Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL325873502M
Compliance #: HL325873771C

Date Concluded: October 3, 2024

Name, Address, and County of Licensee Investigated:
The Sanctuary of West St Paul
1746 Oakdale Ave
West St Paul
Dakota County

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

Evaluator's Name: Lisa Coil, RN, BSN
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, who is an unlicensed caregiver, neglected the resident when the alleged perpetrator did not follow the resident's service plan. The alleged perpetrator transferred the resident with one assisted when the residents service plan indicated two assists for transfers. During the transfer, the resident fell, sustained an ankle fracture, and required hospitalization with surgical repair to address the fracture.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The alleged perpetrator was responsible for the maltreatment. The alleged perpetrator was not following the residents plan of care resulting in an injury to the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record(s),

facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included left below the knee amputation, diabetes type 2, and neuropathy. The resident's service plan indicated the resident required two staff to physically assist through transfers with the second person for safety. The resident's assessment indicated the resident had mild cognitive impairment and refused help from others.

Progress notes indicated the alleged perpetrator was transferring from a chair to the electric wheelchair with assist of one and the resident slipped while standing. The note indicated the resident went to a squatting position and his right ankle "snapped". Afterwards the resident's ankle was bleeding and not in the correct position.

During an interview, the resident stated he can transfer from wheelchair to recliner by himself but needs two people to assist when he transfers from recliner to wheelchair. The resident stated during this incident he was transferring from the recliner to the wheelchair and should have had two people to assist but there was only one. The resident stated he asked the alleged perpetrator to get help, but the alleged perpetrator did not get anyone else. The resident stated he slid down between the recliner and wheelchair, one of his shoes gripped the carpet and his ankle broke.

During an interview, the family member stated when the alleged perpetrator helped the resident transfer from the recliner to the wheelchair, the resident asked for another person to help. The family member stated the alleged perpetrator said to the resident we have done this before. The family member stated she would help and began getting up from her chair. The family member stated before she could get there to help, the resident lost strength in his legs and slid down the front of the recliner. The family member stated the resident's shoes got caught and did not move and the resident's ankle broke. The family member stated the alleged perpetrator had assisted the resident transfer before, they had a process down, and the family member sometimes helped. The family member stated it was an accident and not the alleged perpetrator's fault.

During an interview, the alleged perpetrator stated she was assigned to pass medications the evening of the incident. The alleged perpetrator stated there were several call lights going off so she told another caregiver she would answer the resident's call light. The alleged perpetrator stated the resident was sitting in his recliner and wanted to transfer to his wheelchair. The alleged perpetrator stated she told the resident to wait so she could call another caregiver for help, but the resident was already rocking back and forth in the recliner in preparation to stand. The alleged perpetrator stated the resident's wife tried to get to the resident and assist but it was too late, the resident had already stood up, then slid to the floor between the recliner and the wheelchair. The alleged perpetrator stated she heard a snap and when she looked, she saw the resident's ankle was bleeding. The alleged perpetrator stated she immediately called 911.

The alleged perpetrator stated the resident was a two-person transfer. The alleged perpetrator stated staff used phones to communicate with each other, but her phone was outside the residents' room on the medication cart and the resident was already attempting to stand up.

During an interview, a manager stated the alleged perpetrator said she transferred the resident with one staff. The manager stated the alleged perpetrator said she thought the two staff were for the resident's behaviors and the wife would count as the second person for transfers.

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:
The facility investigated the incident and sent the resident to the hospital. The facility took corrective action with the alleged perpetrator.

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

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

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
Dakota County Attorney
West St. Paul City Attorney
West St. Paul Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32587	A. BUILDING: _____ B. WING _____	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SANCTUARY AT WEST ST PAUL	1746 OAKDALE AVENUE WEST SAINT PAUL, MN 55118

(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: #HL325873771C/#HL325873502M On September 26, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 145 residents receiving services under the provider ' s Assisted Living with Dementia Care license. The following correction order is issued for #HL325873502M, 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	Please refer to the Public Report for details.	