DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL304342220M
Compliance #: HL304348143C

Date Concluded: May 7, 2026

Name, Address, and County of Licensee Investigated:
St Ann's Residence
330 East 3rd Street
Duluth, MN 55805
St. Louis County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name:
Jana Wegener, 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):
Alleged perpetrators (AP)1 and AP2 abused the resident when they physically restrained and forced the resident to take medication.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Although a facility investigation indicated a staff reported witnessing the resident's hands were held during medication administration, there was a lack of evidence to show the act was done with force to restrain the resident. The resident had restlessness and confusion at end of life. The resident was receiving end-of-life comfort medications (anti-anxiety and pain medication). AP1 and AP2, upon reapproach, held the resident's hand during medication administration in therapeutic conduct. The medication administration was effective and in the best interest of 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, death record, facility internal investigation, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed residents and staff at the facility.

The resident resided in an assisted living facility with diagnoses including stage 4 lung cancer with metastasis to the bone and brain, and mild vascular dementia with behavioral disturbances. The resident's assessment and plan of care indicated the resident received hospice for end-of-life care and medication administration services.

A concern arose when staff reported observing two APs physically restrain the resident by holding the resident's hands, then forced the resident to take his medication.

The resident's facility progress notes two days before the incident occurred indicated the resident was having difficulty swallowing medications and had increased confusion with inability to comprehend direction. The note indicated hospice was updated with instructions to hold all oral medication except comfort medications crushed, dissolved in a small amount of water and administered orally via a syringe. The same day a hospice progress note indicated the resident was very confused with hallucinations and was transitioning to the active phase of dying.

An incident report was requested but none was received. The resident record lacked documentation of the incident or assessment of injuries including potential redness, pain, or bruising after staff reported witnessing the alleged physical restraint and forced medication administration.

A facility investigation report indicated AP1 stated AP2 asked for assistance with the resident's medication pass. AP1 stated when they entered the room, the resident was waving his hands/arms around, so AP1 held the resident's hands so the resident would not hit them. AP1 stated the resident was still able to move his hands while she held them. The report indicated when interviewed AP2 stated the resident was moving his head back and forth so AP1 gently placed her hands on the resident's hands, then AP2 administered his medication. When interviewed the staff witness stated AP1 and AP2 asked the resident if they could give him his medication and the resident shook his head "no." The witness stated AP1 held the resident's hands down until the resident took his medication. The witness was asked to demonstrate how AP1 held the resident's hands and the witness explained the resident's hands were together over his body then demonstrated AP1 had placed her hands on top of his hands. The report failed to indicate AP1 utilized any force to restrain the resident when she held his hands.

The resident medication administration record indicated AP2 administered an anti-anxiety medication and pain medication. The medication was effective, and the resident was "ok" afterwards.

When interviewed, facility leadership stated prior to the incident the resident was experiencing "terminal agitation" (a severe state of restlessness, and confusion during the final hours or days

of life), was very confused, hallucinating, and described observing the resident frequently reaching and grabbing into the air around the time of the incident. Facility leadership indicated AP2 asked AP1 for assistance when she re-approached the resident and tried to administer his medications.

When interviewed, AP1 stated she was on one side of the bed and AP2 was on the other. AP1 stated the witness was behind AP2 not near the resident during the medication administration. AP1 stated the resident was very confused moving his head back and forth and waving his arms in the air when they entered the room. AP1 stated she gently held the resident's hands to provide comfort and distraction, but indicated the resident continued to have the ability to move his hands under hers and denied using any force that restrained the resident's movement.

When interviewed, AP2 stated she was on one side of the resident's bed and AP1 was on the other. AP2 stated AP1 gently placed her hands on the resident's hands and denied the resident showed any resistance or distress to AP1 holding his hands. AP2 stated if AP1 had restrained the resident in anyway she would have immediately told her to stop.

When interviewed, the witness stated she was behind AP2 approximately 10 feet away from the resident's bed when she observed the incident. The witness stated she observed the resident shaking his head "no" then AP1 grabbed the resident's hands with her hands, crossed them over his body and held them down with her arms by using the weight of her body as she laid on top of the resident in his bed restraining him until AP2 administered his medication.

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 likely 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; or

(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
When staff reported the potential abuse, the facility immediately began to investigate the incident. AP2 was re-educated on resident rights and medication administration practices.

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
	30434	A. BUILDING: _____ B. WING _____	C 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANN'S HOME	330 EAST 3RD STREET DULUTH, MN 55805

(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 April 1, 2026, the Minnesota Department of Health initiated an investigation of complaint HL304342220M/HL304348143C. No correction orders are issued.	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.	

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