Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL336136327M
Compliance #: HL336139562C

Date Concluded: December 11, 2024

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

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

Evaluator's Name: Lena Gangestad, 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 the resident when she fell and was later found lying on her back in the bedroom. The resident was admitted to the hospital due to shortness of breath, where she was subsequently diagnosed with a left femur fracture.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident fell in her bathroom and sustained a left femur fracture, however the facility had appropriate safety measure in place and took when the resident was found on the floor.

The investigator conducted interviews with facility staff members, including administrative staff, and unlicensed staff. The investigation included review of the resident's records, internal investigation documentation, incident reports, staff schedules, policies, and procedures.

The resident resided in an assisted living secured memory care building. The resident's diagnoses include dementia. The resident's service plan included safety check at 11:30 AM and 4:30 PM. The resident's assessment indicated she needed cueing and stand by assist with transfer and mobility.

A review of the resident's medical record indicated she fell three times over the course of approximately 24 hours.

The resident's progress notes indicated she fell in the bathroom around midnight on Wednesday. She sustained a bump to the back of her head and a skin tear on her left hand. Her vital signs were normal, Tylenol was administered, and her right leg was elevated to alleviate soreness.

The progress notes indicated the resident had another unwitnessed fall the following morning, Thursday, around 7 a.m. and was found sitting by her recliner. The same document indicated vital signs were stable, and no injuries identified.

Later that same day, a post-fall assessment conducted indicated the resident rated her pain in her left hip although she was able to complete a range of motion exercises without an increase in pain. The same document indicated there was no bruising, however she had an abrasion on her left hand that was scabbed and left open to air. The facility contacted the medical provider who ordered a portable X-ray. The facility also updated the resident's family.

The X-ray report taken on the same day indicated there was no evidence of a fracture nor acute bone abnormalities.

Later evening the resident had another fall. The progress notes indicated she sustained a new skin tear on her right elbow and reported pain. Her vital signs remained stable, and her range of motion was normal.

On Friday morning, a post-fall assessment indicated the resident rated her pain as 4/10 with movement. Her range of motion was within normal limits. The progress notes indicated an additional X-ray was ordered.

However later that same day, the progress notes indicated the resident was sent to the hospital for evaluation of shortness of breath. While hospitalized, she was diagnosed with a left femur fracture. The hospital recommended supportive care without intervention and the resident was transferred back to the facility with orders for home care and supportive therapy.

During an interview, a family member stated that he was notified about the fall(s) when it happened but was unsure how long she had been on the ground. The family member stated the facility conducted an X-ray but did not find anything, so they ordered a second one. In the

meantime, the resident experienced shortness of breath, prompting her transfer to the hospital, where they discovered she had Covid as well as a hip fracture.

During an interview, a manager stated the resident's intervention prior to the falls included a toileting schedule every 3-4 hours during waking hours while overnight there were two scheduled safety checks. The manager stated there were recent orders for physical and occupational therapy due to risk for falls. The facility completed a new assessment when the resident returned from the hospital with orders for home care. Since the resident's return, there had been no further falls.

During an interview, an unlicensed caregiver stated that the resident lived in the memory care unit and received safety checks in the morning and afternoon in addition to toileting assistance and medication administration. She said that the resident used her wheelchair to move around and used her pendant to call for help when needed.

In conclusion, the Minnesota Department of Health determined neglect 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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility conducted a post-assessment after each fall and sought appropriate care.

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
	33613	A. BUILDING: _____ B. WING _____	C 11/20/2024

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 On November 20, 2024, the Minnesota Department of Health initiated an investigation of complaints #HL336136327M/HL336139562C. No correction orders are issued.	0 000		