Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL359706922M
Compliance #: HL359701396C

Date Concluded: January 13, 2025

Name, Address, and County of Licensee Investigated:
Cerenity Marian
200 Earl Street
Saint Paul, MN 55106
Ramsey County

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

Evaluator's Name: Peggy Boeck, RN, Special Investigator

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 perpetrator (AP), facility staff, abused a resident when the AP had sexual contact with the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health (MDH) determined abuse was substantiated. The AP was responsible for the maltreatment. The resident consistently reported a traumatic sexual encounter with the AP. The resident stated the AP sexually touched her vagina when she was laying naked on the bed.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family and law enforcement. The investigation included review of the resident records, hospital records, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report,

related facility policy and procedures. Also, the investigator observed location of the resident's apartment in the memory care, staff, and resident interactions.

The resident lived assisted living memory care unit due to diagnoses that included Alzheimer's disease. The resident's service plan indicated the resident independently completed hygiene, dressing, and toileting with minimal supervision, but staff administered medications. The resident's assessment indicated the resident required some redirection when anxious and occasionally refused cares. The resident's room was located at the farthest end of the unit, out of view of common areas.

An incident report indicated the resident told an unlicensed staff the AP said sexual things to her, requested the resident stand naked in front of the AP, and made the resident uncomfortable by talking about doing things to her.

During an interview, the unlicensed staff stated the resident told her of an uncomfortable incident with a staff the resident identified as the AP. The unlicensed staff stated she followed procedure and sent the resident to talk with a nurse.

During an interview, the nurse stated the resident needed little supervision, and occasionally forgot some family members, but had never reported anything of a sexual nature. The nurse stated the resident told her the AP said nasty things to her. The nurse stated she asked the resident if the incident had to do with the AP assisting the resident with getting her pajamas on, and the resident stated "No, this was different" and described how the AP made the resident lie down naked and touched her sexually. The nurse stated a skin check revealed a bruise on the resident's arm. The nurse stated she reported the incident to an administrative staff and a family member took the resident to the hospital for an exam.

During an interview, a family member stated the resident had told her about an incident where the AP "molested" the resident. The family member stated she had never made a similar accusation. The family member stated the resident said the AP scared her, made her lie down, and touched her sexually. The family member stated the resident was examined at the hospital and had a bruise on her arm that looked fresh. The family member said the police had contacted her and told her they were processing the sexual assault kit.

During an interview, the resident stated the AP was not in her room a lot, but the resident was uncomfortable when the AP was around her. The resident stated the AP behaved like he believed, "a female was less than a man." The resident stated sometimes she forgot things unintentionally, but "if it was traumatic enough" she remembered, and now "doesn't want to think about," what happened with the AP. The resident stated she felt safer now that the facility fired the AP, and she knew police were involved. The resident said the police pressed charges against the AP.

Hospital records indicated the resident told the sexual assault nurse examiner (SANE) that the AP engaged sexually with the resident more than once, and it mostly happened in the evening. During an examination with the SANE nurse, the resident stated the AP told the resident to disrobe and he would “do stuff with me”, giving a specific example. The resident told the SANE nurse that she could not forget the way the AP treated her “like a thing he could play with.” The resident said she was scared, and it was hard for her to talk about as it made her “all jittery.” The resident cooperated with evidence collection and received medication for the prevention of sexually transmitted diseases.

Law enforcement provided a portion of the requested information as the incident was in active status.

The AP declined an interview.

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, 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.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: The AP declined an interview.

Action taken by facility:
The facility investigated the incident, interviewed all residents regarding safety, re-educated all staff on the Minnesota Vulnerable Adult Act. The AP no longer works at the facility.

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.

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
Ramsey County Attorney
St. Paul City Attorney
St. Paul Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35970	A. BUILDING: _____ B. WING _____	C 12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - MARIAN OF ST PAUL	200 EARL STREET SAINT PAUL, MN 55106

(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, this correction order is 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: #HL359701396C/#HL359706922M On December 18, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 22 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL359701396C/#HL359706922M, 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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CERENITY CARE CENTER - MARIAN OF ST PAUL	200 EARL STREET SAINT PAUL, MN 55106

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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(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		