Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL305575181M
Compliance #: HL305576981C

Date Concluded: November 27, 2024

Name, Address, and County of Licensee Investigated:
White Bear Lake White Pine
1235 Gun Club Rd
White Bear Lake, MN 55110
Ramsey County

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

Evaluator's Name: Brandon Martfeld, RN BSN
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 facility neglected the resident when they failed to administer the resident's medications according to the physician orders.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although the resident did not receive the correct dose of Paxlovid (antiviral medication used to treat Covid-19) as ordered by the medical provider, it could not be determined whether the resident's hospitalization could have been prevented had the resident received the correct dose of Paxlovid.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member and the medical provider. The investigation included review of the resident records, hospital

records, facility incident reports, staff schedules, and related facility policy and procedures. Also, the investigator observed resident and staff interactions.

The resident resided in an assisted living memory care unit. The resident's diagnoses included spastic quadriplegic cerebral palsy (spasms that affect all four limbs, the trunk, and sometimes the face, causing significant stiffness and tightness in the muscles, making movement very difficult and often preventing walking), acute (sudden) respiratory failure, and asthma. The resident's service plan included assistance with medication administration. The resident's assessment indicated the resident needed assistances with activities of daily living and was alert and oriented.

The resident's progress notes indicated one day the resident reported a cough and felt he was getting a cold. Three days later, the resident was diagnosed with Covid-19. Five days later the resident became disorientated, and a family member requested the resident be transferred to the hospital.

The facility incident report indicated the day the resident was diagnosed with Covid-19 and prescribed Paxlovid three tablets twice a day for five days. The facility incident report indicated upon review by a nurse, it appeared Paxlovid was not given as prescribed or entered into the medication administration record. The staff administered one pill twice a day instead of three pills as ordered.

The hospital records indicated the resident was admitted to the hospital with acute respiratory failure, Covid-19, and pneumonia. The hospital record indicated the resident was "critically ill" due to hypoxic hypercapnic (occurs when the body's oxygen and carbon dioxide levels are abnormal) respiratory failure due to Covid-19 requiring mechanical ventilation intubation (tube in the airway to assist with breathing.) The resident was hospitalized for nine days and transferred to a higher level of care.

During an interview, facility leadership stated the resident tested positive for Covid-19 and was prescribed Paxlovid. Leadership stated the resident was to take three pills twice a day for five days. The resident only received one pill instead of three. The resident's medical provider was notified of the medication error. The staff was educated on administering Paxlovid, the pharmacy was contacted, and arranged for the medication to be packaged differently. The resident was sent to the hospital for increased confusion.

During an interview, the medical provider stated the resident was diagnosed with Covid-19 and with his diagnoses of cerebral palsy and asthma, the resident was at an increased risk for severe infection. The Paxlovid was used in attempt to reduce the risk of severe infection. The results vary when this medication is used, and it is difficult to determine if the resident's hospitalization could have been prevented if he would have received the medication as ordered.

During an interview, the resident stated the staff managed his medications. The resident could not recall details pertaining to his hospitalization.

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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility provided education to staff on administering Paxlovid. The facility also contacted the pharmacy and requested the medication to be packaged differently for easier 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
	30557	A. BUILDING: _____ B. WING _____	C 10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE BEAR LAKE WHITE PINE	1235 GUN CLUB ROAD WHITE BEAR LAKE, MN 55110

(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 October 15, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL305575181M/#HL305576981C. No correction orders are issued.	0 000		