Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL336136125M
Compliance #: HL336131540C

Date Concluded: September 28, 2023

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

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

Evaluator's Name: Lissa Lin, RN
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 to supervise resident #1 and resident #2 when resident #2 sexually abused resident #1 when he entered her room naked one night. Resident #1 reported vaginal bleeding and cramping of unknown origin.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. While the facility failed to immediately file a report to the Minnesota Adult Abuse Reporting Center (MAARC), on the suspicion of alleged abuse, they conducted an internal investigation. Resident #1 denied any male resident entered her room and denied any inappropriate or sexual contact with anyone. Resident #1 was later evaluated by her physician and probable cause of vaginal bleeding was determined. Resident #3 also had vaginal bleeding around the same time as resident #1. Six days after resident #3's report of vaginal bleeding, resident #3 was seen by her provider and started on an antibiotic.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the case worker and former staff members. The investigation included review of resident records, provider communication, policies and procedures, and incident reports. Also, the investigator observed hospice staff caring for resident #2 and his wife, resident #3, seated in his room.

Resident #1 lived in the memory care unit. Her diagnoses included history of traumatic brain injury, mood disorder and lung cancer with metastasis to the brain. She was prescribed a blood thinner. Resident #1's service plan included assistance with medication administration, safety checks, behavior management, and cueing for activities of daily living. Resident #1's assessments indicated she made her own decisions and could make her needs known. She had periods of confusion and short-term memory impairment. She moved to memory care due to significant orientation issues.

Resident #2 lived in the memory care unit. His diagnoses included dementia with behavioral disturbance, inappropriate sexual behavior, and late onset Alzheimer's. Resident #2's services included assistance with dressing, behavior management, medication administration and safety checks.

Resident #3 lived in assisted living. Her diagnoses included diabetes with polyneuropathy. Her services included assistance with activities of daily living, and medication administration.

One day, resident #1 reported vaginal bleeding and cramping to the nurse. The nurse contacted the primary care provider (PCP) triage nurse and was instructed to monitor the bleeding and call with any changes or concerns. A few days later resident #1 indicated to nursing staff she had the vaginal bleeding on and off for an extended period, but it had stopped. Records reviewed indicated "mention was made" that a naked male resident had been in resident #1's room but nothing happened. The male resident was not identified and there was no date of the alleged incident. On the same day, resident #3's progress notes indicated resident #3 also reported vaginal bleeding. Nursing staff sent a communication note to resident #3's PCP.

Record review indicated two days later, resident #1's PCP reviewed a recent pelvic completed by oncology four days before the report of her vaginal bleeding which showed she had uterine wall thickening. That condition could have caused sporadic vaginal bleeding. Six days after the report of vaginal bleeding, resident #3 was seen by her PCP and ordered an antibiotic. There was only one episode of vaginal bleeding for resident #3.

During an interview, a nurse manager said the nurse who posted the naked male incident information on the PCP communication portal was an agency nurse. She should have notified facility management of the incident but did not and was reassigned. The nurse manager said she found out about the allegation from the PCP. The facility started an internal investigation. Management reviewed memory care camera footage from several nights; no male residents entered resident #1's room. The nurse manager said it was not clear the allegation was about

resident #2 but since his wife, resident #3, had recently complained of vaginal bleeding as well, he was suspected. They interviewed resident #1. She denied any incident occurred and told staff there was a male resident who occasionally helped her to her room or held the door for her. The nurse manager said they did not interview resident #2 or file a MAARC report since there were no specifics on who the male resident was, when the incident occurred or who reported the information to the nurse.

During an interview, a former nurse said she and a memory care manager interviewed resident #1 as part of the internal investigation. Resident #1 denied any incident happened and if it did, she would tell the nurses. Resident #1 declined a vaginal exam but agreed to a gynecological exam. A referral was made but she did not make an appointment. The nurse said resident #2's inappropriate sexual behavior may have involved his wife [resident #3], but she could not recall the details.

