Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306505166M
Compliance #: HL306508881C

Date Concluded: July 20, 2023

Name, Address, and County of Licensee Investigated:
Blaine White Pine Senior Living
12446 Jamestown Street Northeast
Blaine, MN 55449
Anoka 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 did not receive wound care and medications/ treatments for comfort when she was going through her last days of life.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility provided cares and medication administration according to the resident's individual plan of care. The residents' wounds were being cared for by hospice and documentation indicated wound care was completed and the wounds continued to worsen. The resident had physician orders for Emla cream (topical numbing cream) to be applied to the resident's kidney dialysis access prior to dialysis treatment. The facility failed to document applying the Emla cream for approximately three months. However, the resident received the Emla cream when the dialysis unit applied the Emla cream on the resident's dialysis access prior to treatment.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family, the dialysis treatment center, and the pharmacy. The investigation included review of medical records, pharmacy records, hospice notes, facility policies and procedures, nurses' notes, staff charting, and medication administration records. Also, the investigator observed staff providing cares and medications to residents.

The resident resided in an assisted living facility. The resident's diagnoses included end stage renal disease, pressure sores, and chronic pain. The resident's service plan included assistance with activities of daily living, medication administration, meals, laundry, housekeeping, bathing, and skin care.

Facility nursing notes indicated the resident had a decline of health status requiring hospitalization. The nursing notes indicated the resident was hospitalized for fluid volume overload and returned to the facility two days later. When the resident returned, she was admitted to hospice care for end-of-life care and remained in the facility for continued care under the direction of hospice.

Hospice nursing notes indicated the resident received hospice care for 23 days prior to passing away. The documentation included wounds on the residents left and right medial (mid) buttocks/ coccyx (tailbone). The wound care was documented, as well as the progression of the wounds.

A coordination of care note completed by the hospice nurse to the facility nine days prior to the resident's death indicated hospice did not complete wound care due to the resident's family request. The family requested if the resident was comfortable and refused wound care it should not be completed.

The residents nursing notes indicated eleven days after the resident was admitted to hospice the "wounds look healthy, skin extremely macerated (wet) calmoseptine (wound cream) and repositioning every two hours". Five days later, the nurse documented she went to change the dressing on the residents' wounds, but family told staff they wanted hospice to take care of the wounds.

The resident's medication administration record indicated the residents pain medication was increased and scheduled (instead of as needed) the days prior to the resident's death. The facility staff were documenting the resident was repositioned every two hours and staff were monitoring the resident's pain and documenting administration of pain medications as ordered.

When interviewed a resident family member stated the resident's health declined and she was hospitalized. The resident was discharged from the hospital back to the facility with hospice care. The family member stated the resident's wounds on her bottom were getting worse and she did not see facility nursing ever change the residents' wound dressings. The family also stated after the resident passed away the facility gave the family several boxes of leftover Emla cream.

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

Action taken by facility:
No action taken

Action taken by the Minnesota Department of Health:
No further action taken.

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 06/06/2023

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 On June 6, 2023, the Minnesota Department of Health initiated an investigation of complaint #HL306502391C/#HL306506626M and #HL306508881C/ #HL306505166M. No correction orders are issued.	0 000		