DEPARTMENT OF HEALTH

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name:			Report Number:	Date of Visit:
Blaine White Pine			HL26857010	October 13, 2017
Facility Address:			**Time of Visit:**	**Date Concluded:**
12446 Jamestown Street NE			8:45 a.m. to 4:30 p.m.	February 27, 2018
Facility City:			**Investigator's Name and Title:**	
Blaine			Kathleen Smith, DNP, RN, PHN, Special Investigator	
State:	**ZIP:**	**County:**		
Minnesota	55449	Anoka		

☒ **Home Care Provider/Assisted Living**

Allegation(s):

It is that neglect of supervision occurred when Client #1 was inappropriately touched by Client #2.

☒ State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483)

☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)

☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of the evidence, neglect of supervision is substantiated. The home care provider was aware of Client #2 inappropriately entered the rooms of other clients, but did not implement an effective intervention to keep other clients safe until several weeks later.

Both clients received services from the home care provider, and resided in a secured area of the facility.

A complaint was filed with the home care provider stating Client #2 was entering the room of Client #1 at night. Three days later, home care provider administration observed Client #2 on the night shift entering the room of Client #1 and that of other clients. At that time, administration redirected Client #2 to his/her room and safety checks were increased to hourly, however these were not documented.

Two nights later Client #1 contacted a family member during the night stating a man was on top of her. This incident was reported to administration and home care provider staff were informed to keep the client doors locked at night, since staff had a master key and the doors could be unlocked from the inside by turning the knob. The family member stayed with Client #1 during the night and observed Client #2 rattling door knobs and entering the room of another client who was not able to move. No staff were available to redirect Client #2.

Three weeks after this occurrence, Client #2 was transferred to a non co-ed secured living area.

Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557)

Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557):

☐ Abuse ☒ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ Individual(s) and/or ☒ Facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The home care provider was aware of Client #2's behaviors, but did not implement an effective intervention to keep other clients safe until several weeks after this awareness.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

State Statutes for Home Care Providers (MN Statutes section 144A.43 - 144A.483) - Compliance Not Met
The requirements under State Statutes for Home Care Providers (MN Statutes, section 144A.43 - 144A.483) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Not Met
The requirements under State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

(a) 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.

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- [x] Medical Records
- [x] Assessments
- [x] Care Plan Records
- [x] Facility Incident Reports
- [x] Service Plan

Other pertinent medical records:

Additional facility records:

☒ Staff Time Sheets, Schedules, etc.

☒ Facility Internal Investigation Reports

☒ Personnel Records/Background Check, etc.

☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: One

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A

Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

◉ Yes ○ No ○ N/A

Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with reporter(s) ○ Yes ○ No ○ N/A

Specify: _____

If unable to contact reporter, attempts were made on:

Date: _____ Time: _____ Date: _____ Time: _____ Date: _____ Time: _____

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation:

◉ Yes ○ No ○ N/A Specify: _____

Did you interview additional residents? ◉ Yes ○ No

Total number of resident interviews: Five

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: Four

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: _____

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:

If unable to contact was subpoena issued: ◯ Yes, date subpoena was issued _____ ◯ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Nursing Services
☒ Call Light
☒ Cleanliness
☒ Dignity/Privacy Issues
☒ Meals
☒ Facility Tour

Was any involved equipment inspected: ◯ Yes ◯ No ◉ N/A

Was equipment being operated in safe manner: ◯ Yes ◯ No ◉ N/A

Were photographs taken: ◯ Yes ◉ No Specify: _____

cc:

Health Regulation Division - Home Care & Assisted Living Program

The Office of Ombudsman for Long-Term Care

Blaine Police Department

Anoka County Attorney

Blaine City Attorney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H26857	A. BUILDING: _____ B. WING _____	C 02/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLAINE WHITE PINE	12446 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 ******ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, these correction orders are issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: On October 13, 2017, a complaint investigation was initiated to investigate complaint #HL26857010. At the time of the survey, there were 60 clients that were receiving services under the comprehensive license. The following correction orders are issued.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings, which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Time Period for Correction. 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
0 325 SS=D	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights: (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all	0 325		

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0 325	Continued From page 1 forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on interview and document review, the home care provider failed to prevent maltreatment (neglect) of two of two clients (C1 and C2), when C2 touched C1 inappropriately. This resulted in a level 2 violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death) and is issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or that a situation has occurred only occasionally). The findings include: Client #1 resided in a secured area and received services from the home care provider, including safety checks every two hours. Upon interview with Client #1 on October 13, 2017, the client stated a man came into the room and touched my shoulder. Client #1 stated this happened more than once. The client contacted a family member about Client #2 in the room, and stated the man was no longer there. During an interview with a family member it was stated the door for Client #1 was to be locked at night and staff must have left it unlocked. The family member stated Client #1 called and was "hysterical" stating a man was on top of her. Client #1 was assessed and there was no injury	0 325		

