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 #: HL304624161M
Compliance #: HL304624863C

Date Concluded: October 2, 2024

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

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

Evaluator's Name: Brandon Martfeld, RN BSN
Special Investigator

Finding: Substantiated, facility 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 facility neglected a resident to provide appropriate supervision and interventions when the resident was found smoking with supplemental oxygen in use.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Despite facility staff awareness and the resident's history of smoking with oxygen, the facility failed to implement interventions to prevent the resident from smoking unsafely.

The investigator conducted interviews with facility staff members, including, nursing staff, and unlicensed staff. The investigator contacted the resident and attempted to contact the resident's family member. The investigation included review of the resident records, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed the resident.

The resident resided in an assisted living facility. The resident's diagnoses included chronic respiratory failure and dependence on supplemental oxygen. The resident's service plan included assistance with ordering, changing, and filling oxygen tanks. The resident's assessment indicated the resident was independent with mobility and used supplemental oxygen continuously. The resident had a history of smoking while using supplemental oxygen and staff were directed to report any suspicion of smoking with oxygen on inside of the resident's apartment. The resident's smoking assessment indicated the resident did not want to stop smoking.

A facility incident report indicated one early morning, the resident was outside smoking and her oxygen tank/tubing started on fire.

Review of video located at the entrance of the facility shows the resident standing with the wheelchair next to the resident on the front patio of the facility. The back of the wheelchair was engulfed with three-to-four-foot flames. The wheelchair tires can be seen on each side of the flame. The resident is partially visible from behind a pillar in the front of the building, standing, and facing the wheelchair. The video shows a security guard coming out of the building, walking towards the fire.

Approximately one month after the incident, another facility incident report indicated the resident was found smoking in her apartment while wearing her oxygen with the stationary liquid oxygen tank less than four feet away from the resident.

The resident's record indicated six and nine months prior to the resident's wheelchair incident, the resident had two other incidences of smoking with supplemental oxygen in use. The facility's interventions included education about the dangers of smoking with supplemental oxygen. The resident's medical record lacked evidence of implementing additional interventions to ensure the resident did not smoke near supplemental oxygen.

During an interview, the facility nurse stated the resident had a history of not smoking safely. After the incident in which the resident's wheelchair caught fire, the portable oxygen tank was discontinued. After the resident was found smoking in her apartment, the resident had hourly safety checks and was issued a termination of services.

During an interview, the resident stated she had an incident when she was smoking, she extinguished her cigarette and somehow the oxygen tank started on fire. The resident stated she was to go to staff to have them remove her oxygen tank from her wheelchair. The resident stated she had multiple smoking violations and was moving out of the facility.

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: No. Family declined.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The resident was educated on the dangers of smoking while using oxygen. The resident’s portable oxygen tank was discontinued after the wheelchair caught fire. The resident’s assisted living contract was terminated, and the resident was in the process of relocating to a different facility during onsite visit.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. 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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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

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

Minnesota Department of Health

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 **09/16/2024**

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 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: #HL304624161M / #HL304624863C #HL304625383M / #HL304627380C On September 16, 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 66 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for # HL304624161M / #HL304624863C, 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		

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 09/16/2024

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