

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL321668782M
Compliance #: HL321666521C

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: 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) neglected the resident when she did not check on his whereabouts and found him unresponsive and not breathing outside a few hours later.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated for the responsibility of the AP. The resident was his own decision maker and able to have unlimited alone time in the community. His service plan indicated staff members needed to ask where the resident was going and when he planned to return if he left the facility. The AP saw the resident and a visitor leave through the front door, but did not ask where he was going because he never left the facility when she worked and assumed he was going outside per his usual habit. The resident failed to return for his evening medications and the AP followed policy by notifying the manager and following directions provided.

The Minnesota Department of Health determined neglect was inconclusive for the responsibility of the facility. Although the resident had a history of alcohol and substance abuse and received treatment at a pain clinic, it was not clear what the resident's substance abuse patterns were and what signs of substance abuse staff were to monitor for. The resident's provider recommended substance abuse treatment, however the resident declined due to having poor insight about his drug addiction and continue to be his own independent decision maker. It was inconclusive if the facility had sufficient specific interventions and if facility leadership directed the AP to search for the resident when he was missing for an hour, it could have been anticipated the resident would use drugs in the facility garage. After being missing for about an hour later, the AP found him in the garage not breathing and unresponsive. The resident died from fentanyl toxicity.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement and the medical examiner. The investigation included review of the resident record, death record, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, and related facility policy and procedures.

The resident lived in an assisted living facility. His diagnoses included bipolar disorder, substance abuse and pain. His service plan indicated he was independent in most activities of daily living. He needed some cueing and reminders. He received medication administration. He received treatment at a pain clinic and had a history of alcohol and substance abuse. The service plan and assessment lacked details of the resident's patterns of drug abuse and signs of substance abuse staff were to monitor for. The nurse assessed him able to have alone time in the community but was also a wandering risk due to leaving the facility without telling staff. Staff were instructed to know where he was going and when he would be back. Concerns were reported to the nurse and manager.

An incident report approximately two months prior to his death indicated he had diverted another resident's medication card of morphine from the facility medication cabinet the month prior and used it. The nurse followed up and offered coordination of the resident attending a substance abuse program because of his continued struggle with substance abuse. The resident declined.

The resident's medical provider note indicated about a month prior to the resident's death, the provider recommended substance abuse treatment, however the resident declined due to having poor insight about his drug addiction and continue to be his own independent decision maker.

The law enforcement report indicated a male visitor stopped by to see the resident. The AP said she had never seen the visitor before. She said hello and went to help another resident with his laundry. The AP was in the basement for a few minutes. When she came upstairs, she saw the resident and the male visitor go out the front door. She did not ask the resident where he was

going because when she worked, he either stayed in his room and slept or went outside to smoke around 7:00 or 8:00 p.m. so it was not unusual for him to go outside at that time.

The AP said she helped another resident with his shower and did other tasks. Around 8:00 p.m. the AP prepared the evening medications. She expected the resident to come in for his evening medications, but he did not. The AP thought the resident had left the facility without telling her resulting in missed his medications, so she contacted the manager, per policy and procedure. The manager told the AP to wait another 30 minutes until the window to pass medications ended in case he returned. The AP called the resident's cell phone from the facility house phone. He did not answer. The AP contacted the nurse a half hour later. The nurse told the AP to give the resident until 10:00 p.m. and call her back if he still had not returned. The AP said no one told her to go outside to look for the resident.

The AP finished cleaning for the evening and took the trash out to the garage. She opened the side garage door and saw a foot. She realized it was the resident's foot because of the shoes he wore. She dropped the trash bag and ran to him. The resident was lying on the garage wheelchair ramp. She tapped him and called his name. He was cold and not breathing. The AP called 911 and texted the manager and nurse. Emergency medical technicians arrived and determined the resident was dead. The medical examiner arrived and took the resident's remains for an autopsy. The law enforcement report indicated there was a pipe near the resident's body and his death appeared accidental.

During an interview, the AP said the resident would usually tell staff if he was leaving the facility and needed his medications packed and sent along with him. That was usually when he went out with his girlfriend. He had no specific return time if he left the facility. The AP said she said she did not ask him where he was going because he had the right to come and go freely. She said she thought the visitor was a relative and the two men were outside smoking. She did not know if he left the property while he was outside. The resident did not have a car. The AP said around 9:00 p.m. she went to the garage to take out the trash and found the resident lying on the wheelchair ramp. He was on his back; his head lower than his feet. He was not breathing and unresponsive. The AP said his eyes were red and bulged from their sockets. The AP called 911, the nurse and her manager. There was no sign of the visitor.

During an interview, a manager said the resident had a history of opiate and other substance abuse. He smoked a pipe and was often by the garage in the designated smoking area. He did not always tell staff where he was going and did not always answer his phone when they called to check on him. The manager said the AP handled the situation well.

During investigative interviews, a staff member said the resident did not want to tell staff where he was going or answer his phone if they called. He had no "curfew" and declined to sign in and out when he left. The staff member said she was concerned he did drugs in the community, and

he often smelled of marijuana which she reported to the nurse. Another staff member said on cold days the resident liked to spend time in the garage smoking. Police records indicated there was a pipe near the resident's body and his death appeared accidental.

Medical examiner records indicated the resident died from fentanyl and ethanol (alcohol) toxicity; his death was an accident.

In conclusion, the Minnesota Department of Health determined neglect 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.

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: No, deceased.

Family/Responsible Party interviewed: No, resident his own person.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility offered to assist the resident with attending a substance abuse program and attempted to monitor his leaving of the facility. The facility notified police when the resident diverted medication. The facility provided direction for the AP when the resident was not available for his medications and notified 911 when found deceased.

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

St. Paul Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32166	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/23/2025
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NAME OF PROVIDER OR SUPPLIER SCENIC HILLS ALTERNATIVE CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2197 BONNIE LANE SAINT PAUL, MN 55119
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(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	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>HL321667940C/HL321665644M and HL321666521C/HL321668782M</p> <p>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.</p> <p>No correction orders are issued for HL321667940C/HL321665644M.</p> <p>The following correction order is issued for HL321666521C/HL321668782M, tag identification: 0620.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
0 620 SS=D	<p>144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma</p>	0 620		

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

Minnesota Department of Health

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0 620	<p>Continued From page 1</p> <p>(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.</p> <p>The requirement in Minnesota Statute section 626.557, Subd. 3 is:</p> <p>(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:</p> <p>(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</p> <p>(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).</p> <p>(b) A person not required to report under the provisions of this section may voluntarily report as described above.</p> <p>(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.</p> <p>(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.</p>	0 620		

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0 620	<p>Continued From page 2</p> <p>(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.</p> <p>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.</p> <p>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).</p> <p>The findings Include:</p>	0 620		

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0 620	<p>Continued From page 3</p> <p>R2's medical diagnoses included depression, a traumatic brain injury, chronic pain, alcohol and substance abuse and bipolar disorder.</p> <p>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).</p> <p>R2's Provider Orders for Life Sustaining Treatment (POLST) dated November 1, 2023, indicated R2 wanted cardio pulmonary resuscitation (CPR) attempted.</p> <p>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</p>	0 620		

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0 620	<p>Continued From page 4</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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).</p> <p>A policy titled Reporting Vulnerable Adult Issues and Abuse, undated, indicated when a situation is</p>	0 620		

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0 620	<p>Continued From page 5</p> <p>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.</p> <p>TIME PERIOD TO CORRECT: Seven (7) Days</p>	0 620		