Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL316755765M
Compliance #: HL316754309C

Date Concluded: June 5, 2023

Name, Address, and County of Licensee Investigated:
Blaine White Pine II
12402 Jamestown Street Northeast
Blaine, MN, 55449
Anoka County

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

Evaluator's Name:
Juliet O'Martins, RN, Special Investigator
Maerin Renee, RN, Special Investigator

Finding: Substantiated, facility 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 the resident when multiple resident-to-resident altercations occurred and the facility failed to monitor, assess, and implement interventions to protect the health and safety of the residents.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to provide supervision to protect the resident's health and safety following multiple resident-to-resident altercations. The facility was aware several residents exhibited aggressive behavior and failed to identify and implement interventions to mitigate future incidents.

The investigators conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members. The

investigation included review of resident medical and hospital records, as well as facility policies and procedures, and staff files. In addition, investigators observed resident cares.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and traumatic hemorrhage (bleeding) of cerebrum (brain). The resident's service plan included assistance with bathing, behavioral intervention, medication administration, meals, dressing and grooming, and reassurance checks. The resident's assessments indicated vulnerabilities in verbal abuse and physical violence towards others.

One evening, a staff member saw the resident walking down the hallway with what appeared to be blood on his shirt. When asked, the resident stated he was in a fight with a peer. The staff member noticed the resident's peer had what appeared to be blood on his ear and bruising on his face. The resident's peer was eventually hospitalized for his injuries.

A review of facility documentation indicated soon after admission, the resident developed a pattern of aggression and violence toward staff and peers. The resident also incurred injuries from some encounters.

Soon after he was admitted to the facility, an incident report indicated the resident was engaged in a physical altercation with a peer. The resident sustained a cut above an eye on which he had just had surgery. Progress notes a few months later indicated the resident hit a peer in the face when his peer entered the resident's room. The resident sustained a cut to his finger and the peer sustained a cut around his mouth. Staff did not document an incident report.

A little over a month later, progress notes indicated the resident got into an altercation with a peer. The resident stood over his peer and was pulling his shirt. Staff separated and redirected the residents. Another incident report indicated the resident became agitated and pushed his walker at a peer when the peer approached him.

Notes from the resident's community behavioral provider indicated the resident was triggered when other residents invaded his personal space. The behavioral provider offered recommendations to mitigate further incidents of aggression toward other residents. However, a few months after the resident started treatment with the community behavioral health agency, the facility reported he showed no further behavioral concerns. As a result, although the resident continued to display aggression toward other residents, the services he received from the community behavioral health agency were discontinued.

An incident report indicated the resident hit a peer in the eye when the peer touched his chair. No injuries were noted. Another incident report indicated the resident was found on the floor with an object in his hand, with a peer standing over him in the bathroom. The resident sustained injuries to his left ear. A month later a progress report indicated the resident was in a physical altercation with a peer. The resident was pushed and fell onto the hardwood floor. The

resident sustained a skin tear to his elbow and blood around his teeth. Facility staff updated the resident's provider, no new orders were written.

A month later, progress notes indicated the resident struck a staff member in the back with his walker. When the staff member turned around, the resident hit her in the face three times, resulting in bloody lips and nose. A month after that incident, progress notes indicated the resident stabbed a peer in the hand with a fork.

Despite a pattern of physical aggression demonstrated by the resident and aimed toward peers and staff, facility staff did not consistently conduct assessments following each incident to identify vulnerabilities, susceptibilities to abuse, or new risks of harm to others. Existing interventions were not evaluated, the resident's abuse prevention plan was not updated, and no new interventions were implemented to prevent future incidents.

During an interview, an administrator stated if there is a resident-to-resident altercation, the nurse should follow up with the resident's physician and contact outside behavioral agency for interventions to prevent reoccurrence and protect both residents. The administrator admitted that those steps were not followed at the time the reported incident occurred.

When interviewed, a staff nurse stated she was on-call at the time of the incident and was informed of the altercation between the resident and his peer, and the injuries the resident's peer sustained.

During an interview, a family member expressed concerns about the lack of interventions implemented by the facility.

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, unable to provide information.

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

Action taken by facility:
Procedures for addressing resident-to-resident altercations were updated.

