

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #:** HL305579585M  
**Compliance #:** HL305577505C

**Date Concluded:** February 13, 2024

## **Name, Address, and County of Licensee**

### **Investigated:**

White Bear Lake White Pines  
1235 Gun Club Road  
White Bear Lake, MN 55110  
Ramsey County

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

**Evaluator's Name:** Deb Schillinger, 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), who was an unlicensed caregiver, neglected the resident when the resident slid off toilet fracturing her femur (thigh bone) and humerus (upper arm bone).

### **Investigative Findings and Conclusion:**

The Minnesota Department of Health determined neglect was inconclusive. While it is true the AP transferred the resident alone, the facility's care plan was unclear regarding the assistance she required during toileting. When the resident fell the AP lowered her to the floor and sought help from the on-call nurse. The resident developed pain over the course of two days, which were related to leg and arm fractures neither of which required surgical intervention.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident and family members. The investigation included review of the resident medical record, facility policies and

procedures and facility staff personnel records. Also, the investigator observed interactions between residents and caregivers.

The resident resided in an assisted living memory care unit. The resident's diagnoses included a stroke, chronic low back pain, and left sided paralysis. The resident was oriented and able to make needs known. The resident's assessment indicated she was non-ambulatory.

The care plan indicated the resident required "full physical assistance" with transferring and toileting but did not specify the number of caregivers required. The same document indicated the resident required the use of the EZ stand (mechanical lift assist to stand) for ambulation, however the resident did not walk, and the care plan indicated the resident required two people to transfer but did not address toileting specifically. The resident used a wheelchair for mobility.

The resident's progress notes indicated the resident slid off the toilet during a transfer while toileting and was lowered by the AP onto the floor. The same document indicated the AP, and two other unlicensed caregivers called the nurse when they were unable to get the resident off the floor. The nurse "confirmed" with the caregivers the resident did not fall and advised they use a Hoyer (a total-assist) lift to get the resident off the floor. The computer timestamp indicated the progress note was a late entry written two days after the event in the bathroom.

The progress notes indicated the resident reported back pain during incontinence cares, one day following the event at approximately 10:30 a.m., which was relieved using PRN (as needed) Tylenol (non-narcotic pain medication) "throughout the day". The nurse documented no apparent injuries were identified. The computer timestamp indicated the progress note was also a late entry, written two days after the event in the bathroom.

However, the electronic medication administration record (EMAR) indicated the resident received one dose of PRN Tylenol, one day after the event in the bathroom at approximately 7:30 p.m.

Later that same evening, the resident's progress notes indicated the resident had escalating pain. The facility notified the medical provider who ordered an X-ray to rule out a fracture. The medical provider intended to see the resident in-person the next day. The computer timestamp indicated the progress note was also a late entry, written two days after the event in the bathroom.

The next morning, two days after the bathroom incident, the progress notes indicated the medical provider was unable to see the resident, so the facility sent the resident to the hospital for evaluation. While at the hospital the resident was diagnosed with a left humerus and a right femur fracture. The hospital intended the resident to return to the facility the same day but due to issues with transportation the resident stayed overnight in the hospital and returned the next day.

The hospital records indicated the resident's right femur fracture did not require immobilization and recommended use of a sling for her left arm. The imaging report used to diagnose the resident's fractures indicated the resident had osteopenia (low bone density).

During an interview, the AP stated she knew how to find the care plan in the Electronic Medical Record (EMR), however she could not recall whether she read the care plan or not. The AP stated the reason she did not call for assistance was because the "float" caregiver was not scheduled for the second half of the shift, and all other caregivers were busy providing care to other residents. The AP stated the resident did fall one other time when she assisted the resident to do a pivot transfer in the shower room. The AP stated she notified the nurse, and she thought the nurse completed an assessment.

A review of the schedule for the day of the event indicated the unlicensed caregiver assigned to the "float" position left before the event in the bathroom occurred.

A review of the resident's medical records did not indicate an incident report was completed by the AP or a nurse in the previous three months prior to the event for any other incident.

During an interview, the nurse stated caregivers are trained to check care plan in the electronic medical record (EMR) at beginning of shift for instructions on how to provide care to residents and for updates made to care plan. The nurse agreed the care plan did not give clear instructions for the caregivers regarding the use of the EZ stand for transfers, however it did indicate the resident did require the assistance of two caregivers for transfers. After this event, the unlicensed caregivers were provided additional training on use of the EZ stand and on the fall policy.

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:** Yes

**Action taken by facility:**

The AP is no longer employed by the facility. The facility investigated the incident and retrained existing staff.

**Action taken by the Minnesota Department of Health:**

No action taken at this time.

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:  <b>30557</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>12/20/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WHITE BEAR LAKE WHITE PINE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1235 GUN CLUB ROAD</b> <b>WHITE BEAR LAKE, MN 55110</b>
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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><b>Initial Comments</b></p> <p>On December 20, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL305577505C #HL305579585M.</p> <p>No correction orders are issued.</p>	0 000		

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