Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL316751540M
Compliance #: HL316759142C

Date Concluded: May 16, 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 she fell and broke her hip.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While the resident did fall and sustain a hip fracture, the facility had taken reasonable steps to reduce the risk for falls. When the fall did occur, the facility sought appropriate medical care for the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted the resident's family. The investigation included review of facility records, policies and reports, resident records, staff records and schedules. Also, the investigator observed staff interactions with other staff, residents, and visitors.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia with behavioral disturbances, high blood pressure and weakness. The resident's service plan included assistance with dressing, grooming, toileting, feeding, transfers, and mobility. The resident's assessment indicated the resident was on 2-hour safety checks, was mostly nonverbal and was a poor decision-maker.

A document titled Uniform Assessment tool, indicated the resident had an elevated risk of falling related to impulsive behavior, weakness, and prior history of falling.

A document titled service checkoff list indicated the resident was on 2-hour safety checks, and these were documented as completed every 2 hours including the day of the fall.

The resident's progress notes indicated the resident was found on the floor in her room by the nurse and was assessed and assisted to bed. The same document shows the nurse called the residents doctor and x-rays were ordered. When the results of the x-rays were known, the nurse called the doctor, and the resident was transferred to the hospital for care of the fractured hip.

During an interview, a nurse stated that the resident had experienced at least 2 falls before this incident and the safety checks were implemented to help prevent the resident's impulsive behavior. The facility also implemented toileting every 2 hours to assist with the impulsive behavior.

During an interview, a family member had no concerns about the care of the resident and stated the facility calls him any time there is an issue. The family member was notified of the fall and transfer to the hospital.

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, non-verbal
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility assessed the resident immediately, notified the doctor and followed the ordered plan of care. The facility notified the family and sent the resident to the hospital as ordered.

Action taken by the Minnesota Department of Health:
No further actions 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 #HL316759142C/#HL316751540M. No correction orders are issued.	0 000		