*Protecting, Maintaining and Improving the Health of All Minnesotans*

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL397767042M
**Compliance #:** HL397761662C

**Date Concluded:** March 25, 2025

**Name, Address, and County of Licensee Investigated:**
St Charles Assisted Living
402 W 4th St
St Charles, MN 55972
Winona County

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

**Evaluator's Name:** Julie Serbus, 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 the resident had multiple falls in a short time.

**Investigative Findings and Conclusion:** The Minnesota Department of Health determined neglect was not substantiated. While the resident did have multiple unwitnessed falls at his bedside, the facility implemented appropriate fall prevention interventions along with advocating for a more appropriate bed and mattress on his behalf.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The investigation included review of the resident record(s), emergency room discharge visits forms, care plans, fall reports, recap of services provided to the resident, and related facility policy and procedures. Also, the investigator observed resident and staff interactions in the memory care unit.

The resident resided in an assisted living memory care unit. The resident's diagnoses included chronic back and knee pain and cognitive impairment. The resident's care plan indicated the resident needed one-person assist to sit up in bed and transfer out of bed along with standby help and supervision to walk. The resident required reminders and encouragement to use his walker.  The resident had a decline in strength and endurance.

An assessment indicated the resident's bed had a standard frame and a mattress which was original to the bed.  The assessment indicated the resident required case management regarding financial matters, shopping for personal supplies, care decisions, and appointments. The resident displayed impaired judgement and had an active power of attorney for decision making.

A concern arose when the resident had multiple falls in a short period of time.  The facility attempted interventions to alleviate future falls.  The falls were all located in the resident's room near his bed.

After one of the first falls the resident's medical provider faxed an order for the resident to receive a hospital bed and mattress. The order indicated the bed was required as the resident had a condition which required the head of his bed to be elevated and repositioning, The same document indicated the resident required assistance to get out of bed.

A review of the fall's documentation indicated they occurred when the resident slid off the bed and, on one occasion, even tipping the bed over while the resident repositioned himself while still in it.

A progress note indicated the facility attempted to reach the resident's power of attorney to obtain signed authorization for the new bed, but those attempts were unsuccessful.

At the same time the facility was working with the county establishing new guardianship and eventually a new guardian was appointed to better address the resident's needs.

During an interview, a family member stated the resident had his own personal full-size bed and did not have a hospital bed.  The family stated she was unaware the facility was working on getting a hospital bed and thought something was wrong with the mattress as it would slide off the bed along with the resident.

During an interview, the manager stated the resident always had back pain and resident's health had been declining.

During interviews, multiple unlicensed caregivers stated the resident previously ambulated independently but later had required a walker and the falls began to occur more frequently after he had the walker. Multiple caregivers stated the falls occurred in his room and were unwitnessed.  The fall prevention interventions included additional safety checks, toileting

reminders, ensuring proper footwear, and removing clutter in the room. The resident kept his door closed and, at times, barricaded the door to keep people out. The resident did know how to use his call pendant, but often hid the pendant so that caregivers had to find it. Caregivers stated the resident was not an accurate reporter and it was possible he would lie down on the floor.

During an interview, a nurse stated the resident was to the emergency department for some of the falls related to possible head strike and, on most occasions, returned after evaluation and sustained no injuries.  On his last fall the resident was twisted in blankets and rolled out of his bed and was sent to the emergency department where a nondisplaced rib fracture was identified but was not new although it was uncertain when they occurred. There were no new orders at that time.

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
**Family/Responsible Party interviewed**: Yes
**Alleged Perpetrator interviewed**: NA

**Action taken by facility:** Facility made a report to the Minnesota Adult Abuse Reporting Center.

**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 |
|---|---|---|---|
| | 39776 | A. BUILDING: _____ B. WING _____ | C 02/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST CHARLES ASSISTED LIVING | 402 WEST 4TH STREET SAINT CHARLES, MN 55972 |

| (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<br><br>On February 24, 2025 through February 25, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL397761662C/#HL397767042M. No correction orders are issued. | 0 000 | | |