Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL336133327M
Compliance #: HL336132660C

Date Concluded: July 7, 2026

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

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

Evaluator's Name:
Jana Wegener, 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 resident was neglected when recurring falls occurred causing a decline of condition and death.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident had repeated falls related to dementia with impulsivity and poor safety awareness; the facility had implemented services, interventions, and supervision to help prevent recurring falls. The resident's plan of care was followed with scheduled toileting and safety check provided approximately 20 minutes prior to the fall that caused the resident's decline in condition.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident record(s), death record, facility incident

reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed residents and staff in the facilities secured memory care unit.

A concern arose when it was reported the resident had recurring falls and sustained a serious injury which caused a change of condition and death.

The resident resided in an assisted living secure memory care unit with diagnoses including dementia with psychotic disturbance, anxiety disorder, urge incontinence, overactive bladder, bradycardia (slow heart rate), chronic fibrillation (heart dysrhythmia), disorders of bone density and structure, and osteoarthritis. The resident's service plan of care included interventions to help reduce the resident's risk for falls including scheduled toileting alternating with scheduled safety checks every hour. The resident's assessment approximately five days prior to the incident indicated the resident had dementia with cognitive impairment and was oriented to self only. The assessment indicated the resident had a fear of falling with a history of hospitalization for bradycardia and recurring falls. The assessment indicated that the resident lacked self-preservation skills and could not recognize her own safety needs or physical limitations. The assessment indicated the resident engaged in self-injurious behavior including self-transfers, self-toileting, self-ambulation and utilized hospice for end-of-life care.

Facility incident reports showed the resident had a pattern of recurring falls with a total of 15 falls in the last 5 months prior to the incident. The reports indicated three of the falls occurred when the resident fell out of a wheelchair being pushed by staff without using foot pedals. The reports indicated none of the falls out of the wheelchair caused serious injuries, staff were re-educated following the incidents and the resident's services were updated with instructions for staff to use foot pedals when transporting the resident in her wheelchair. The fall incident report prior to the resident's decline in condition indicated the resident was found on the floor in her bathroom at 10:20 a.m. unable to say what happened due to dementia/confusion. The report indicated the resident was assessed for injuries with concerns for a possible fracture noted. The report indicated hospice and the resident's family wanted to keep the resident comfortable at the facility. A post fall evaluation indicated that the resident's plan of care was followed with scheduled safety check and toileting provided within an hour prior to the fall occurring.

The resident's service delivery record showed a safety check was completed as scheduled at 9:00 a.m. then the resident was toileted with staff assistance as scheduled at 10:00 a.m. approximately 20 minutes prior to the fall occurring.

The resident's record of death indicated the resident died 12 days later of natural causes with contributing factors including Alzheimer's dementia.

When interviewed unlicensed personnel (ULP) staff stated the resident needed assistance with transfers and toileting at the time of the incident. ULP staff stated the resident was anxious,

moved constantly, self-transferred, and was very impulsive despite providing scheduled toileting and safety checks.

When interviewed facility leadership stated that the resident was not ambulatory and needed assistance from staff but was confused, impulsive, and had poor safety awareness. Leadership stated staff tried to anticipate the resident's needs and provided toileting and safety checks prior to the incident, but despite interventions the resident self-transferred and fell.

When interviewed the resident's family member indicated the fall incident that caused the resident's decline in condition was not preventable.

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, deceased
Family/Responsible Party interviewed: No, failed to respond to interview attempts.
Alleged Perpetrator interviewed: N/A

Action taken by facility:
The facility provided fall interventions including assistance with transfers, scheduled toileting, and scheduled safety checks to help reduce the resident's risk for falls.

Action taken by the Minnesota Department of Health:
No further action is 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
	33613	A. BUILDING: _____ B. WING _____	C 06/17/2026

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 On June17, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL336133327M/#HL336132660C. 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.	