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 #: HL321665644M
Compliance #: HL321667940C

Date Concluded: March 3, 2025

Name, Address, and County of Licensee Investigated:
Scenic Hills Alternative Care
2197 Bonnie Lane
St. Paul, MN 55119
Ramsey County

Facility Type: Assisted Living Facility (ALF)

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 alleged perpetrator (AP) financially exploited the resident when she took the resident's prescription narcotics for her own use.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined financial exploitation was not substantiated. While the AP did not follow facility policy and procedure for counting resident #1's narcotic medication, she did not take the morphine. Another resident and vulnerable adult who lived at the facility, resident #2, reported taking resident #1's prescription morphine for his own use.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and resident #1's family. The investigation included review of resident #1 and resident #2 records, pharmacy record, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator

observed the locked medication storage cabinet, signage reminding staff to keep the medication cabinet locked, medication preparation and administration, and entries in the narcotic medication logbook.

Resident #1 resided in an assisted living facility. Her diagnoses included dementia, cognitive impairment and a brain tumor. Resident #1's service plan included medication administration. The resident's assessment indicated she had depression and anxiety.

Resident #2 resided in an assisted living facility. His diagnoses included bipolar disorder, substance abuse and pain. Resident #2's service plan indicated he was independent in most activities of daily living and needed some cueing and reminders. He received medication administration. He received treatment at a pain clinic.

In late summer, resident #1 was enrolled in hospice due to her dementia diagnosis. The hospice provider ordered morphine 2.5 milligrams dissolvable tablets, take one tablet every hour as needed (prn) for pain and shortness of breath. The morphine card held 15 tablets. Pharmacy records indicated it arrived the next day and two unlicensed personnel (ULP) logged it on the narcotic inventory sheet.

The facility's internal investigation indicated, about five days later, during an overnight shift, the AP could not find resident #1's morphine card in the medication cabinet lockbox or during a search through the house. The AP contacted the nurse and told her the morphine had never been delivered. The nurse went to the facility the next morning to investigate the missing medication and contacted the police. Resident #1's morphine had been delivered a few days earlier, was counted and logged in by two ULP. During the internal investigation, the nurse and a manager interviewed the AP and other ULP who worked when the morphine card was still present. The AP and ULP gave conflicting information on how and when the narcotic medication counts were done; no staff followed the two-person count policy and procedure.

Narcotic records indicated the AP and another ULP counted and signed for the morphine card of 15 tablets three days earlier during shift change. When the nurse asked the AP about that, the AP said she was confused about what medication card she counted. The AP told the nurse she did not conduct the narcotic medication count with the outgoing ULP at shift change, although they signed it was completed together. Later during her shift, the AP could not find resident #1's morphine card. She searched the house, then called and left messages with managers and the nurse.

During an interview, the AP said resident #1's morphine prescription had not been used yet, but staff still had to count it at each shift change. They did not always count the medications together at shift change as they were trained to do but it had never been a problem. The AP said the ULP who often worked the shift before hers was in a hurry to leave that night; he handed her the keys and left. The AP said she called and texted that ULP later to ask him what happened to the morphine card, but he did not answer her calls or texts. The AP said she knew

she “messed up” and took responsibility for not performing the narcotic medication count correctly, but she did not take the medication. The AP said she cried and wondered if she had been set up to take the blame for potential drug theft by another staff person. The AP said she did not leave the medication cabinet or narcotic storage box unlocked or unattended, so no resident could have taken the morphine during her shifts. When staff for the next shift arrived, the AP had her search the house again. The AP said the nurse and a manger interviewed her and terminated her employment.

During an interview, an ULP he did the narcotic medication count with the AP, and the morphine card was there. He had no idea what happened after his shift ended. The ULP said the narcotic medications were kept in a lockbox in the medication cabinet. The medication cabinet had to be locked at all times. He said he was disciplined for not following narcotic medication count policy and procedure.

During an interview, the nurse said the AP gave some conflicting information on the incident but said she did not take the morphine, someone else accessed the medication cabinet. The nurse said the facility is strict about their policies and it was a serious matter.

During an interview, a manager said the AP was the last person to sign off that the morphine card was there, so she was responsible for it. Several other ULP were also disciplined and given written warnings. The manager said she cleaned all the resident rooms hoping to find the morphine card. She started with resident #2’s room first because of his history of substance abuse. She did not find the morphine card. Sometime later, the manager said she helped resident #2 with some paperwork when he said he had a “confession to make.” Resident #2 said he took the morphine card from the unlocked medication cabinet. He used the morphine and disposed of the empty card by sticking it down the storm drain at the end of the driveway. He did not provide an exact date or shift when he took the morphine card. The manager went outside to check the storm drain, but did not find the empty morphine card. The manager notified the nurse who called police with the new information. The nurse and manager offered to help resident #2 get additional treatment for his substance abuse issues but he declined.

Resident #1’s family declined an interview but said they were not aware of the drug diversion and were happy with the cares resident #1 received when she lived there. Resident #1 discharged to a hospice out of state.

Resident #2 died of an accidental drug overdose a few months later after the missing medication incident.

