Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL30650001M
Compliance #: HL30650002C

Date Concluded: October 5, 2022

Name, Address, and County of Licensee Investigated:
Blaine White Pine
12446 Jamestown Street NE
Blaine, MN 55449
Anoka County

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

Evaluator's Name: Lori Pokela RN
Special Investigator
Lena Gangestad RN
Special Investigator

Finding: Inconclusive

Nature of Visit:
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.

Allegation(s):
The alleged perpetrator (AP) verbally abused three different residents one evening. The AP raised her voice and refused to help resident #1. The AP told resident #2 to shut up. The AP yelled at resident #3 until she cried.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. None of the three residents recalled a specific incident regarding the AP. While the AP may have treated the residents in a discourteous manner, there is insufficient evidence to demonstrate abuse.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included a review of policies and

procedures and staff training records. Resident #1's, resident #2's and resident #3's medical records were reviewed.

Resident #1, #2 and #3 resided in an assisted living unit.

Resident #1's diagnosis included stroke on the right side, anxiety disorder and diabetes. The resident's service plan included assistance with all activities of daily living which included hygiene, dressing, toileting, medications, meals, and housekeeping. The resident's assessment indicated he required mobility assistance with two staff and hoyer to transfer.

Resident #2's diagnosis included cerebral infarction and hemiplegia on her left side. The resident's service plan included assistance with all activities of daily living which included hygiene, dressing, toileting, medications, meals, and heavy housekeeping. The resident's assessment indicated she required mobility assistance with two staff and a sit to stand to transfer.

Resident #3's diagnosis included dementia, bipolar disorder, and gait disorder. The resident's service plan included assistance with all activities of daily living which included hygiene, dressing, toileting, medications, meals, and heavy housekeeping. The resident's assessment indicated she required mobility assistance with two staff and a walker and mechanical/hoyer lift for transferring.

During an interview, resident #1 stated he could not remember the incident.

During an interview, resident #2 stated she could not remember the name of the staff or the specific incident.

During an interview, resident #3 stated she was happy with the staff and could not remember the specific incident.

During an interview, the administrator stated staff members who witnessed the incidents reported it to her. However, she could not remember the exact time the staff member reported the incidents to her. She confirmed the incidents happened on the same evening. The administrator stated started interviewing the residents who involved the next day it was reported to her. The resident #1 did not want to get anyone in trouble, he refused to say anything. The administrator talked to resident #2, she told her paralyzed arm was pulled roughly by the AP. The resident #3 could not remember anything.

During an interview, the caregiver stated she worked with AP on that evening for the first time The caregiver stated she witnessed the AP was rough, argued, raised her voice, and refused to help resident #1. The caregiver stated the AP told resident #2 to shut up and pulled resident #2's paralyzed arm roughly. Later that evening, AP yelled at resident #3 to stand up but resident #3 was unable to stand on her own but the AP kept yelling and made resident #3 cry.

AP roughly put resident #3 on the toilet. The caregiver confirmed she called the administrator to report the incidents around 5 or 6 pm that evening.

During an interview, another care giver who worked that evening stated that she could not remember what happened.

The investigation included attempt to interview the AP, including issuing a subpoena, but proved unsuccessful.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(a) An act against a vulnerable adult that constitutes a violation of, an attempt to violate, or aiding and abetting a violation of:
(1) assault in the first through fifth degrees as defined in sections 609.221 to 609.224;
(2) the use of drugs to injure or facilitate crime as defined in section 609.235;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
A violation includes any action that meets the elements of the crime, regardless of whether there is a criminal proceeding or conviction.
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening
Action taken by facility:
The facility started internal investigation. They filed vulnerable adult report for three residents and the AP was terminated the next day.

Action taken by the Minnesota Department of Health:
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.

