

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306505442M
Compliance #: HL306507561C

Date Concluded: December 6, 2024

Name, Address, and County of Licensee

Investigated:

Blaine White Pine LLC
12446 Jamestown Street Northeast
Blaine, MN 55449
Anoka County

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

Evaluator's Name:

Maerin Renee, RN, Special Investigator

Finding: Not Substantiated

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 multiple staff members failed to administer nine doses of lorazepam to the resident over one weekend.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was not substantiated. Over the course of one weekend, three staff members signed off in the resident's medication administration record (MAR) the resident's lorazepam (a narcotic medication used to manage anxiety) was not available. None of the three staff members notified the on-call nurse resulting in the resident missing eight doses of Lorazepam. Although the resident missed eight doses of lorazepam, the resident had no adverse effects, and the incident did not rise to the level of maltreatment.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted a family member. The

investigation included review of the resident records, death record, pharmacy records, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed cares and staff interactions with residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and chronic heart failure. The resident's assessment indicated the facility managed her medications, the resident required total staff assistance for all cares and received hospice services.

The resident's progress notes indicated she was prescribed lorazepam 0.5mg every four hours PRN (as needed). One weekend (Saturday and Sunday), the resident missed eight doses of lorazepam. There was no lorazepam in the medication cart for staff to administer and staff did not notify the nurse. The on-call nurse called the facility Sunday morning and staff told her the resident did not have any lorazepam available for administration. The on-call nurse arrived at the facility, obtained lorazepam from the overstock lockbox, and placed it in the medication cart for staff to administer. The on-call nurse checked on the resident and found the resident sleeping soundly with no signs of distress. The on-call nurse provided verbal and written warnings to the three staff members who had not contacted her regarding the resident's lorazepam.

The resident's MAR indicated on Saturday all three staff members documented the resident's lorazepam as either "Other: med ordered," or "Medication Ordered" as the reasons they did not administer lorazepam to the resident. On the Sunday overnight shift, one of the staff members documented three doses of lorazepam as "Medication Ordered."

When interviewed, the on-call nurse said although the resident did not have lorazepam available in the medication cart, there was lorazepam available in the overstock lock box located in the nurse's office. If staff had contacted her about the lorazepam, the on-call nurse said she would have gone to the facility, obtained the lorazepam from overstock, and placed it in the medication cart for staff to use. By the time the on-call nurse was notified, the resident had already missed eight doses of the lorazepam. Once staff notified the on-call nurse of the missing lorazepam, she corrected the situation immediately and the resident continued to receive lorazepam.

The staff member who worked overnights that weekend did not respond to requests for interview.

When interviewed, the staff member who worked the day shift said the overnight staff member told her she had notified the on-call nurse. The day shift staff member said it did not occur to her to call the on-call nurse when the medication did not arrive because she kept expecting the medication to be delivered and the overnight staff member had already called her.

When interviewed, a staff member who worked the evening shift said she was told the resident was out of lorazepam, but the on-call nurse had been notified and the medication had been ordered. The staff member did not call the on-call nurse when the lorazepam never arrived because she was told the on-call nurse already knew about the missing medication.

A family member stated they had no concerns regarding the resident not receiving medications and felt the resident received good care when at the facility.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

“Not Substantiated” means:

An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment 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: Yes.

Alleged Perpetrator interviewed: Yes, two of the three staff members interviewed; the third did not respond to requests.

Action taken by facility:

Staff leadership counseled the three staff members and provided re-training regarding medication management policies and procedures. The procedure for reordering medications was updated.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30650	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2024
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NAME OF PROVIDER OR SUPPLIER BLAINE WHITE PINE	STREET ADDRESS, CITY, STATE, ZIP CODE 12446 JAMESTOWN STREET NE BLAINE, MN 55449
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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>#HL306507561C/#HL306505442M</p> <p>On November 5, 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 55 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction order is issued for #HL306507561C/#HL306505442M, tag identification 1760.</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>	
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication	01760		

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

Minnesota Department of Health

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01760	<p>Continued From page 1</p> <p>Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee staff failed to administer lorazepam (an antianxiety medication) as prescribed for one of one resident, R1. R1 missed eight doses of lorazepam.</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> <p>R1's medical record indicated the resident had diagnoses including dementia and heart failure.</p> <p>R1's service plan, dated August 1, 2024, indicated R1 received services for medication</p>	01760		

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01760	<p>Continued From page 2</p> <p>management, meals, and assistance with activities of daily living. R1's medical chart indicated she was receiving hospice services from an outside agency.</p> <p>R1's Medication Administration Record (MAR), dated August 2024, indicated R1 was prescribed one tablet of 0.5 milligram (mg) Solu-tab of Lorazepam by mouth/under tongue every three hours for anxiety. R1's MAR indicated staff did not administer eight doses of lorazepam as prescribed to R1 from August 17-August 18, 2024, and documented the medication was not available.</p> <p>R1's progress note, dated August 18, 2024, indicated over the weekend (August 17-18, 2024), R1 missed eight doses of lorazepam. There was no lorazepam in the medication cart for staff to administer, and staff did not notify the on-call nurse, Licensed Practical Nurse (LPN)-A. LPN-A called the facility Sunday morning and at that time staff told LPN-A R1 did not have any lorazepam available for administration. LPN-A arrived at the facility, obtained lorazepam from the overstock lockbox, and placed it in the medication cart for staff.</p> <p>During an interview on November 5, 2024, at 2:15 p.m., unlicensed personnel (ULP)-E the overnight staff member, ULP-D, told her she had notified LPN-A. ULP-E said it did not occur to her to call LPN-A when the medication did not arrive because she kept expecting the medication to be delivered and the overnight staff member had already called her.</p> <p>During an interview on November 5, 2024, at 2:25 p.m., ULP-F said ULP-E told her R1 was out of lorazepam but LPN-A had been notified and the</p>	01760		

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01760	<p>Continued From page 3</p> <p>medication had been ordered. ULP-F did not call LPN-A when the lorazepam never arrived because she was told LPN-A already knew about the missing medication.</p> <p>During an interview, LPN-A said although R1 did not have lorazepam available in the medication cart, there was lorazepam available in the overstock lock box located in the nurses office. If staff had contacted her about the lorazepam, LPN-A said she would have gone to the facility, obtained the lorazepam from overstock, and placed it in the medication cart for staff to use. By the time LPN-A was notified, R1 had already missed eight doses of the lorazepam. Once staff notified LPN-A of the missing lorazepam, she corrected the situation immediately and R1 continued to receive lorazepam.</p> <p>The facility's Medication & Supplies-Reordering policy dated April 1, 2024, indicated prior to holidays and weekends staff would plan for the needs of residents for refills on prescriptions.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days.</p>	01760		