Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306505843M
Compliance #: HL306501040C

Date Concluded: May 31, 2023

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

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

Evaluator's Name: Brandon Martfeld, 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 facility staff failed to provide the resident an anti-psychotic medication, Clozaril, according to the physician orders.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Staff provided the resident Clozaril according to the provider order.

The investigator conducted interviews with facility staff members, including administrative staff, and nursing staff. The investigator contacted the family member. The investigation included review of resident's medical record and facility policies and procedures. Also, the investigator observed common areas in the facility.

The resident resided in an assisted living facility. The resident's diagnoses included mood disorder, anxiety, Parkinson's disease, and psychotic disorder. The resident's service plan

included staff assistance with medication management and administration. The resident's assessment indicated the resident was prescribed a psychotropic medication. The resident's assessment indicated unlicensed personnel administered medications to the resident. The resident was able to make her needs known to staff.

The resident's medication administration record (MAR) indicated the resident was prescribed Clozaril for Parkinson's disease. The MAR indicated the resident received 12.5 milligrams (mg) at noon and 50 mg at eight at night. Staff provided the resident with Clozaril as prescribed.

Additional concerns included missed doses of other medications. The resident's progress notes indicated the day of admission, the resident received all the medications from the pharmacy but Clonazepam, used for anxiety. The pharmacy required a separate hand-written prescription for the resident's Clonazepam according to the pharmacy-controlled substance policy. The pharmacy provided the facility with the resident's Clonazepam the following afternoon.

During the investigation, the facility's medication incident report form indicated the resident was to take Clonazepam, one-half tablet (0.25) mg twice a day and daily as needed for anxiety. Staff failed to provide the resident one dose of Clonazepam six days after admission, and one time a day for four days. Despite missing one dose a day of Clonazepam, the resident did not complain of increased anxiety or require an as needed dose until the day the error was discovered by staff.

Another concern investigated included a 17-hour delay in the resident's medication administration due to a broken key in the medication cart preventing staff access to the cart. When the key broke off in the medication cart, facility staff contacted a locksmith who repaired the lock in three and one-half hours. At that time, staff provided the resident with her medications.

During an interview, the family member stated facility staff made them aware of the medication errors, but the family decided to transfer the resident to a different facility due to the errors.

During an interview, the nurse stated the resident's medication, Clonazepam was to be given twice a day for anxiety. The nurse stated multiple staff missed one dose of the medication two days in a row, then five days later multiple staff missed one dose of the medication for four days. The resident either missed a morning dose or the evening dose.

During an interview, management stated there was an issue the day of the resident's admission to the facility when the pharmacy failed to deliver the resident Clonazepam. Management could not recall the exact reason for the delay but did recall facility staff requested the pharmacy deliver the medication within four hours. Management stated there was also concerns with staff missing doses of the resident's Clonazepam. The resident either received the morning dose and not the evening dose or would not receive the morning dose and receive the evening dose.

Once aware of the medication error, facility staff were provided education and the family was updated.

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, unable to contact.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility notified the resident’s provider of the Clonazepam medication error and provided education to the staff involved with the medication error.

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

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 04/26/2023

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 April 26, 2023, the Minnesota Department of Health initiated an investigation of complaint HL306505843M/HL306501040C. No correction orders are issued.	0 000		