

# State Rapid Response Investigative Public Report

*Office of Health Facility Complaints*

**Maltreatment Report #: HL305573643M**  
**Compliance #: HL305575981C**

**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:** Substantiated, individual responsibility

**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 alleged perpetrator (AP), facility staff, neglected a resident when the AP failed to complete provider referral orders for skilled nursing wound care. As a result, the resident did not receive wound care for an extended period of time and required emergency medical attention.

**Investigative Findings and Conclusion:**

The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for the maltreatment. The AP failed to ensure the resident's provider referral orders for a contracted skilled nursing service to complete sacral ulcer wound care was received and accepted by an agency. As a result, the resident did not receive wound care for an extended period of time and was hospitalized with complaints of pain at the wound site and an elevated temperature.

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

The resident resided in an assisted living facility. The resident's diagnoses included a sacral (coccyx) ulcer, type 2 diabetes, kidney disease stage 3, cancer, and heart disease. The resident's service plan included assistance with medication management, diabetes management, bathing assistance, vital sign monitoring, nursing assessments, and wound care.

Hospice nursing notes indicated due to the resident's improvement in health, the resident was discharged from hospice at the end of September with hydrogel (dressing with gel and water) orders for the sacral ulcer.

During an interview, the hospice nurse stated upon discharge from hospice, the AP was informed the resident's wound care would need to be continued two times a week to the sacral ulcer.

A review of progress notes indicated eight days after hospice discharged the resident from services, the AP requested a referral order for a contracted skilled nursing agency to evaluate and treat the wound. The signed order was received on day nine. The notes indicated thirteen days after the order for a contracted home care agency referral was received, wound care was still not in place. That same day, the AP documented the home care agency declined the referral, and she sent out a second referral to another agency. At that time, the AP completed a simple dressing change by cleansing the wound and applying a new dressing. Four days later the resident was hospitalized with complaints of pain at the wound site and an elevated temperature. There was no evidence a contracted home care agency accepted the referral for the resident's sacral ulcer wound care.

The hospital record indicated the resident's admitting diagnosis included sepsis (infection). The physician found the resident's sacral ulcer packed with old gauze with a significant amount of foul-smelling purulent (pus) discharge. The resident was treated with antibiotics. Upon discharge the physician indicated the infection was likely secondary to the infected sacral ulcer or pneumonia. The record indicated the resident did not receive proper wound care prior to the resident's hospitalization. The record indicated the resident discharged from the hospital to a transitional care unit ten days later with diagnoses that included a stage 3 (appears as a crater) large sacral ulcer with associated cellulitis (bacterial skin infection.)

During an interview, the AP stated she requested and received a physician order for a referral to a contracted skilled nursing agency to evaluate and treat the resident's sacral ulcer. The AP stated she was unsuccessful in setting up a home care agency to provide wound care for the resident. The AP stated it took several weeks for the home care agency to notify them that the referral was declined. The AP stated she provided a dressing change to the resident's sacral ulcer one time. The AP stated the facility nurses provided only simple skin treatments.

During an interview a family member stated the facility nurse informed her that after the resident was discharged from hospice a wound care nurse would provide wound care. Two weeks later, the family member was informed the referral for wound care nurse services was declined, however the nurses at the facility said they would provide wound care until a nursing agency was in place.

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

**Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.**

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

**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:** Yes.

**Action taken by facility:**

The facility investigated the incident and sent the resident to the hospital. The AP was no longer employed by the facility.

**Action taken by the Minnesota Department of Health:**

The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

You may also call 651-201-4200 to receive a copy via mail or email.

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.

cc:

The Office of Ombudsman for Long Term Care  
The Office of Ombudsman for Mental Health and Developmental Disabilities  
Ramsey County Attorney  
White Bear Lake City Attorney  
White Bear Lake Police Department  
Minnesota Board of Nursing

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>30557</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/17/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WHITE BEAR LAKE WHITE PINE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1235 GUN CLUB ROAD</b> <b>WHITE BEAR LAKE, MN 55110</b>
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(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	<p><b>Initial Comments</b></p> <p>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.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
02360 SS=G	<p><b>144G.91 Subd. 8 Freedom from maltreatment</b></p> <p>Residents have the right to be free from physical,</p>	02360		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Minnesota Department of Health

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02360	<p>Continued From page 1</p> <p>sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act.</p> <p>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.</p> <p>Findings include:</p> <p>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.</p>	02360		