

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL316755564M
Compliance #: HL316759520C

Date Concluded: May 23, 2023

Name, Address, and County of Licensee

Investigated:

Blaine White Pine II
12402 Jamestown St NE,
Blaine, MN 55449
Anoka County

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

Evaluator's Name: Brandon Martfeld, 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) abused a resident when the AP slapped the resident's left foot and pushed the resident's legs into the resident's chest while being assisted to bed.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined abuse was substantiated. The AP was responsible for the maltreatment. Recorded video of the resident's bed showed the AP assisting the resident into bed. With the resident lying flat on his back, the AP walked to the end of the bed and slapped the top of the resident's left foot and toes. Next, the AP picked up the resident's legs by his ankles, and with bent knees, pushed both legs into the resident's chest. The AP held the resident's bent legs with one hand, while he picked up the blankets and tossed the blankets over the resident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member.

The investigation included review of the resident's medical record, law enforcement report, and policy and procedures. Also, the investigator observed the resident, the resident's room, and the common areas of the facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia. The resident's service plan included staff assistance with dressing, grooming, safety checks, mobility, and transfers. The resident was severely cognitively impaired. The resident's individualized abuse prevention plan identified the resident as a vulnerable adult due to the resident's diagnoses, limited range of motion, and the inability to report abuse.

The video, that pointed at the foot of the resident's bed, showed the AP assisting the resident into bed. With the resident lying flat on his back, the AP walked to the end of the bed and slapped the top of the resident left foot and toes. The slap made an audible sound on the recorded video. Next, the AP picked up the resident's legs by his ankles, forcibly pushed both legs so that the knees bent into the resident's chest causing the resident to yell. The AP held the resident's bent legs with one hand, picked up the blankets at the foot of the bed, released the resident's feet, and tossed the blankets over the resident.

During an interview, the AP denied slapping the resident's foot. The AP stated his hand hit the resident's foot on accident. The AP stated the resident complained of pain earlier while in the bathroom with the AP, so when the AP lifted the resident's legs to get the blankets, the resident yelled out.

During an interview, management stated they were notified of the incident involving the resident and AP the same evening. Management stated they immediately removed the AP from resident care and the AP was sent home. The following day, a family member came into the facility and showed management the recorded video.

During an interview, the family member stated on the recorded video, she saw the AP slap the resident's foot and push the resident's legs into his chest.

Review of the law enforcement report indicated the incident was forwarded to the city attorney for misdemeanor fifth degree charges.

In conclusion, the Minnesota Department of Health determined abuse 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.

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

Vulnerable Adult interviewed: No, unable due to cognitive impairment.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility educated all staff regarding vulnerable adult abuse and reporting. The AP is 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

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: 31675	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/26/2023
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NAME OF PROVIDER OR SUPPLIER BLAINE WHITE PINE II	STREET ADDRESS, CITY, STATE, ZIP CODE 12402 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>*****ATTENTION*****</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: #HL316755564M/#HL316759520C</p> <p>On April 26, 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 41 residents receiving services under the provider's Assisted Living license.</p> <p>The following correction orders are issued for #HL316755564M/#HL316759520C, tag identification 2360.</p>	0 000	<p>The Minnesota Department of Health documents 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 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 and/or Investigators' findings is the Time Period for Correction.</p> <p>Per Minnesota Statute §144G.30, Subd. 5 (c), the assisted living facilities must document any action taken to comply with the state correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys and/or complaint investigations.</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>	

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

Minnesota Department of Health

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0 000	Continued From page 1	0 000	THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO THE MINN. STAT. § 144G.31, SUBDIVISION 2 and 3.	
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> <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. Please refer to the public maltreatment report for details.</p>	02360	<p>No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.</p>	