Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL305573124M
Compliance #: HL305575073C

Date Concluded: February 1, 2023

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

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

Evaluator's Name:
Katie Germann, 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 the resident had an unwitnessed fall resulting in a fractured right hip.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident was independent with transfers and had a history of falls. Although the resident did have an unwitnessed fall in her room causing a right hip fracture, the residents plan of care was being followed at the time of the fall.

The investigator conducted interviews with facility administrative staff and the resident's family. The investigation included review of the residents' medical records, hospital records, incident reports, facility policy and procedures, and staff training.

The resident resided in an assisted living facility with diagnoses including memory loss, hearing loss, long term use of anticoagulants, and macular degeneration. The resident's service plan included assistance with meals, housekeeping, laundry, safety checks, bathing, and medication management. The resident's assessment indicated the resident was independent with transfers with her walker and hallucinates related to her macular degeneration.

A review of the facility incident report indicated late one night, the resident was heard yelling for help and when staff entered her room the resident was on the floor by her dresser and table. The staff called the nurse, checked vital signs, assisted the resident to the bathroom, elevated her right leg in bed, and gave the resident Tylenol for pain. The incident report indicated the resident was reporting pain in her right leg and hip. The report indicated the resident was sent to the hospital the morning of the incident.

A 24-hour report written the morning after the fall indicated the resident was confused and unable to move her right leg. R1 was sent to the emergency room.

When interviewed management stated staff called her at the time of the incident to inform her of the residents fall. The following morning the resident had unresolved pain in her hip/ leg and was sent to the hospital for evaluation.

When interviewed the resident's family member stated the resident called after the fall around 2:00- 3:00 a.m. The family member stated the resident seemed to be okay at that time and they agreed to talk in the morning. The family member stated he received a phone call from the facility around 7:00- 8:00 a.m. the next morning to tell him the resident was in pain and unable to move her leg and the resident was going to be sent to the hospital. The family member stated the resident had a partial hip replacement, went to rehab after the hospitalization, and is now back at the facility doing well.

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

Action taken by facility:
The facility updated the resident's care plan to reflect changes in resident needs.

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 01/10/2023

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WHITE BEAR LAKE WHITE PINE	1235 GUN CLUB ROAD WHITE BEAR LAKE, MN 55110

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL305576118C/#HL305573743M #HL305573124M/ #HL305575073C On January 10, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 36 residents receiving services under the provider's Assisted Living with Dementia Care license. The following immediate correction order is issued for #HL305576118C/#HL305573743M, tag identification 1290. The immediacy was removed on January 26, 2023, however, non-compliance remains at a scope and severity of I. The following correction orders which are not immediate are issued for	0 000	The Minnesota Department of Health documents the State Licensing 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the correction order. A copy of the provider ' s records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider ' s Plan of Correction." The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144G.31, Subd. 2 and 3.	

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0 000	Continued From page 1 #HL305576118C/#HL305573743M, tag identification 2310 and 2360.	0 000		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to complete a background study prior to staff providing direct care services, for one of three unlicensed personnel, (ULP)-B, of employee records reviewed. This had potential to affect all 36 residents receiving services from the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that	01290		

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01290	Continued From page 2 has affected or has potential to affect a large portion or all of the residents). The facility was notified of the immediate correction order on January 17, 2023. The immediacy was removed on January 26, 2023. However non-compliance remains at a S/L of I. The findings include: On January 17, 2023, at 2:56 p.m., ULP-B's employee record was received from the facility via fax. ULP-B was hired on April 23, 2012 and provided direct care for residents at the facility. The facility was unable to provide any record ULP-B had a cleared background study completed in the 11 years of employment. A search of the Minnesota Department of Human Services background study website (https://netstudy2.dhs.state.mn.us/Live/Employees/SearchRoster) conducted on January 17, 2023 at 4:15 p.m. indicated on December 13, 2022, the facility submitted a request for a background study for ULP-B. ULP-B did not complete the required fingerprints and the background study was closed on January 4, 2023, indicating ULP-B must be removed from providing direct care to residents. The facility submitted another background request for ULP-B on January 6, 2023. The background study website indicated the background check was in process and required ULP-B's fingerprints to complete the background study. Although ULB-B was to be removed from providing direct care to residents, the facility schedule indicated ULP-B provided direct care services to residents on January 9, 11, 12, 13, 15,	01290		

