Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL316751281M
Compliance #: HL316758705C

Date Concluded: May 21, 2024

Name, Address, and County of Licensee Investigated:
Blaine White Pine II
12402 Jamestown St NE
Blaine MN 55449
Anoka County

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

Evaluator's Name: Maggie Regnier
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 a resident when he developed a urinary tract infection and was hospitalized for sepsis.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While the resident did develop a urinary tract infection and was hospitalized for sepsis, however the facility followed guidelines and communicated with the physician.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members and case workers. The investigation included review of facility records, hospital records, training records, facility internal communication records, and resident records. Also, the investigator observed staff to staff interactions as well as staff to resident interactions. Also, the investigator observed the general order and cleanliness of the facility and resident rooms.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, cerebral palsy, encephalopathy (brain dysfunction) and incontinence. The resident's service plan included assistance with meals, bathing, dressing, grooming, toileting, and medications. Additionally, the service plan included behavior reminders such as reassurance checks and to help minimize time in his room. The resident's assessment indicated he was incontinent of stool and had a history of exit-seeking behaviors. The assessment also indicated the resident became angry or agitated at times.

The resident's progress notes indicated one day the resident woke up with a fever. The facility registered nurse (RN) was notified, and the resident was tested for covid and flu, which came back negative. The same document indicated the RN assessed the resident, who then called the family and the medical provider. The facility sent the resident hospital.

The hospital records indicated the resident was diagnosed with sepsis with a prostate abscess. The record also indicated the resident was incontinent of both urine and stool. The hospital record indicated on several occasions the resident smeared his stool over his bed, his body and clothes. The hospital record also stated the resident would be discharged with a Foley (indwelling) catheter in place even though the resident was at risk for self-removal related to his dementia.

The facility service checkoff list demonstrated the resident was on hourly safety checks and every two-hour toileting assistance.

The facility's training documents indicated it had provided Foley catheter care training to ensure caregivers gave proper care for the resident's catheter.

During an interview, a manager said the resident resided in a male only memory care unit. The manager stated the resident had some behaviors that could be challenging at times, but staff were responsive to his needs.

During an interview, a nurse stated she provided the education for the staff on how to care for the resident's catheter. The nurse also expressed concern for the resident to have a catheter related to him pulling it and because he was incontinent of stool.

During an interview, an unlicensed caregiver stated she was trained and felt confident in caring for the resident with his catheter but that at times the resident would become combative and resistant to cares. The caregiver stated when this happened the staff would either wait for a little while or get other staff to distract the resident so care could be provided.

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, not able related to dementia
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility identified the resident needed to be sent to the hospital for the fever. The facility documented the residents' cares and trained all staff on foley catheter care.

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
	31675	A. BUILDING: _____ B. WING _____	C 04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLAINE WHITE PINE II	12402 JAMESTOWN STREET NE BLAINE, MN 55449

(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 April 11, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL316758705C/#HL316751281M. No correction orders are issued.	0 000		