Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304621340M
Compliance #: HL304628786C

Date Concluded: April 29, 2024

Name, Address, and County of Licensee Investigated:
Cerenity Residence on Humboldt
514 Humboldt Ave
Saint Paul, MN 55107
Ramsey County

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

Evaluator's Name: Yolanda Dawson, 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, neglected a resident when the AP did not respond to a resident's call pendant for two hours. The resident had fallen, cut his head, and required emergency medical attention.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP did not follow facility policy and procedures when he did not carry a pager to receive resident pendant calls during the AP's shift. A resident that was on blood thinners fell, hit his head, and bled for over two hours before receiving staff assistance.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident and employee

records, facility policies and procedures, and facility internal investigation documents. Also, the investigator observed resident pendant alert response times.

The resident resided in an assisted living with dementia care facility. The resident's diagnoses included peripheral vascular diseases (blood circulation disorder), difficulty walking, and long-term (current) use of anticoagulants. The resident's service plan included assistance with medication management, escorts to meals, reminders to use his walker, and room cleaning assistance.

The facility report indicated the resident resided on the second floor of the facility. One evening, at 8:56 p.m., the resident activated his call pendant requesting staff assistance. The resident had fallen in the bedroom, hit his head on a door frame, and crawled about five feet to where his call pendant was attached to his walker and activated the pendant. The AP was assigned to care for the resident and did not take the pager to alert him to the resident's call pendant alerts. Instead, periodically the AP left the second floor, and went to the first floor to monitor the main pager system. The facility policy indicated the pager, and a walkie talkie for staff communication were part of the employee's uniform and must be worn at all times. At 11:00 p.m. the AP reported to the next shift and stated the resident's call pendant had been going off for about one hour and the AP requested the other staff check the resident.

The next shift responded to the resident's room 10 minutes after the change of shift report or (two hours and fourteen minutes) after the resident initially activated the pendant. Staff found the resident sitting on the floor in his apartment near the doorway with a head laceration (cut) and a blood-soaked towel in the resident's hand. Staff notified the nurse on-call, pressure was placed on the head laceration, and the resident was transported to a hospital for an evaluation.

Hospital records indicated the resident sustained a 3 centimeter (cm) in length laceration with mild to moderate blood loss. The laceration required tissue adhesive to close the wound and the resident returned to the facility.

During an interview, a ULP stated she was working on the first floor the same evening shift with the AP. The ULP stated she saw the pendant call from the resident on her pager and went to look for AP and saw the AP at that end of the hall near the resident's room. The ULP thought the AP answered the resident's call pendant.

During an interview, another ULP stated at the change of the shift at the end of the evening, the AP stated the resident needed to be checked because the resident's call pendant was activated. The ULP stated she found the resident sitting on the floor near his apartment door with a blood-soaked towel in his hand and his head bleeding. The nurse and 911 were called, and the resident transported to the hospital for an evaluation.

During an interview, the AP stated he did not have a pager because the pager was broken. The AP stated he told the ULP working the same evening on the first floor to call him if a resident

called, and she did not call him. The AP stated the last time he saw the resident was at 7:45 p.m. when passing medications. The AP stated he checked the office computer on the first floor at 10:45 p.m. and saw that the resident was calling. The AP stated the resident often pressed his pendant by accident, so he did not hurry to his room. The AP stated he told the next shift that the resident was calling, and the AP went home.

During an interview, nursing leadership stated the AP had prior education on wearing the pager and walkie talkie on his uniform at all times. The nurse stated the AP indicated the pager was broken however, all pagers were functioning at the time of the incident, the AP just “did not wear one” (pager.)

During an interview, the resident stated he tried to step over a bag and hit his head on the bathroom doorframe. The resident stated he crawled to the living room and pressed the pendant that was hanging on his walker. The resident stated he felt the blood on his head and grabbed a towel to hold on the cut. The resident stated he sat on the floor for over two hours before help arrived.

Facility policy and procedures indicated all direct care staff were required to have a working pager and walkie talkie on them at all times during their shift. If unable to find a working pager or walkie talkie staff were instructed to contact the on-call nurse immediately. Documentation indicated the AP signed this document to indicate he received and understood this policy.

In conclusion, the Minnesota Department of Health determined neglect 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.

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: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:

An internal investigation was completed. The AP was suspended while investigation was underway. Reeducation of all staff was completed during change of shift meetings. Staff assisted resident to clear walking pathways in apartment.

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
Saint Paul City Attorney
Saint Paul Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30462	A. BUILDING: _____ B. WING _____	C 04/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY RESIDENCE ON HUMBOLDT	514 HUMBOLDT AVENUE SAINT PAUL, MN 55107

(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 order 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: #HL304628786C/#HL304621340M On April 2, 2024, 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 70 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL304628786C/#HL304628786M, 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 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		