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01290	Continued From page 3 16, and 17, 2023. During interview on January 17, 2023, at 1:30 p.m. the administrator stated the facility submitted another background study request for ULP-B on January 6th, 2023. The administrator stated the background check was not complete and ULP-B was going to have fingerprints completed on January 18, 2023. The administrator confirmed ULP-B continued to provide direct care to residents after January 4th, 2023, when background studies indicated ULP-B should be removed from providing direct resident cares. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) Days	01290		
02310 SS=J	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide care and services according to acceptable health care standards, medical or nursing standards for one of one resident, R1, reviewed with an injury of unknown source. R1 experienced significant cuts and skin tears on her right arm, a broken clavicle, and a subdural hematoma. Although the resident was unable to move without assistance of two staff,	02310		

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02310	Continued From page 4 the facility completed no assessment or investigation to determine the cause of the resident's significant injury. The resident died approximately two weeks following the incident from the head injury. This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: R1's medical record indicated the resident was admitted to the facility on July 17, 2020, with diagnosis including dementia, atrial fibrillation, and long term use of anticoagulants. R1's service plan dated November 3, 2022, indicated the resident used an "EZ stand" (a mechanical standing lift) with two staff for all transfers. Staff were directed to handle the resident "gently due to easy bruising." . R1's uniform assessment dated July 14, 2022, show a brief interview for mental status (BIMS) score of 3/15 indicating the resident had severe cognitive impairment. R1's physician orders dated November 2, 2022, indicated the resident's INR (lab test to determine dosing of blood thinner) was 3.98 (which indicated the resident was at increased risk for bleeding). The facility was directed to hold the resident's Coumadin (a blood thinning medication) for three days, then resume Coumadin at 2 mg on Monday and Friday, 3 mg	02310		

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02310	Continued From page 5 all other days, and recheck INR on November 9, 2022. A facility incident report dated November 3, 2022, at 10:00 a.m. completed by unlicensed personnel (ULP)-B indicated R1 had skin tears and a right "forehead injury (swelling). " The report had a diagram of a person where staff were to circle the areas on the person where the residents injuries were. ULP-B circled the upper left arm, right wrist, and right forehead. The incident report did not indicate any incident that occurred to cause R1's significant injury's. The incident report dated November 3, 2022, indicated the nurse post fall follow up was completed by registered nurse (RN)-C. R1's post fall nurse follow-up indicated R1 had skin tears, swelling, and bruising on the resident's right arm, right hand, and right forehead. The right arm skin tear was 9 cm (centimeters) x 3 cm, the right-hand skin tear was 13 cm x 8 cm, and the right forehead bruising was 10 cm x 8 cm. RN-C documented the cause of the residents injuries was "unknown." RN-C noted, "Resident on Coumadin. Was held November 2, 2022." The follow up incident report indicated the RN was to "review residents service plan, assess needs to safe transfers and mobility, or increased need of assistance with ADLs and if any changes were made". RN-C documented "No changes. Staff to continue to use EZ stand with all transfers." RN-C documented on the post fall follow up that she notified the residents physician and family member but did not indicated what time the notification occurred. R1's progress note dated November 3, 2022 at 3:39 p.m. written by RN-C indicated, "At around 10:00 a.m.," a staff reported the resident had "2	02310		

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02310	Continued From page 6 skin tears on her right arm/elbow and 9 cm x 3 cm and right hand and wrist 13 cm x 8 cm. Cleansed and applied gauze and kerlix. At 3:00 p.m. pm resident was still bleeding, and gauze was soaked through. Also noted swollen bruised area on right forehead 10 cm x 8 cm". The note indicated 911 was called and R1 was sent out of the facility at 3:30 p.m. The facility had no documentation the residents primary physician was notified about the initial skin tears or bleeding after the incident. In addition, there was no further nursing assessment or documentation of R1's health status between 10:00 a.m. and 3:00 p.m. An ambulance run report dated November 3, 2022 at 3:01 p.m. indicated facility staff told the paramedics the resident had had an "unwitnessed fall this morning at approximately 9:00 a.m.". The paramedics visual assessment noted a 3 x 3 inch hematoma on the right side of R1's forehead. Staff told the paramedics, "They did not recognize (the hematoma) and claimed it was within the last 15 minutes it [the hematoma] showed up". The paramedics noted, "obvious blue bruising" to R1's right forehead. R1's hospital notes dated November 3, 2022 indicated the resident had an "acute fracture of the right distal clavicle" and a "large right-frontal scalp hematoma". The resident had "significant soft tissue laceration to right hand not amenable to suturing given superficial injury and frailty of her skin". A internal facility email written by administrator A (Admin)-A dated November 4, 2022, titled, "writer initiated internal bleeding investigation," was sent to staff regarding R1's injury. The document indicated, "I am in the middle of investigating a possible fall that led to family moving R1 out of	02310		

