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 #: HL304625383M
Compliance #: HL304627380C

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: 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 facility failed to provide care and services to prevent recurring hospitalizations for infections and falls.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Facility staff collaborated with outside agencies and the resident's provider for wound care. In addition, the facility sent the resident to the hospital numerous times for further evaluation when signs and symptoms of infections of the wound were observed. While the resident did have falls, the facility added interventions in attempt to prevent further falls.

The investigator conducted interviews with facility staff members, including nursing staff, and unlicensed staff. The investigator contacted the resident's family members. The investigation included review of the resident records, hospital records, facility incident reports, home care

notes, staff schedules, and related facility policy and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included diabetes, dementia, heart disease and heart failure. The resident's service plan included collaboration for wound care with a home care agency. The resident's assessment indicated the resident had left heel and toe wounds and staff were to update the nurse with any changes in the resident's skin. The resident was at risk for falls, had intermittent confusion and short-term memory loss.

Hospital records indicated the resident and facility staff were advised by a physician to send the resident into the hospital because of worsening kidney function following routine lab work. While hospitalized, the resident's right diabetic foot wound was assessed. The resident's foot wound had Methicillin-resistant Staphylococcus aureus (antibiotic resistant) infection and osteomyelitis (bone infection). It was discussed with the resident that wounds would not close on their own because of the bone infection and poor blood flow to the wound location. The resident required his leg amputated however; the resident chose to delay the amputation at that time. The hospital records indicated the resident was discharged back to the facility.

The resident's record indicated upon returning from the hospital, the resident's blood sugar was 542 (normal range 70-100). The facility sent the resident back to the hospital. At the hospital, due to the spread of infection, the resident had below the right knee amputation. The resident transferred from the hospital to a higher level of care.

The resident's record indicated the resident's wounds were treated, monitored, and care was coordinated with outside agencies. At times, the resident was sent into the hospital due to concerns with wound infections. The resident was treated at the hospital, started on antibiotics, and returned to the facility.

The resident's incident reports indicated the resident had seven falls in seven months. The incident reports indicated interventions were added after each fall and at times following a fall, the resident record indicated the resident was sent into the hospital for evaluation.

During an interview, the nurse stated the resident lived at the facility for approximately nine months and was in and out of the hospital due to infections to his wounds and falls. The nurse stated the resident admitted to the facility with wounds to his foot. The resident had two different homecare agencies and was seen at a foot and ankle specialty clinic for his foot wounds. The nurse stated the resident had complex wound care, and if there were concerns with the wound, the homecare agency was notified. The nurse stated when facility staff or nurses observed signs and symptoms of infection, the resident was sent to the hospital for further evaluation. The nurse stated the resident did have falls. When the resident fell, staff contacted a nurse, staff took vital signs, and the nurse assessed the resident for injuries. The nurse stated following a fall, the resident's plan of care was updated, and new interventions were added in attempts to prevent further falls.

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. Resident no longer resided at the facility.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
When the resident fell, the resident was sent to the hospital for an evaluation if the resident had injuries or hit his head. In addition, the resident was sent into the hospital multiple times for infections to his foot wounds, pneumonia, and high blood sugars.

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
	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		

Minnesota Department of Health

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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 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		