

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL231584284M
Compliance #: HL231587304C

Date Concluded: June 15, 2023

Name, Address, and County of Licensee

Investigated:

Scenic Hills Alternative Care
2170 Snowshoe Lane
St. Paul, MN 55119
Ramsey County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brooke Anderson, RN
Special Investigator

Finding: Substantiated, individual 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):

The alleged perpetrator (AP), a facility staff member, financially exploited a resident when the AP used the resident's account to make personal purchases.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP accessed the resident's account and made unauthorized purchases. The resident's account statements identified the AP's PayPal account, which included the AP's name, was a recipient of transactions.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement. The investigation included review of the resident's medical record, bank statements, personnel files, and facility policies and procedures. At the time of the onsite visit, the investigator toured the facility and observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included schizoaffective disorder and obsessive-compulsive disorder. The resident's service plan included assistance with medication management, toileting, and bathing. The resident's assessment indicated the resident was not able to identify or protect herself from potential risks. The resident's medical record indicated the resident needed assistance with shopping, had a financial worker and needed full assistance with money management related to her diagnoses. Medical records indicated the resident did not leave the facility unattended and staff assisted with any outings or appointments.

The resident alerted staff that her card was declined, but funds should have been available. Law enforcement was notified, and staff assisted the resident in obtaining account statements.

Review of account statements indicated 10 transactions over a period of five days were made to a staff member/alleged perpetrator (AP)'s PayPal account in the amount of \$210.21. Over a period of three months, an additional 67 unauthorized transactions were made. The additional unauthorized charges included door dash, fast food restaurants, Amazon prime purchases, television subscriptions, ATM withdrawals, and PayPal transactions to an unknown account. Review of the account indicated the resident did not have a history of making similar purchases.

Law enforcement was contacted but no report was available in relation to this incident.

During an interview, facility staff stated the resident reported to them she was missing money. The next day, facility staff obtained the resident's account statements and went through the charges with the resident. The facility staff indicated the resident's card was usually stored in the resident's apartment or with the resident.

During an interview, the facility nurse stated the resident went shopping, didn't have money available on her card, and reported the concern to facility staff. Facility staff and the resident called the bank and identified fraudulent charges. The nurse stated staff and the resident found specific charges on the statements identifying the AP's name associated with a PayPal account. The nurse said the resident did not have a personal phone or computer and could not independently accrue the charges identified on the statement. The facility notified law enforcement, completed an internal investigation, and terminated the employee.

The resident was unable to recall the unauthorized charges but stated she previously had left her door unlocked which may have allowed staff to access her card.

The AP did not respond to multiple requests for an interview. Facility documents indicated the AP received training on abuse prevention including financial exploitation.

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

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, did not respond to requests for interview.

Alleged Perpetrator interviewed: No, AP originally agreed to interview then did not respond to further attempts at communication.

Action taken by facility:

The facility conducted an internal investigation, notified law enforcement, completed a facility wide audit, and implemented a new process for storing the resident's financial information. The AP is no longer employed at the facility.

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>

You may also call 651-201-4200 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Ramsey County Attorney

St. Paul City Attorney
St. Paul Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23158	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/24/2023
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NAME OF PROVIDER OR SUPPLIER SCENIC HILLS ALTERNATIVE CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2170 SNOWSHOE 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. 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>#HL231587304C /#HL231584284M</p> <p>On May 24, 2023, 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 6 residents receiving services under the provider ' s Assisted Living license.</p> <p>The following correction order is issued/orders are issued for #HL231587304C /#HL231584284M, tag identification 2360.</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>	
02360	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>Residents have the right to be free from physical,</p>	02360		

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

Minnesota Department of Health

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02360	<p>Continued From page 1</p> <p>sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.</p> <p>This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment.</p> <p>Findings include:</p> <p>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and a facility staff member was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.</p> <p>No plan of correction is required for this tag.</p>	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	