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02310	Continued From page 7 the community. So I wanted to reach out to PM/NOC [evening and night] staff to see if she [R1] has fallen in the last couple days between Wednesday night and Thursday early morning? R1 suffered some pretty serious injuries such as a fractured clavicle, fractured wrist, and bleeding on the brain. As some of you may know family has removed her from the community as stated. I have reported the injuries to the state. So if there is any more information that would be helpful, please let me know ASAP." One response to the email from an un-named staff (only identified as caregiver) replied, "Hello, no there was no falls or injuries when I was working with her last time." The caregiver went on to say another caregiver could verify that cares were given properly on that shift. Admin-A indicated during interview the unknown caregiver who responded to the email request was working the p.m. shift the evening prior to the fall. During interview on January 11, 2022 at 4:19 p.m., RN-C stated she did not know how R1's injuries occurred and stated when she saw the wounds they appeared to be "fresh." RN-C stated she did not see any bandages on the resident prior to her first seeing the resident already out of bed and on the toilet. RN-C dressed the wounds but did not do any follow up assessment on the resident until she learned the resident was still bleeding and had bled through her bandages around 3:00 p.m., at which time staff noted the resident had right forehead bruising as well. Upon seeing the continued bleeding and forehead injury,RN-C stated she called 911 to transport the resident to the hospital for further evaluation. RN-C indicated she asked staff that worked with R1 that morning what happened but was unable to get any answers from other staff. RN-C stated she was not able to	02310		

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02310	Continued From page 8 determine how R1 sustained the significant injury's. During interview on January 10, 2023 at 1:30 p.m., Admin-A indicated no further investigation occurred outside of sending staff the email and calling to ask staff what happened on their shifts. Admin-A stated the morning of the incident, ULP-B came to her office to ask her to come to R1's room as soon as possible. Admin-A stated when she entered R1's room the resident was sitting on the toilet and there was no bandage on her arm/ hand/ wrist. Admin-A stated R1 required assistance of two staff and EZ stand mechanical lift for transfers. Initially Admin-A denied knowing who assisted ULP-B with transferring R1 to the toilet on the morning shift of November 3, 2022, and stated ULP-B must have done the transfer without another staff. However, later during the interview Admin-A stated ULP-B and ULP-D told her they had transferred R1 the morning of November 3, 2022. During interview on January 11, 2023 at 5:03 p.m., ULP-D stated the first time she saw R1 on the morning of November 3, 2022 was when the resident was already on the toilet. ULP-D denied assisting with transferring the R1 to the toilet on November 3, 2022. ULP-D stated she was working as a medication technician that morning and went into R1's room when ULP-B asked her for some supplies including gauze to bandage R1's arm. ULP-D stated she never saw another bandage on R1's arm that morning but did assist the nurse to wrap R1's wounds with gauze. When interviewed on January 12, 2023 at 3:30 p.m., ULP-B stated he went into R1's room on the morning of November 3, 2022 to get her out of bed. ULP-B stated when he pulled R1's covers	02310		

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02310	Continued From page 9 back the resident had a bandage on her right hand that was bloody. He got R1 out of bed and transferred her on the toilet and was going to change her bandage. ULP-B stated R1 transferred with two staff and a EZ stand mechanical lift. ULP-B stated the morning of November 3, 2022, he transferred R1 from the bed to the toilet without assistance of another staff. ULP-B stated once he assisted R1 to the toilet, he pulled the bandage off R1's arm and there was blood "dripping and oozing out" of the resident's arm. ULP-B stated he left the room and got the nurse to assist with bandaging R1's arm. ULP-B stated he was not aware what caused R1's significant injury's. A facility form titled "Re-education hoyer lift, 2 person transfers" dated November 4, 2022 indicates staff was re-educated on use of 2-person transfers for lift transfers. When interviewed on January 17, 2023 at 1:30 p.m. Admin-A stated the education was not done related to a specific incident, it was just general training. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days.	02310		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, 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:	02360		

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02360	Continued From page 10 Based on interviews and document review, the facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. R1 was neglected. Findings include: The Minnesota Department of Health (MDH) issued a determination that neglect occurred, and an individual staff member was responsible for the maltreatment in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	