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

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9
"Financial exploitation" means:
(1) engages in unauthorized expenditure of funds entrusted to the actor by the vulnerable adult which results or is likely to result in detriment to the vulnerable adult; or
(2) fails to use the financial resources of the vulnerable adult to provide food, clothing, shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the failure results or is likely to result in detriment to the vulnerable adult.
(b) In the absence of legal authority a person:
(1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;

Vulnerable Adult interviewed: No, resident #1 had severe cognition issues and moved out of state. Resident #2 is deceased.
Family/Responsible Party interviewed: Resident #1's family declined. Resident #2 was his own person.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility conducted an internal investigation and contacted police. Management disciplined and retrained ULP. Management posted signage about medication count requirements for ULP to follow. The facility no longer employed the AP at facility. The facility searched for the medication at the time it was missing and after resident #2 reported diverting it.

Action taken by the Minnesota Department of Health:
cc:
  The Office of Ombudsman for Long Term Care
  The Office of Ombudsman for Mental Health and Developmental Disabilities

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32166	A. BUILDING: ______ B. WING ______	C 01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	**2197 BONNIE LANE 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 ******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: HL321667940C/HL321665644M and HL321666521C/HL321668782M On January 23, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction order is issued. At the time of the complaint investigation, there were 4 residents receiving services under the provider's Assisted Living license. No correction orders are issued for HL321667940C/HL321665644M. The following correction order is issued for HL321666521C/HL321668782M, 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 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.	
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma	0 620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32166	A. BUILDING: ______ B. WING ______	C 01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	**2197 BONNIE LANE 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
0 620	Continued From page 1 (a) The assisted living facility must comply with 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.	0 620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32166	A. BUILDING: ______ B. WING ______	C 01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	**2197 BONNIE LANE 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
0 620	Continued From page 2	0 620		

(e) A mandated reporter who knows or has 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 interviews, licensee staff failed to report the unexpected death of one of one residents (R2) after he left the licensee without telling staff where he was going and for how long. Unlicensed personnel (ULP)- G found R2 outside by the garage, cold and unresponsive a few hours later.

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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

The findings Include:

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32166	A. BUILDING: ______ B. WING ______	C 01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	**2197 BONNIE LANE 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
0 620	Continued From page 3	0 620		

R2's medical diagnoses included depression, a traumatic brain injury, chronic pain, alcohol and substance abuse and bipolar disorder.

R2's service plan agreement dated November 6, 2024, indicated R2 was his own decision maker. He received medication administration but was independent with many of his activities of daily living (ADLs) or needed minimal cueing. The nurse assessed R2 as having unlimited alone time in the community and was a wandering risk because he left the facility without letting staff know where he was going. Staff were instructed to find out where R2 was going and when he planned to return. Any concerns needed reporting to the program manager (PM) or registered nurse (RN).

R2's Provider Orders for Life Sustaining Treatment (POLST) dated November 1, 2023, indicated R2 wanted cardio pulmonary resuscitation (CPR) attempted.

A resident incident report dated, December 30, 2024, indicated R2 left the facility with an unknown male sometime around 7:00 p.m. ULP-G saw R2 and the unknown male go into R2's room briefly before they went back upstairs and exited by the front door. ULP-G noticed the front door was left open and she thought R2 was returning to the house. After 30 minutes passed she shut and locked the front door. Around 8:07 p.m. ULP-G contacted PM-D to let her know R2 left the house earlier and was not back to take his 8:00 p.m. medications. ULP-G asked PM-D if she should contact the nurse on call or wait another 30 minutes when the window to give R2 his medications ended. ULP-G also called R2's cell phone but he did not answer. At 8:38 p.m. ULP-G

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32166	A. BUILDING: ___ B. WING ___	C 01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	**2197 BONNIE LANE 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
0 620	Continued From page 4	0 620		

contacted licensed practical nurse (LPN)-H to let her know R2 left the house, was not reachable by phone and missed his 8:00 p.m. medications.

LPN-H instructed ULP-G to wait until 10:00 p.m. and call her back if R2 was still not back. Around 9:00 p.m., ULP-G finished her cleaning tasks and went to take the garbage outside. She opened the garage door and saw a foot. ULP-G went outside and saw R2 lying on the garage wheel chair ramp. He was unresponsive and his eyes were red and bulging outward. ULP-G called 911, and PM-D. LPN-H was added to the group chat while ULP-G was on the phone with a 911 operator.

LPN-H told ULP-G to administer Narcan but the 911 operator told ULP-G not to give Narcan if R2 was cold to the touch, had no pulse and was not breathing. Five to 10 minutes later paramedics and police arrived. ULP-G gave emergency medical services and police R2's medical emergency paperwork while another program manager from a nearby sister facility arrived to help ULP-G. PM-D arrived soon afterwards. The medical examiner arrived at took R2 around 11:00 p.m.

During an interview on January 23, 2025, at 11:55 a.m., director of nursing (DON)-A said they only contacted the police about R2's death.

During an interview on February 11, 2025, at 1:30 p.m., PM-D said ULP-G did an incident report on R2. The nurses complete and send reports to the Minnesota Adult Abuse Reporting Center (MAARC).

A policy titled Reporting Vulnerable Adult Issues and Abuse, undated, indicated when a situation is

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32166	A. BUILDING: ______ B. WING ______	C 01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	**2197 BONNIE LANE 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
0 620	Continued From page 5 discovered in which a vulnerable adult reports or is thought to be at risk of abuse, the agency and its representatives will react quickly in a coordinated manner to help them overcome difficulties. Staff and its mandated reporters will immediately report a concern to the appropriate persons and agencies. TIME PERIOD TO CORRECT: Seven (7) Days	0 620		