Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL336133202M
Compliance #: HL336133261C

Date Concluded: June 26, 2024

Name, Address, and County of Licensee Investigated:
The Sanctuary at St Cloud
2410 20th Ave SE
St Cloud MN 56304
Sherburne County

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

Evaluator's Name: Maggie Regnier
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 perpetrators (AP #1 and AP #2) neglected a resident when they failed to do safety checks on a resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. AP #1 and AP #2, who were both unlicensed caregivers, were responsible for the maltreatment. Neither AP followed the resident's service plan which included safety checks to be done every two hours over a period of 14 hours during which time the resident had fallen in her room and was unable to get up nor call for help.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted family members. The investigation included review of facility records, hospital records, resident records, facility

internal investigation, policy's, staff records and training records. Also, the investigator observed staff interactions with other staff, visitors, and residents.

The resident resided in an assisted living facility. The resident's diagnoses included high blood pressure, diabetes, and coronary artery disease. The resident's service plan included assistance with meals, laundry medication management and assistance getting to the dining room and needed assistance for toileting 8-12 times a day. The resident's assessment indicated the resident was hard of hearing and forgetful.

An incident report indicated the resident was found on the floor of her room. The resident was found to be shaky and quiet, and she had swelling on her right side of her face. This record also indicated the nurse and physician were notified and the resident was sent to the local emergency department for evaluation.

The internal investigation report indicated the facility reviewed facility video footage to validate the residents all two-hour safety checks were done as documented. These documents indicated a review of the video footage determined neither AP entered the resident's room from 7:20 pm until 9:20 am the following morning when the resident was found on the floor and the resident transferred to the hospital. The same document indicated the hospital indicated the resident said she laid on the floor most of the night and had increased fluid "pooling" on the right side of her face.

The hospital record reports the resident had elevated creatine kinase, an enzyme that is released when there is muscle damage, likely from lying on the floor for a prolonged period of time.

The facility service checkoff list indicated the resident was on every 2-hour safety checks every two hours, day and night. The document indicated a "safety check" meant the unlicensed caregiver was to perform a face-to-face check on the resident's status. The same document indicated the following during the time the video footage showed no unlicensed caregivers entered the resident's room.

- AP #1's initials appeared on the night shift indicating services were provided by AP #1 at 9 PM and 11 PM on the previous evening then 1 AM, 2 AM, 3 AM, and 5 AM after midnight
- AP #2's initial appeared on the day indicating services were provided by AP #2 at 7 AM, 730 AM, and 8 AM

A document titled supervision of unlicensed personnel, list specifically accurate documentation of services and expectation of documentation and completion of services. Both the AP's received this education.

During an interview, leadership stated that video footage confirmed that neither AP had gone into the resident's room over a 14-hour period. Leadership also stated both APs admitted to documenting the safety checks had been done but they actually did not do them. Leadership also stated both APs were terminated immediately for not following policies and procedures.

During an interview, nursing stated that both APs had received education on the importance of safety checks and the correct documentation for the safety checks. Nursing also stated that all staff were re-educated on these points after this incident and that the facility has implemented random audits for safety checks matching documentation with video timing.

During an interview, AP #1 stated she documented the safety checks for the resident but did not actually do them.

During an interview AP #2 stated she documented providing services for the resident but did not actually do them.

During an interview, the resident's family member stated they were saddened to find out the resident laid on the floor for an undetermined amount of time. The family member also stated that overall, they were happy with the care at the facility and agreed that the facility did the right thing by terminated the APs.

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 did an internal investigation and immediately terminated both APs. The facility also implemented re-education of all staff and random audits to ensure staff are doing what they are documenting.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33613	A. BUILDING: _____ B. WING _____	C 06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SANCTUARY AT ST CLOUD	2410 20TH AVENUE SE SAINT CLOUD, MN 56304

(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 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: #HL336133261C/#HL336133202M On June 5, 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 105 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL336133261C/#HL336133202M , tag identification 2360.	0 000	No plan of correction is required for this tag.	
02360 SS=F	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, 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:	02360		

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02360	Continued From page 1 The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and two individual persons were responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		