Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL294083523M
Compliance #: HL294085756C

Date Concluded: March 23, 2023

Name, Address, and County of Licensee Investigated:
Mendota Heights White Pine
745 South Plaza Drive
Mendota Heights MN 55120
Dakota County

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

Evaluator's Name: Maggie Regnier
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):
Allegation #1: The facility neglected a resident when the facility failed to recognize the resident had a femur fracture.

Allegation #2: The facility neglected a resident when the facility delayed sending the resident to the hospital.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated.

Allegation #1: When the resident reported a concern regarding her hip, the facility assessed the resident and updated the resident's provider, who ordered a portable X-ray to rule-out a fracture. The X-ray showed a fracture was present and the resident was hospitalized for treatment.

Allegation #2: When the resident had intermittent confusion, the facility assessed her and when she showed further decline later, the facility contacted the resident's medical provider and sent her to the hospital.

The investigator conducted interviews with facility staff members, including nursing staff, and unlicensed staff members. The investigation included a review of the resident's facility and hospital medical records.

The resident lived at the facility for one month and admitting diagnoses included quadriplegia (paralysis of arms and legs), lower back pressure wounds, malnutrition and used anticoagulant (medication to prevent blood clots) medications due to a history of problems with blood clots. The resident's service plan indicated she required assistance of two caregivers for bed mobility, incontinence cares, and transferred with a Hoyer (total-assist lift). The resident's admission assessment indicated she the resident had a suprapubic urinary catheter and sacral (buttocks) wounds with a referral for an outside agency to provide wound cares. The resident's medical record indicated she made her own decisions independently and could leave the facility unsupervised. The same documents indicated she spoke softly and slowly. The resident's prescreening assessment indicated she weighed approximately 100 pounds.

One afternoon the resident's progress notes indicated one she returned from an offsite appointment complaining of right hip pain and saying her hip had "popped" a few days earlier. The same document indicated the nurse updated the resident's provider who ordered a portable X-ray, which identified the resident's bones as demineralized (loss of bone density) along with a femur fracture, so the resident was hospitalized.

The facility conducted an internal investigation which included interviews of the unlicensed caregivers who worked with her during the days just prior to the resident's report of hip pain but did not identify a specific event of when the femur (upper leg) fracture may have occurred. The facility interviewed the resident; however, she made inconsistent comments about what occurred. The same document indicated a nurse assessed the resident when she complained of right hip pain and identified "some hardness" in the resident's leg but no other signs of injury, which prompted an update to the resident's medical provider and the resident's pain was relieved with Tylenol.

The resident's hospital record indicated she underwent surgery for her femur fracture and returned to the facility about a week later. Over the next two weeks the facility monitored the resident's coagulation levels but the results were consistently too high (meaning her blood took to long to clot) and so the resident's medical provider discontinued the use of anticoagulants.

A few days after the resident's anticoagulant medications were discontinued, the resident's progress notes indicated the nurse observed the resident seemed more confused but did not

have any other signs or symptoms of illness or stroke. Two days later the resident had increased tiredness, so the facility nurse assessed the resident and sent her to the hospital.

The resident's emergency records showed her vital signs remained stable upon admission to the hospital, but admitted to the hospital. The resident's hospital records indicated she tested positive for COVID-19. The same records indicated the resident would spit out her food and starvation ketoacidosis (which is a bodily response to prolonged fasting). About a week after she admitted to the hospital, the resident had a cardiac arrest and passed.

During investigative interviews, multiple staff members stated the facility used two people to move or transfer the resident and would report if any harm would happen to the resident if not used correctly.

During an interview, the nurse stated she assessed the resident when the unlicensed caregivers told her the resident's confusion was more pronounced along with delayed responses and sent her to the hospital.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated for allegation #1 nor allegation #2.

"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: Attempts to reach family unsuccessful
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility completed did an internal investigation regarding the resident's femur fracture.

The facility verified education on equipment and proper transfer of residents and resident assessments.

Action taken by the Minnesota Department of Health:
No further action 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
	29408	A. BUILDING: _____ B. WING _____	C 01/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MENDOTA HEIGHTS WHITE PINE	745 SOUTH PLAZA DRIVE MENDOTA HEIGHTS, MN 55120

(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 Januay 24 2023, the Minnesota Department of Health initiated an investigation of complaint #HL294085756C/#HL294083523M. No correction orders are issued.	0 000		