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
	30650	A. BUILDING: _____ B. WING _____	C 07/07/2022

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 Initial comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482/144G.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. On July 7,2022 through July 7,2022, 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 62 clients receiving services under the provider's Assisted Living with Dementia Care license. *****REVISED***** The following correction order is issued/orders are issued for #HL30650002C/#HL30650001M, tag identification 620 and 3000. On July 7,2022, the Minnesota Department of Health initiated an investigation of complaint #HL30650004C/#HL30650003M. No correction orders are issued.	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.	
0 620 SS=D	144G.42 Subd. 6 (a) Compliance with requirements for reporting ma	0 620		

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0 620	Continued From page 1 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility 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 record review, the licensee failed to comply with the requirements for reporting suspected maltreatment for two of three residents (R2, R3). The facility was aware of the incident but did not report the incident to the Minnesota Adult Abuse Reporting Agency (MAARC) within 24 hours. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). The findings include: R2 was admitted on August 24, 2020, with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and gastro-esophageal reflux disease and neuralgia. R2's Service Agreement dated August 24, 2020, indicated R2 resided in assisted living unit and received assistance with all activities of daily	0 620		

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0 620	Continued From page 2 living which included hygiene, dressing, toileting, medications, meals, and heavy housekeeping. The resident's assessment indicated she required mobility assistance with two staff and a sit to stand to transfer. R3 was admitted on January 07, 2021, with diagnoses which included dementia, bipolar disorder, and gait disorder. R3's Service Agreement dated January 07, 2021, indicated R3 resided in assisted living unit and received assistance with all activities of daily living which included hygiene, dressing, toileting, medications, meals, and heavy housekeeping. The resident's assessment indicated she required mobility assistance with two staff and mechanical/Hoyer lift for transferring. When interviewed on September 9, 2022, at 2:55 p.m., administrator (LALD)-A stated she created an incident report or MAARC as soon as possible but did not remember the exact time. She acknowledged the incidents for both residents R2 and R3 happened in the evening of February 13, 2022. When interviewed on September 8, 2022, at 4:09 p.m. an unlicensed personnel (ULP)-C confirmed the incident happened on February 13, 2022, and she reported to the LALD-D around 5 or 6 p.m. on the same date. A MAARC report for R2, date and time submitted February 15 at 1:48 p.m. indicated the incident happened on February 13, 2022, at 3:00 p.m. A MAARC report for R3, date and time submitted February 15 at 2:17 p.m. indicated the incident happened on February 13, 2022, at 9:00 p.m.	0 620		

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0 620	Continued From page 3 The licensee's Vulnerable Adult Maltreatment Policy dated August 1, 2021, indicated for reporting maltreatment any staff person who witnesses, or suspects maltreatment of a vulnerable adult (VA) would immediately report the incident to their assisted living director and that person would complete an incident report. If the incident appears to be suspected abuse, neglect, or financial exploitation, assisted living director/regional nurse would immediately make a report to the CEP (common entry point). MAARC website was indicated on the policy. "Immediately" means as soon as possible, but no longer than 24 hours from the time the assisted living director/registered nurse received initial knowledge that the incident occurred. If it appears at any time a crime may have been committed, assisted living director/regional nurse would immediately contact the police if the witness had not already done so. Internal Investigation: staff would complete an incident report. The DNS, LALD, or designee would complete an internal investigation pertaining to the report of potential or suspected maltreatment. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is	03000		

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03000	Continued From page 4 admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of	03000		

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03000	Continued From page 5 the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to comply with the requirements for reporting suspected maltreatment for two of three residents (R2, R3). The facility was aware of the incident but did not report the incident to the Minnesota Adult Abuse Reporting Agency (MAARC) within 24 hours. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). The findings include: R2 was admitted on August 24, 2020, with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side and gastro-esophageal reflux disease and neuralgia. R2's Service Agreement dated August 24, 2020, indicated R2 resided in assisted living unit and received assistance with all activities of daily living which included hygiene, dressing, toileting, medications, meals, and heavy housekeeping. The resident's assessment indicated she required mobility assistance with two staff and a sit to stand to transfer. R3 was admitted on January 07, 2021, with diagnoses which included dementia, bipolar	03000		

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