Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL305573024M
Compliance #: HL305574946C

Date Concluded: August 23, 2023

Name, Address, and County of Licensee Investigated:
White Bear Lake White Pine
1235 Gun Club Rd
White Bear Lake, MN 55110
Ramsey County

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

Evaluator's Name: Yolanda Dawson, 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 a resident when they did not properly care for the resident's injuries after multiple falls. Also, the facility neglected a resident when staff did not administer medications according to provider orders.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Facility staff contacted and consulted hospice and the family when the resident sustained injuries from falls. Hospice and the family made the decision to have the resident's injuries treated and cared for by the hospice staff. The investigator, the facility nurse, and hospice nurse could not identify a medication that was administered incorrectly to the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted hospice care and a family member. The investigation included review of resident facility and hospice records, employee

records and facility policies and procedures. Also, the investigator observed medication administration and a staff member providing assistances with activities of daily living.

The resident resided in an assisted living memory care unit. The resident's diagnoses included acute and chronic obstructive pulmonary disease (COPD), emphysema, Alzheimer's disease, dementia with behavioral disturbance, and anxiety. The resident also received hospice skilled nursing for symptom management for end stage Alzheimer's disease. The resident was dependent on others for decision making. The resident's service plan included assistance with transfers and all activities of daily living.

During an interview, the hospice nurse stated the resident was declining and while she still had the strength to move herself, she was unable to make rational decisions concerning safety and as a result had many falls. The nurse stated staff could not always be with the resident and staff did the best they could to keep the resident safe.

During an interview, a hospice nurse stated when the resident admitted to hospice, it was the family's decision whether to send the resident to the hospital if care was needed. The hospice nurse stated families often deferred to hospice recommendations to make the decision. The resident had a head laceration (deep cut) from a previous fall that began to bleed. Hospice staff determined the laceration could be treated at the facility and applied steri-strips (thin adhesive strips) to the wound. The hospice nurse stated the resident's medications were changed several times in four months. The nurse stated staff felt the resident was over medicated and did not consistently administer the scheduled morphine (pain medication.)

Review of the resident's medication record indicated staff administered the resident's medication as prescribed.

During an interview, a facility nurse stated when the resident was admitted to hospice care, the resident remained under the care of the facility, however, hospice became the primary caregiver. The facility nurses deferred to the hospice nurses when there were changes in condition and medications.

During an interview, a family member stated hospice gave the resident the care she needed. The family member stated facility staff notified the family when the resident had falls and hospice was also notified, and they would come and do an assessment and provide whatever care the resident needed.

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: The resident was deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility: Incident reports and interventions were completed for falls. Hospice and the resident’s family were consulted regarding the resident’s care and injuries.

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
	30557	A. BUILDING: _____ B. WING _____	C 05/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE BEAR LAKE WHITE PINE	1235 GUN CLUB ROAD WHITE BEAR LAKE, MN 55110

(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 May 16 through May 17 2023, the Minnesota Department of Health initiated an investigation of complaint #HL305575981C/#HL305573643M and HL305574946C/#HL305573024M. No correction orders are issued.	0 000	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. 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. 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.	
02360 SS=G	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

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02360	Continued From page 1 sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident's reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		