

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL325875543M
Compliance #: HL325879556C

Date Concluded: October 19, 2023

Name, Address, and County of Licensee

Investigated:

The Sanctuary at West St Paul
1746 Oakdale Avenue
West St Paul Minnesota 55118
Dakota County

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

Evaluator's Name: Holly German, 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) abused a resident when she continued to perform cares after the resident told her stop and told the resident to shut up.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined abuse was inconclusive. There was not enough specific information to determine if the AP's actions constituted abuse. The AP denied the allegation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted a family member. The investigation included review of the resident's medical record, staff schedules, personnel files, facility policies, facility incidents and grievances, and the internal investigation. Also, the investigator toured the facility and observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included unspecified intracranial injury and unspecified mental disorder. The resident's service plan included assistance with blood glucose monitoring, dressing, transfers, toileting and bathing. The resident's assessment indicated she required use of a wheelchair and was alert and oriented.

The facility schedule indicated the AP was assigned to the care of the resident on the date of the incident. The resident reported to the facility management the AP accused her of purposeful incontinence and wiped "too hard." The resident also reported the AP told her to shut up. The resident stated she felt harassed and retaliated against. The incident report failed to include specific details of actions that constituted wiping "too hard" and actions of the AP that made the resident feel harassed.

During an interview, a nurse stated the resident reported to her the AP was aggressive with perineal cares and did not stop when she told her to. The resident stated the AP made rude comments but could not recall the exact nature. The nurse stated she interviewed the AP and suspended her pending her investigation.

During an interview, the AP denied abusing the resident. She stated there were times she was not assigned to the resident, but she would try to help her. She stated the resident would often mistake her for other staff members. She stated she voiced concerns of the residents decline and possible over self-medicating to nursing staff.

During an interview, unlicensed personnel (ULP) stated the AP speaks with her country's dialect, which can sometimes sound harsh to others, even though it is not what she intends. The ULP stated she never heard of any complaints about the AP.

During an interview, a family member stated the resident would often voice complaints about the care received at the facility. The family member stated she was a reliable reporter. The family member did not feel she received proper care at the facility.

The resident was not able to complete an interview as she had passed away before the investigation.

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;
- (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: No. Deceased.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility reported the incident timely and suspended the AP. The AP is no longer employed at the facility.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32587	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/05/2023
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NAME OF PROVIDER OR SUPPLIER THE SANCTUARY AT WEST ST PAUL	STREET ADDRESS, CITY, STATE, ZIP CODE 1746 OAKDALE AVENUE WEST SAINT PAUL, MN 55118
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(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	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>#HL325875187C/#HL325878125M #HL325879556C/#HL325875543M</p> <p>On October 5, 2023, 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 148 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction order is issued for #HL325875187C /#HL325878125M, tag identification 2360.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
02360	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>Residents have the right to be free from physical,</p>	02360		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Minnesota Department of Health

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02360	<p>Continued From page 1</p> <p>sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.</p> <p>This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment.</p> <p>The findings include:</p> <p>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.</p>	02360		