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0 325	Continued From page 2 noted. One night, after receiving this call, the family member stayed overnight and observed Client #2 rattling Client #1's door and then enter the room of another client, who was immobile. Client #2 resided in the same secured area and received services from the home care provider, including safety checks every two hours. Upon interview with Client #2 on October 13, 2017, the client was friendly, but did not remember entering the rooms of other clients. A document dated September 6, 2017, posted by the home care provider revealed Client #2 was to be kept close. Another posted document dated September 12, 2017, indicated Client #2 was not to be in the rooms of female clients. An interview with the housing manager on October 13, 2017, at 1:29 p.m., revealed after becoming aware Client #2 entered Client #1's residence, staff were informed to lock the door of Client #1. After completion of an investigation all clients doors were locked at night. Client #2 was relocated to a non co-ed secured area. An interview with Registered Nurse (RN-F), on October 13, 2017, at 2:23 p.m., revealed safety checks were increased to hourly in the secured area, after being made aware of Client #2's behaviors. TIME PERIOD FOR CORRECTION: TWENTY-ONE (21) DAYS	0 325		
0 805 SS=D	144A.479, Subd. 6(a) Reporting Maltrx of Vulnerable Adults/Minors Subd. 6. Reporting maltreatment of vulnerable	0 805		

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0 805	Continued From page 3 adults and minors. (a) All home care providers must comply with requirements for the reporting of maltreatment of minors in section 626.556 and the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. Each home care provider must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and document review, the home care provider failed to report neglect of supervision when Client #2 (C2) entered other clients' rooms and in some cases physically touched other clients. This resulted in a level 2 violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death) and is issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or that a situation has occurred only occasionally). The findings include: Client #1 resided in a secured area and received services from the home care provider, including safety checks every two hours. Upon interview with Client #1 on October 13, 2017, the client stated a man came into the room and touched her shoulder. Client #1 stated this happened more than once. The client contacted a family	0 805		

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0 805	Continued From page 4 member about Client #2 in the room, and stated the man was no longer there. During an interview with a family member it was stated the door for Client #1 was to be locked at night and staff must have left it unlocked. The family member stated Client #1 called and was "hysterical" stating a man was on top of her. Client #1 was assessed and there was no injury noted. One night after receiving this call, the family member stayed overnight and observed Client #2 rattling Client #1's door and then enter the room of another client, who was immobile. Client #2 resided in the same secured area and received services from the home care provider, including safety checks every two hours. Upon interview with Client #2 on October 13, 2017, the client was friendly, but did not remember entering the rooms of other clients. A document dated September 6, 2017, posted by the home care provider revealed Client #2 was to be kept close. Another posted document dated September 12, 2017, indicated Client #2 was not to be in the rooms of female clients. An interview with the housing manager on October 13, 2017, at 1:29 p.m., revealed after becoming aware Client #2 entered Client #1's residence staff were informed to lock the door of Client #1. After completion of an investigation, all clients doors were locked at night. During an interview with the housing manager on October 13, 2017, at 3:30 p.m., it was stated no report had been made to the Common Entry Point regarding these issues. The home care provider vulnerable adult reporting policy, revised January 27, 2016,	0 805		

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0 805	Continued From page 5 indicated any report received that appears to be neglect should be reported immediately, but with in 24 hours. TIME PERIOD FOR CORRECTION: TWENTY-ONE (21) DAYS	0 805		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Certified Mail Number: 7015 3010 0001 4648 6361

February 27, 2018

Ms. Rhonda Schillinger, Administrator
Blaine White Pine
12446 Jamestown Street Ne
Blaine, MN 55449

RE: Complaint Number HL26857010

Dear Ms. Schillinger:

A complaint investigation (#HL26857010) of the Home Care Provider named above was completed on February 7, 2018, for the purpose of assessing compliance with state licensing regulations. At the time of the investigation, the investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these regulations. These state licensing orders are issued in accordance with Minnesota Statutes Sections 144A.43 to 144A.482.

State licensing orders are delineated on the attached State Form. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes for Home Care Providers. 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by."

A written plan for correction of licensing orders is not required. Per Minnesota State Statute 144A.474 Subd. 8(c), the home care provider must document in the provider's records any action taken to comply with the correction order. A copy of this document of the home care provider's action may be requested at future surveys.

A licensed home care provider may request a correction order reconsideration regarding any correction order issued to the provider. The reconsideration must be in writing and received within 15 calendar days. Reconsiderations should be addressed to:

Renae Dressel, Health Program Rep. Sr
Home Care Assisted Living Program
Minnesota Department of Health
P.O. Box 3879
85 East Seventh Place
St. Paul, MN 55101

It is your responsibility to share the information contained in this letter and the results of the visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Matthew Heffron

Matthew Heffron, JD, NREMT
Health Regulations Division
Supervisor, Office of Health Facility Complaints
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4221 Fax: (651) 281-9796

MLH

Enclosure

cc: Home Health Care Assisted Living File
Anoka County Adult Protection
Office of Ombudsman for Long Term Care
MN Department of Human Services