Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL202718704M
Compliance #: HL202716182C

Date Concluded: June 28, 2024

Name, Address, and County of Licensee Investigated:
Scenic Hills Alternative Care
2187 Bonnie Lane
St. Paul, MN 55119
Ramsey County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lori Pokela
Special Investigator

Finding: Substantiated, facility responsibility

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):
Facility staff neglected the resident when staff failed to identify, assess, monitor, and treat skin concerns, and the resident developed multiple pressure ulcers.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to identify, assess, monitor, and provide necessary care to promote healing and prevent worsening of the resident's wounds. The resident developed pressure wounds to the ear, sacral area, both heels, and toes.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted hospital staff. The investigation included review of the resident record(s), hospital records, facility incident reports, personnel files, and facility policies and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included schizophrenia, dementia, and diabetes. The resident's service plan identified the resident was cognitively impaired and required assistance with medication management, toileting, incontinent cares, and reminders and supervision for bathing and eating. The resident was independent with bed mobility and used a walker with stand-by assistance of staff for ambulation.

The medical record indicated the resident's condition declined the last three months of their stay at the facility. The medical record indicated the resident experienced weight loss, fatigue, and changes in behavior, mobility, and cognition.

Facility documentation indicated staff contacted emergency medical services (EMS) due to complaints of leg and right ankle pain and the resident was transferred to the hospital. Hospital records indicated the resident was evaluated, labs and x-rays were obtained, and no skin concerns or pressure injuries were present. Ankle x-rays were negative for fracture and the resident transferred back to the facility later that day.

Two weeks later, the resident was transferred to the hospital again due to increased weakness and the need for two staff to assist with transfers. A skin check was completed by a licensed nurse one hour prior to the resident's transfer to the hospital. The nurse documented that the resident had no open areas but noted the coccyx area had blanchable (skin that remains white or pale for longer than normal when pressed; indicative of lack of blood flow to the area) redness and both heels were pink.

Hospital records indicated the resident had multiple pressure injuries present upon arrival. The ambulance report indicated facility staff told emergency medical personnel the resident had increased weakness the last couple of days and had pressure wounds from lying in bed. Hospital staff noted pressure injuries on the right ear, sacrum (coccyx), right great toe, right second toe, and both heels. Hospital documentation described the sacral area wound as a full thickness pressure injury with areas of slough (thick, stringy, tissue that is yellow or tan), peeling skin, and a small amount of drainage. Both heels were firm and leathery, with black eschar (dead tissue that forms a scab-like covering over deep wounds) present. On the right foot, the large toe had two areas of black discoloration and an area of black discoloration was also noted on the second toe. Hospital staff cleansed and treated the wounds, and a consult was ordered with the wound care team. Hospital notes indicated facility staff reported that the areas of pressure injury developed over the last week. The resident was hospitalized for eight days and discharged to another care facility.

During investigative interviews, unlicensed staff recalled that the resident had a bloody, blackened, and scabbed, sore on the right ear and dark areas, the size of a quarter, on both heels. Unlicensed staff stated the resident sat too much and developed a red open area on the buttocks. Unlicensed staff stated they reported the open area on the buttocks to a facility nurse, but never received clear direction on how to treat the area.

During interview, the licensed nurse who completed the skin check prior to the resident's transfer to the hospital, recalled the resident's sacral area and heels were intact and pink in color. The nurse did not recall a wound on the right ear or areas of concern on the toes.

During interview, administrative nursing staff stated that unlicensed staff completed skin checks and if a concern was noted, staff updated the nurse, and the nurse assessed the area. Administrative nursing staff indicated that the facility's process for informing the nurse of an area of concern included for unlicensed staff to text a picture of the area to the nurse. Administrative nursing staff stated they were informed of an area on the resident's right ear and when they assessed the area, it was pink. The nurse directed staff to apply an antibiotic ointment to the area, but the treatment was not added to the resident's service plan. Administrative nursing staff indicated they were also informed of the sacral wound and recalled that when they assessed the area, the skin was pink and intact. The nurse directed staff to apply a barrier ointment to the area and to turn and reposition the resident every two hours, but the interventions were not added to the service plan. Nursing staff were aware of skin concerns on the resident's heels but stated when they last assessed the areas, the skin was pink and intact. Administrative nursing staff confirmed that no skin assessments were documented by the facility's registered nurse, the areas of concern were not monitored, the medical provider was not updated on all areas of concern, no orders were obtained for treatment of the wounds, and interventions to prevent further development of the wounds were not implemented.

During an interview, the resident's family member stated that they were not informed by the facility of any skin issues until the resident was transported to the hospital. At that time, the family member was told that the resident had a wound on the sacral area. The resident's family member was shocked to find out about the multiple pressure injuries at the hospital and were told by hospital staff that the areas were not recent developments but that they had developed over a period of time.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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, per family request
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
None.

Action taken by the Minnesota Department of Health:

The responsible party will be notified of their right to appeal the maltreatment finding.

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
Ramsey County Attorney
Ramsey City Attorney
St. Paul Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20271	A. BUILDING: _____ B. WING _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS ALTERNATIVE CARE	2187 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: #HL202716182C/HL202718704M On April 10, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were six residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for, #HL202716182C/#HL202718704M, tag identification 2360.	0 000		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.	02360		

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02360	Continued From page 1 This MN Requirement is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure one of six residents reviewed (R1) was free from maltreatment. R1 was neglected. Findings include: On May 1, 2024, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No plan of correction is required.	