Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304629285M
Compliance #: HL304626935C

Date Concluded: May 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: Yolanda Dawson, RN
Special Investigator

Finding: Inconclusive

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), contracted staff, abused a resident when the AP had an altercation with the resident. The resident sustained a right rib fracture.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. Although there was an altercation between the AP and the resident, the resident and the AP provided conflicting information regarding the cause of the resident's injury. There were no witnesses to the altercation and when later interviewed by a security guard of the facility, the resident did not mention being injured by the AP.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a staffing agency regarding the AP. The investigation included review of employee and resident files, and facility policies and

procedures. Also, the investigator observed unlicensed personnel (ULP) perform resident cares and several residents during their daily activities.

The resident resided in an assisted living facility. The resident's diagnoses included major depression, dysphagia (difficulty swallowing), and restless leg syndrome. The resident's service plan included assistance with medication management and behavior management. The resident had impaired judgement, decreased safety awareness, was very hard of hearing, and at risk for falls. The resident had a history of exhibiting verbal aggression and throwing objects at staff when frustrated. The resident often reacted out of anger and admitted that in the moment of anger, the resident was unable to realize the consequences of his actions.

A facility report indicated late one evening the resident came out of his room and saw the AP in the hallway that the resident did not recognize. The resident was concerned because he did not know what the AP was up to, and that the AP did not belong in the facility. The resident approached the AP, followed the AP down the hall, and repeatedly asked the AP to identify himself however, the AP continued to ignore the resident. The resident became agitated and aggressive with the AP, throwing two pop cans and hitting the AP in an attempt to get the AP out of the facility. After being hit by the cans, the resident stated there was a verbal altercation between the resident and AP when the resident pushed his stomach against the AP. The AP responded by shoving/pushing the resident into a wall with an attached railing, four to five times and the AP walked away.

The facility report indicated when interviewed the AP stated late one evening, the AP heard the resident yelling accusing the AP of trespassing and being homeless. The AP attempted to explain to the resident that he was an employee however, the resident continued yelling at the AP. The AP offered to get the security guard for the resident however, the resident threw a pop can and bag of chips at the AP. The AP indicated the resident pushed his stomach into the AP. The AP indicated the resident swung his arms many times towards the AP, missing the AP causing the AP to fall against a wall. The AP left and brought a security guard to talk with the resident.

The security guard report included a conversation with the resident and AP approximately 20 minutes after the altercation. The report indicated the resident said he contacted the AP with his stomach but made no mention of being shoved or pushed into a wall by the AP.

The following morning, the resident complained to staff of right-side rib pain and stated the AP had pushed the resident into a wall the previous evening. Staff arranged for an evaluation of the resident at a local hospital. Following the hospital evaluation, the resident returned to the facility the same day with a diagnoses of a right rib fracture and a prescription for pain medication.

During an interview, a facility director stated the AP had been working on a regular basis at the facility from a staffing agency. The director stated following the incident, staff conducted additional resident interviews and they had no concerns with the care provided by the AP.

During an interview, the AP stated he was standing in the hallway charting when the resident came out of his room and approached him. The resident asked the AP if he was a drug dealer or doing drugs and he responded by saying his name and that he worked there. The AP tried to walk away, and the resident threw a pop can at him. The resident approached the AP and tried to grab him and tore his shirt pocket as the AP stepped back. The resident continued to swing at the AP and swung so hard he lost his footing and fell back against the doorframe and to the floor. The AP stated he walked away, and the resident followed him, so he went down the stairwell and asked the security guard for assistance. The AP stated during the altercation, he repeatedly told the resident he worked at the facility. The AP stated at no point did he put his hands on the resident.

During an interview, the resident stated that night following the altercation with the AP and when on his way to his room, the AP returned with the security guard who defused the situation. The security guard identified the AP as a worker and pointed out to the resident, the AP was wearing a badge, a scrub top, a fanny pack, and holding a computer.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of 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.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: No, resident stated he was self-directed.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility conducted an internal investigation. The security guard filled out incident report. The AP was removed from the schedule. The facility communicated with the staffing agency. Staff were reeducated during change of shift meetings.

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 12/20/2023

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 On December 20, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL304626935C/#HL304629285M. No correction orders are issued.	0 000		