Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL286057242M
Compliance #: HL286052280C

Date Concluded: April 14, 2025

Name, Address, and County of Licensee Investigated:
Summit Hill Senior Living
1824 Old Hudson Rd
Saint Paul, MN 55119
Ramsey County

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

Evaluator's Name: Brooke Anderson, 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) financially exploited the resident when the AP took the resident's morning medications including narcotics, for personal use but reported she destroyed the medications in the sharp's container.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was inconclusive. Due to incomplete and conflicting accounts of the incident, it could not be determined if maltreatment occurred.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident record, facility internal investigation, facility incident reports, personnel files, staff schedules, a law enforcement report, and related facility policy and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included spinal stenosis. The resident's service plan included assistance with medication management. The resident's assessment indicated the resident was cognitively intact.

The facility's internal investigation indicated the resident called 911 and reported she was not administered her morning medications. The investigation indicated the AP attempted to administer the resident her medications but did not watch the resident take the medications. The internal investigation indicated the AP provided inconsistent stories about what happened to the medications.

During an interview, the AP stated the resident did not want staff in her apartment so the medications were left on the shelf inside the apartment. The AP denied placing the medications in the sharps container and denied taking the resident's medications for personal use.

During an interview, the resident stated a staff member stole her medications; however, the resident could not identify any specific staff member. The resident stated when she did not receive her morning medication, she reported the concern to facility staff and called police. The resident stated she had chronic pain and was in pain the day of the incident.

During an interview, a facility nurse stated the resident was very particular about her medications. The AP reported she gave the resident's medications to the resident's friend that was also a resident at the facility because the resident was sleeping. When questioned later, the AP reported the resident didn't take the medications, so the AP removed them from the resident's room and put them in the sharp's container. The sharps container was inspected, and no medications were found. Video footage was reviewed but was blurry and could not provide a clear account of the incident. A facility nurse stated when a medication needed to be destroyed staff were educated to place the medication in a white envelope with a label and notify the nurse.

Video footage was not available for review at the time of the investigation.

In conclusion, the Minnesota Department of Health determined financial exploitation 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.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means:
(b) In the absence of legal authority a person:
(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;

(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;
(3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or
(4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: No, attempts made were not successful.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility investigated the incident, updated the medical provider and provided education to facility staff regarding medication administration.

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
	28605	A. BUILDING: _____ B. WING _____	C 02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT HILL SENIOR LIVING	1824 OLD HUDSON ROAD SAINT PAUL, MN 55119

(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 February 18, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL286052280C/#HL286057242M. No correction orders are issued.	0 000		