Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL316756942M
Compliance #: HL316751482C

Date Concluded: February 13, 2025

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

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

Evaluator's Name: Angela Vatalaro, 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 staff failed to provide supervision, the resident eloped from the facility and was found outside of the memory care unit bleeding and required an evaluation at a hospital.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident was found outside of the locked memory unit, staff were following the residents plan of care. It could not be determined how the resident exited the facility.

The investigator conducted interviews with facility staff members, including administrative staff. The investigation included review of the resident records, hospital records, facility internal investigation, facility incident report, and related facility policy and procedures. Also, the investigator observed the resident, staff interactions with the resident, and the resident's locked memory care unit.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and agitation. The resident's service plan included every two-hour safety check with staff physically visualizing the resident to ensure safety. The resident's assessment indicated the resident walked independently, was oriented to person, was confused, and had poor decision making. The resident wandered, stated he wanted to leave the facility, and wanted to go home. The facility was a locked building, and the resident required staff assistance to exit the unit. The resident was a risk for elopement requiring placement in the locked unit.

Records indicated one day around midnight, the resident called 911 and stated he had been held hostage in the building for eight years against his wishes, the resident was agitated. Police informed facility staff of the resident's phone call. At 3:30 a.m., the resident was seen sitting on his bed. Between 4:20 and 4:45 a.m., the resident had knocked on an outside window of another resident's room on the first floor. Staff on the resident's unit (second floor) were in the laundry room finishing tasks during the timeframe when the first-floor staff found the resident outside. A resident on the first floor used her call light and let staff know a man had knocked on her window. Staff looked outside and saw the resident walking towards another building. Staff went outside and called 911. The back of the resident's head was bleeding. Staff walked the resident back to the facility, put a towel on the resident's head and applied pressure while waiting for the ambulance to arrive.

Hospital records indicated the resident's scalp laceration was repaired with staples. The resident had a possible wrist fracture, which required a Velcro brace, and follow-up appointment with orthopedics.

Scheduled services records indicated the resident received safety checks as scheduled.

During an interview, leadership said the resident had got a hold of a phone from another resident on the unit, called 911, and said he was being held hostage. Leadership stated the facility had a first and second floor. The resident resided on the second floor, a locked unit. One day, the resident had gotten off the unit and was found outside. While outside, the resident had tapped on a first-floor resident window. The resident had hit his head. Leadership stated stairwell exits were located at each end of the resident's unit, that required punching a code into a keypad to unlock. If opened, the stairwell exits alarmed (fire alarm type sound.) If someone pushed on the doors, doors would be locked. The unit also had a keypad at the balcony/deck area, which was also alarmed. Only staff could open the door. The elevator required punching a code into the keypad to leave the second-floor unit. Leadership said the resident did not have the code for any of the keypads. In addition, the unit's windows could not open wide enough for the resident to exit. Leadership said they spoke to staff who worked the day of the incident. Staff said no alarms sounded and they had no idea the resident was outside the facility until a different resident notified them of a man tapping on their window. Shortly before the resident had been found outside, staff saw the resident during their rounding check. Leadership reviewed camera footage and said nothing was seen regarding the resident exiting.

Leadership said the facility investigated and could not determine how the resident got off the locked unit. Leadership said there had been no other similar incidents.

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

Action taken by facility:
The facility sent the resident to the hospital for evaluation and conducted an internal investigation.

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 01/16/2025

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 January 16, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL316751482C/#HL316756942M. No correction orders are issued.	0 000		