

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306506626M
Compliance #: HL306502391C

Date Concluded: September 11, 2023

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:

Katie Germann, RN, Special Investigator
Jessica Sellner, 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 the resident when the AP failed to provide the resident cares overnight and the resident was found lying on the floor covered in stool. The resident was transferred to the hospital.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined neglect was substantiated. The AP is responsible for the maltreatment. The AP failed to provide the resident with cares overnight according to the residents individualized needs. The resident was found by morning staff laying on the floor covered in stool. The resident was transferred to the emergency room by ambulance and diagnosed with Rhabdomyolysis (a breakdown of muscle tissue that releases a damaging protein into the blood).

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of medical records, incident reports, facility policies and procedures, hospital notes, and staff training. Also, the investigator observed staff provide cares and administer medications.

The resident resided in an assisted living facility with diagnoses including left sided hemiparesis (weakness), vascular dementia, and history of seizures and stroke. The resident's service plan included assistance with activities of daily living, toileting, transfers, meals, housekeeping, and laundry. The resident's assessment indicated the resident had a history of falls and required assistance of one staff, using a gait belt and a walker for transferring and walking. The resident's service plan indicated the resident required one staff assistance with personal hygiene and incontinence care and was to be checked on by facility staff every two hours overnight.

A facility incident report indicated the resident was found about 7:00 a.m. laying on the floor on her stomach, parallel to her bed. The resident was lying on the right side of her face and was covered in stool. The resident's face was swollen, and the resident's speech was slurred. The resident was unable to open her eyes, had limited range of motion of both legs, and was sent to the hospital by ambulance. The incident report indicated the interventions implemented related to the incident included reeducating staff regarding the importance of two-hour checks and what the consequences will be if not completed.

The ambulance report indicated when they arrived at the facility the resident was laying on the floor. Staff reported the resident, "has been on the ground all night since the previous evening," and staff also stated, "no one checked in on [resident] last night." The resident complained of pain all over, had swelling on her face, and the resident was, "beginning to develop sores from being on the ground [for an extended time]." The resident was transported to the hospital for further evaluation.

The resident's hospital notes indicated the resident was being evaluated after a fall. The resident was last seen at 8:00 p.m. and found the next morning at 7:30 a.m. Emergency medical services reported the resident was confused, had low oxygen saturations, and had high blood pressure when they arrived at the facility. The hospital notes indicated the resident had traumatic rhabdomyolysis, which was consistent with lying on the floor for an extended period of time. The resident also had congestive heart failure exacerbation and a non-ST-elevation myocardial infarction (heart attack). The resident told hospital staff she was trying to sit down on her chair but was weak and slid to the floor.

When interviewed the AP stated she was assigned to provide cares for the resident on the overnight shift of the incident. The AP stated she asked a coworker to provide safety checks/cares for the resident. However, the AP stated she checked on the resident around 2:30 a.m. after coming out of another resident's room. The AP stated the resident was lying in bed sleeping. The AP stated she did not check on the resident any time after 2:30 a.m.

When interviewed an unlicensed staff stated the night of the incident, she observed the resident only once during the overnight shift at approximately 2:00 a.m. and the resident was asleep in her recliner at that time. The staff stated she did not tell the AP she would provide cares for the resident on the overnight shift of the incident.

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, due to cognition.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility provided education to facility staff on providing reassurance checks.

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
Anoka County Attorney
Blaine City Attorney
Blaine Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30650	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/06/2023
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NAME OF PROVIDER OR SUPPLIER BLAINE WHITE PINE	STREET ADDRESS, CITY, STATE, ZIP CODE 12446 JAMESTOWN STREET NE BLAINE, MN 55449
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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>Initial Comments</p> <p>*** Revised ***</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>#HL306502391C/ #HL306506626M and #HL306508881C/ #HL306505166M</p> <p>On June 6, 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 60 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction orders are issued for #HL306502391C/ #HL306506626M, tag identification 2360.</p>	0 000		
02360	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>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.</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>This MN Requirement is not met as evidenced by: The facility failed to ensure one of one residents reviewed (R1) was free from maltreatment.</p> <p>Findings include:</p> <p>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the AP was responsible for the maltreatment, in connection with incidents which occurred at the facility.</p> <p>Please refer to the public maltreatment report for details.</p>	02360		