During an interview, a multiple staff members said resident #2 wandered the memory care hallways but did not enter resident rooms. They said there were "rumors" that resident #1 invited male residents in her room during the overnight shifts but there were no specific incidents. Staff said another male resident on memory care had inappropriate behaviors towards female staff and he would sometimes wander into resident rooms, but there were no reports of any sexual activity between him and female residents.

During an interview, a social worker said she was concerned that the facility did not file a MAARC report and took too long to investigate the issue. She had several residents in memory care on her caseload, including residents #1, #2 and #3. Resident #3 was seen by the PCP and she denied any sexual abuse by resident #2.

Resident #3 declined an interview due to resident #2's hospice cares but said she visited him daily and sometimes slept in his room because of his anxiety. No concern about behavior was brought to her attention.

The agency nurse did not respond to phone calls for an interview.

Resident #2 could not be interviewed due to cognition and health.

In conclusion, the Minnesota Department of Health determined abuse 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: Resident #1, no, deceased. Resident #2, no, on hospice, cognition and health issues. Resident #3, no, declined.

Family/Responsible Party interviewed: Resident #1, no, was her own decision maker. Resident #2, no, resident #3 was his decision maker and declined an interview.

Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility conducted an internal investigation and updated medical providers via the provider portal.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

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

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

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 08/28/2023

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

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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: #HL336131540C/#HL336136125M On August 28, 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 94 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for ##HL336131540C/#HL336136125M, tag identification 0620.	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 License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
0 620 SS=E	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with	0 620		

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0 620	Continued From page 1 the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has	0 620		

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0 620	Continued From page 2 reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to comply with the requirements for immediately (within 24 hours) reporting suspected maltreatment of a vulnerable adult to the Minnesota Adult Abuse Reporting Center (MAARC) for three of four residents (R1, R2 and R3) reviewed for sexual abuse. R1 had vaginal bleeding and abdominal pain of unknown origin. R2 was married to R3 who also had vaginal bleeding of unknown origin. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not	0 620		

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0 620	Continued From page 3 found to be pervasive). Findings include: R1's medical diagnoses included type 2 diabetes, history of traumatic brain injury (TBI), lung cancer with metastasis to the brain, dysthymic disorder and anxiety. R1 was assessed as able to make her needs known but had increased confusion and moved from assisted living (AL) to the memory care (MC) unit. R1's service plan agreement dated February 9, 2022, indicated R1 received assistance with dressing, medication administration, behavior monitoring, toileting and safety checks. R1's medication management included regular blood clotting tests for a prescribed blood thinner. R2's medical diagnoses included Alzheimer's, unspecified dementia with behavioral disturbance. R2's service plan agreement dated December 1, 2022, indicated R2 received assistance with activities of daily living (ADLs), medication administration, and behavior management. R2's comprehensive assessment dated March 30, 2023, indicated R2 had assault behavior (threw things when frustrated), socially and sexually inappropriate behaviors but was redirectable. His wife, R3, was actively involved in his cares. R3's medical diagnoses included type 2 diabetes, neuropathy and mixed incontinence. R3's service plan agreement dated December 12,	0 620		

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0 620	Continued From page 4 2022, indicated R3 received assistance with dressing, and medication administration. R3 lived in the AL building. On August 28, 2023, at 9:30 a.m., during a memory care unit tour, executive director (ED)-G indicated R1's room was on one end of the unit and R2's room was on the other hallway at the far end. Anyone moving from one side to the other would pass the common area, staff station and the hallway cameras. On August 28, 2023, at 10:35 a.m., the MDH surveyor observed R2 in his bed. R3 and hospice staff were with him. R2 was moaning and restless. Hospice staff indicated R2 had stopped eating and drinking and received end of life cares. R1's progress note dated April 9, 2023 at 7:34 a.m., indicated R1 had some vaginal bleeding. The note indicated nursing staff contacted the on call nurse on April 8, 2023 at 11:25 p.m. to report R1's minor abdominal cramps and bleeding. Triage nurse instructed staff to monitor resident and return call if worsens or other concerns. No return call was documented. R1's progress note dated April 11, 2023, at 5:07 p.m., by registered nurse (RN)-D indicated R1 had "vaginal bleeding for an extended period of time now off and on." She had no vaginal bleeding visible currently. R1 had "twisting" abdominal pain that came and went and on April 8, 2023, it was the worst pain she had in awhile. A report was made today that there was another resident [R2] in R1's room some time ago that was naked with no proof that anything happened at that time but the nurse did report that the spouse is also having vaginal bleeding at this time. Information sent to the physician with	0 620		

