Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL305573743M
Compliance #: HL305576118C

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: 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 facility neglected a resident when the resident had significant, unexplained injuries including a broken clavicle and subdural hematoma resulting in the resident's death.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. Based on a preponderance of evidence, the alleged perpetrator (AP), a facility unlicensed staff, was responsible for the maltreatment. The resident was sent to the hospital with significant bleeding of her wrist/arm. At the hospital the resident was found to have a broken clavicle and a subdural hematoma (bleeding on the brain). The AP transferred the resident with a EZ stand mechanical lift that morning without the assistance of a second staff. Although the AP denied the resident was injured during the transfer, the resident was not observed to have any injury until she had been transferred independently by the AP out of bed to the toilet.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family. The investigation included review of medical records, hospital records, ambulance run report, facility investigation, incident report, nurses progress notes, and facility policies and procedures.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia, atrial fibrillation, and long-term use of anticoagulants. The resident's service plan included assistance with activities of daily living, transfers, escorts, medication management, housekeeping, laundry, and meals. The resident's assessment indicated the resident had cognitive impairment related to dementia and required assistance to transfer due to inability to move on her own without assistance. The resident was transferred by two staff using and EZ stand mechanical lift.

Review of the facility incident report documented by both the AP and a facility nurse, indicated the resident had skin tears, swelling as well as bruising on the resident's right arm, right hand, and right forehead. The right arm skin tear was 9 cm x 3 cm, the right-hand skin tear was 13 cm x 8 cm, and the right forehead bruising was 10 cm x 8cm. A facility nurse documented the cause of the residents' injuries was "unknown". The nurse noted the resident was receiving Coumadin (a blood thinning medication) but was held the prior evening due to the residents high INR (lab test to determine coumadin dosing). The follow-up incident report indicated the nurse 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". The nurse documented no changes were made in the resident's care. The incident report indicated the nurse notified the physician, however, there was no documentation when the physician was contacted.

A nurse progress note from the day of the incident indicated around 10:00 a.m. an unlicensed staff reported the resident had 2 skin tears on her right arm/elbow 9 cm x 3 cm, and on her right hand and wrist 13 cm x 8 cm. The injuries were cleansed and covered with gauze and kerlix. Approximately 5 hours after the resident was found with the injuries the progress note indicated the "resident was still bleeding, and gauze was soaked through." The progress note indicated the nurse also noted the resident had a swollen, bruised area on her right forehead measuring 10 cm x 8 cm.

The resident's physician orders indicated the resident's INR (lab test to determine dosing of blood thinner) from the day prior to the incident was 3.98 (which indicated the resident was at increased risk for bleeding).

An ambulance run report indicated the facility staff told the paramedics the resident had an "unwitnessed fall earlier that morning" approximately six hours prior. The paramedics indicated the resident had a 3-inch x 3-inch hematoma on the right side of the resident's forehead. Facility staff told the paramedics the hematoma on the resident's head just started to show up in the past 15 minutes. The paramedic note indicated, "obvious blue bruising" to the resident's right forehead.

The resident's hospital records indicated the resident sustained a fractured clavicle and a subdural hematoma from a fall.

Review of the resident's medical record included no documentation regarding the resident's health status in the 5 hours between discovering the resident's injury's and sending the resident to the hospital.

When interviewed the facility administrator stated the morning of the incident, the AP came to her office to ask for assistance in the resident's room as soon as possible. The administrator stated when she entered the resident's room the resident was sitting on the toilet, her arm/ hand were bleeding, and there was no bandage covering any of the wounds. The administrator stated no one knew how the residents' injuries occurred. The administrator initially stated the AP "must have" transferred the resident without assistance of another staff member. However, later in the same interview she stated another unlicensed personnel told her she assisted the AP with transferring the resident the morning of the incident. The administrator stated she spoke to the staff who worked the evening and night shift prior to the resident's injuries who all denied seeing any injuries on the resident.

When interviewed a facility nurse stated she was called into the resident's room and the resident was sitting on the toilet and her arm/ hand were bleeding. There was no bandage covering it when the nurse went in. The nurse indicated when she saw the wounds, she felt they were "fresh." The nurse stated she covered the wounds and did not assess the resident until five hours later when staff alerted her the resident was still bleeding and had bled through her bandages. The nurse stated at that time she noticed the hematoma on the resident's forehead and called 911 to transport the resident to the hospital for further evaluation. The nurse indicated she asked staff what happened to cause the residents significant injuries, "but was unable to get any answers from staff."

When interviewed an unlicensed staff member stated the first time they saw the resident with injury's was when the resident was already transferred out of bed and on the toilet. The unlicensed personnel denied assisting the AP with transferring the resident out of bed to the toilet the morning of the incident. The unlicensed staff stated she went into the resident's room when the AP asked her for some supplies including gauze to bandage the resident's arm. The resident was in the bathroom sitting on the toilet. The unlicensed staff stated the only bandage she observed on the resident was the one the nurse put on the resident.

When interviewed the AP stated when he went to assist the resident out of bed that morning, he noticed the resident had a bandage on her right hand with some blood on the bandage. The AP stated he transferred the resident out of bed onto the toilet to change the bandage. The AP stated he was aware the resident required assistance of two staff and an EZ stand mechanical lift, however, that morning he transferred the resident alone without the assistance of a second staff. The AP stated that was the first time he had transferred the resident without assistance of

another staff. The AP stated when the resident was sitting on toilet, he removed the residents bandage and blood was dripping and “oozing” out of the resident’s arm. The AP stated he left the residents room to request staff assistance due to the residents significant bleeding. Although no one saw the resident with any injuries until after the AP transferred the resident out of bed to the toilet; the AP denied anything occurred during the transfer that could have contributed to the residents significant injury.

When interviewed the resident’s family stated the resident was unable to transfer or move without assistance. The family stated the morning of the incident the facility nurse called to let them know the resident had a skin tear, which was a result of an injury during transfer, and they had bandaged the injury. Later in the day family received a call from the facility nurse notifying them the resident was being sent to the hospital by ambulance. A short time after that, the paramedics called and stated they were bringing the resident to a trauma center because of the large hematoma on the right side of her head. The family stated the resident was hospitalized, discharged to a skilled nursing facility, and passed away two weeks later due to her injuries sustained at the facility.

The resident’s death record indicated the residents cause of death was complications due to a closed head injury.

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: No, passed away
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:

No action was taken by the facility.

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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

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

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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		

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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.	