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
Anoka County Attorney
Blaine City Attorney
Blaine Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31675	A. BUILDING: _____ B. WING _____	C 03/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLAINE WHITE PINE II	12402 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 ******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: #HL316754309C/#HL316752509M #HL316755765M/#HL316755947C On March 15, 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 with Dementia Care license. The following correction orders are issued for #HL316755765M/#HL316755947C and #HL316754309C/#HL316752509M, tag identification 0630 and 2360.	0 000	Minnesota Department of Health is documenting 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 which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 630 SS=I	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each	0 630		

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0 630	Continued From page 1 vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to update the individual abuse prevention plan (IAPP) with noted incidents for two of two residents (R1 and R2) with records reviewed. Both residents were involved in multiple instances of resident-to-resident aggression and the facility failed to update R1 and R2's IAPPs to reflect the incidents, R1 and R2's vulnerabilities when interacting with other residents, and specific measures to minimize risk to R1, R2, and the other residents. 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 has affected or has potential to affect a large portion or all of the residents. The findings include: Review of R1's medical record indicated R1 was admitted to facility to facility on June 23, 2022. R1's diagnoses included dementia, Alzheimer's	0 630		

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0 630	Continued From page 2 with behavioral disturbances, hyperlipidemia, and type 2 diabetes. R1's IAPP, dated June 23, 2022, indicated vulnerabilities in behaviors posing risk to self (wandering) and physical violence or potential to harm others. R1's IAPP failed to address specific measures staff would take to minimize risk to R1 and other residents during resident interactions. R1's service plan, dated October 01, 2022, included reassurance checks, medication administration, assistance with transfers, dressing, and grooming, and assistance with meals. Review of R2's medical record indicated R2 was admitted to the facility on August 10, 2021. R2's diagnoses included dementia and traumatic brain hemorrhage. R2's IAPP, dated October 10, 2022, indicated vulnerability in Physical violence or potential to harm others. R2's IAPP failed to address specific measures staff would take to minimize risk to R1 and other residents during resident interactions. R2's service plan, dated March 15,2022, included assistance with bathing, behavioral intervention, medication administration, meals, dressing, grooming, and reassurance checks. A review of documents revealed: August 28, 2021: R2 Shoved a resident, causing him to fall. No incident report was completed, no behavioral interventions were documented or instituted. IAPPs were not updated. October 21, 2021: A resident hit R2, causing	0 630		

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0 630	Continued From page 3 serious injuries around R2's eyes which required medical intervention. No behavioral interventions or changes in care plans were documented or instituted. IAPPs were not updated. December 16, 2021: R2 was involved in an altercation with another resident, in which R2 sustained injuries. No incident report was completed, no behavioral interventions were documented or instituted. IAPPs were not updated. March 3, 2022: R2 punched a resident when the other resident entered his room and wouldn't leave. No incident report was completed, no behavioral interventions were documented or instituted. IAPPs were not updated. April 17, 2022: R2 was involved in an altercation with another resident. No incident report was completed, no behavioral interventions were documented or instituted. IAPPs were not updated. June 27, 2022: R1 became aggressive with staff. No incident report was completed, no behavioral interventions were documented or instituted. R1's IAPP was not updated. June 28, 2022: R1 became aggressive with staff. No incident report was completed, no behavioral interventions were documented or instituted. R1's IAPP was not updated. July 5, 2022: R1 entered another resident's room and pushed the resident to the floor. No incident report was completed, no behavioral interventions were documented or instituted. IAPPs were not updated.	0 630		

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0 630	Continued From page 4 July 10, 2022: R1 and R2 were involved in an altercation and sustained serious injuries. No behavioral interventions were documented or instituted. IAPPs were not updated. July 18, 2022: R1 Punched another resident in the face. No incident report was completed, no behavioral interventions were documented or instituted. IAPPs were not updated. July 28, 2022: R2 pushed his walker at another resident. No incident report was completed, no behavioral interventions were documented or instituted. IAPPs were not updated. July 31, 2022: R1 and R2 were involved in an altercation, both sustained serious injuries. R1 required medical attention. No behavioral interventions were documented or instituted. IAPPs were not updated. September 16, 2022: R1 hit another resident. The other resident developed a brain bleed. No behavioral interventions were documented or instituted. IAPPs were not updated. October 6, 2022: R2 was involved in an altercation with another resident. No behavioral interventions were documented or instituted. IAPPs were not updated. October 8, 2022: R2 was found on the floor with another resident standing beside R2, who sustained injuries. R2 was trying to get another resident out of his room. No incident report was completed, no behavioral interventions were documented or instituted. IAPPs were not updated. During an interview on March 29,2023 at 1:07	0 630		

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0 630	Continued From page 5 p.m., licensed assisted living director (LALD)-H admitted the facility failed to update R1 and R2's IAPPs with specific measures to minimize risk to R1, R2, and the other residents. The facility's Individual Abuse Prevention policy, dated August 01, 2021, stated each resident's IAPP will contain an individualized review or assessment of the resident's vulnerability to abuse by another individual. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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: The facility failed to ensure two of two residents reviewed (R1 and R2) were free from maltreatment. The findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	