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0 620	Continued From page 5 consideration of further testing or urine sample to be collected. There was not documentation the licensee made a MAARC report regarding R1's vaginal bleeding within 24 hours a suspicion of maltreatment prior to further investigation. R3's progress note dated April 11, 2023, at 9:33 a.m., indicated R3 had concerns about blood in her toilet and on her "pad" that a.m., no pain just itching. It was just one incident and thought the blood was vaginal not rectal. Nursing staff sent a message to the physician. There was not documentation the licensee made a MAARC report regarding R3's vaginal bleeding within 24 hours a suspicion of maltreatment prior to further investigation. During an interview on August 28, 2023, at 12:50 p.m., R3 said her husband, R2, lived in the memory care unit and she saw him daily. He did wander the hallways but she was not aware he wandered into rooms or took his clothes off. R3 said R2 was anxious at night and often asked for her to stay and sleep with him,which she did. During an interview on August 28, 2023, at 1:22 p.m., unlicensed personnel (ULP)-A said R1 had bleeding in her "private area" one day when ULP-A helped change her clothes. ULP-A reported that to RN-F. ULP-A said there were rumors from overnight staff who talked about male residents invited into R1's room at night and she had vaginal bleeding from sexual intercourse. ULP-A said she never saw male residents in R1's room. During an interview on August 28, 2023, at 1:54	0 620		

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0 620	Continued From page 6 p.m., ULP-B said R1 was cognitively intact when first started working at the licensee and R1 lived in the assisted living building. He was away from the job awhile and when he returned to work, R1 had moved to the memory care unit and was more confused. ULP-B said he heard during the overnight shift R1 had a male resident in her room. ULP-B said a few male residents in memory care wandered the halls during the day, including R2, but he did not go into other rooms. ULP-B said staff members are to do safety checks every two hours and report anything unsafe or inappropriate. During an interview on August 28, 2023, at 3:13 p.m., director of health services (DHS)-C said she was made aware of R1's vaginal bleeding from a nursing note posted on the physician communication portal by RN-D. R1's nurse practitioner contacted her about the note. DHS-C said the nursing note indicated an unnamed naked male was in R1's room. No specifics were given. DHS-C said she started an internal investigation that lasted a few days and included reviewing the two MC hallway cameras. The cameras did not give good clear pictures but would have shown if a naked male was going down the hallway towards R1's room. RN-F interviewed R1 who denied any sexual activity with another resident and declined a gynecological exam. DHS-C said they did not file a MAARC report, but should have even though there were no specifics or facts from their investigation to link R1 and R2 sexually, or that R2 had caused R3's vaginal bleeding. During an interview on September 21, 2023, at 1:15 p.m., former staff member RN-F said she heard it was R2 that went into R1's room one night, but there was no exact date. RN-F and	0 620		

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0 620	Continued From page 7 another MC staff member interviewed R1 and she denied any inappropriate behavior with or by R2. RN-F said R2 liked to walk the hallways but he was timid, he did not go into rooms. One of his assessments indicated he was sexually inappropriate but RN-F said that had been an incident towards his wife, R3. RN-F said RN-D took some incomplete information and "ran with it" instead of filing a MAARC report. RN-D did not respond to phone calls for an interview. A policy titled Vulnerable Adult Reporting and Investigation, revised November 15, 2019, indicated staff were required to immediately report to the common entry point (CEP) upon hearing the witness' description of the incident, if the incident appears to be suspected abuse, neglect or financial exploitation, the DHS shall immediately make a web based report, or if the web based site is not an option, an oral report to the CEP. "Immediately" means as soon as possible, but no longer than 24 hours from the time incident occurred. TIME PERIOD TO CORRECT: Seven (7) Days	0 620		