Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL326762341M
Compliance #: HL326761406C

Date Concluded: June 24, 2024

Name, Address, and County of Licensee Investigated:
Crest View Senior Community At Blaine
12016 Ulysses Street Northeast
Blaine, MN 55449
Anoka County

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

Evaluator's Name: Willette Shafer
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 the resident when staff failed to provide hygiene care, proper nutrition, and follow medication orders. As a result, the resident was hospitalized on two separate occasions.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility moved the resident to the memory care unit upon hospital return to accommodate her increased support needs, updated the resident's provider on changes in status and made medication adjustments.

The investigator conducted interviews with facility staff members, including administrative staff and nursing staff. The investigator also interviewed family. The investigation included review of medical records, hospital records and facility policies. Also, the investigator toured the facility and observed resident cares including medication administration and grooming.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease, heart failure, and depression. The resident's service plan included assistance with bathing, grooming, medication management, and behavioral interventions. The resident's assessment indicated the resident had cognitive impairment with poor decision making and was an increased elopement risk.

According to the resident's progress notes, the resident had a behavioral episode where she was physically and verbally aggressive towards staff. Staff sent the resident to the hospital for further evaluation.

According to the hospital record, the resident presented with escalated agitation upon admission. The hospital physician diagnosed the resident with a urinary tract infection. The resident was delirious and placed on a one-to-one staff ratio for supervision. The resident had impaired memory, judgement, and safety awareness. The hospital physician recommended increased assistance once medically stable. In addition, the hospital discharge orders included an order to discontinue the resident's antipsychotic medication (quetiapine).

During an interview, a family member said she questioned whether the resident should have admitted to the memory care unit upon hospital return but said another family member may have approved the move. The family member said upon discharge, the hospital discontinued one medication, but the facility re-ordered it. In addition, the family member was concerned about the recent medication changes made while at the hospital. She said the resident appeared overly sedated when she came to visit after the resident readmitted to the facility and the resident recently fell twice. She reported her concerns to the facility staff. She said the facility reviewed and adjusted medications at that time. The family member said the resident appeared unkept and had dry mucus membranes possibly related to dehydration. The facility staff sent the resident back to the hospital due to low oxygen saturation level. She was diagnosed with pneumonia at the hospital.

The resident's service delivery records indicated the resident's scheduled bath was left blank without documentation as being completed. The family reported staff completed an unscheduled bath later that same week, however the facility staff failed to document completion of the unscheduled bath on the service delivery record.

The resident's medication administration record (MAR) indicated medication order changes were made after family voiced concern. The MAR showed a medication transcription error when quetiapine was not discontinued and was given to the resident for 10 days after returning to the facility.

The resident's nurse practitioner (NP) visit note indicated the NP saw the resident six days after returning from the hospital (five days after the transcription error). The NP noted the hospital order to discontinue quetiapine, reviewed the MAR and additionally wrote an order to

discontinue quetiapine. The NP ordered laboratory tests for the resident. The NP assessed the resident and found no clinical symptoms for respiratory concerns at that time. The NP noted concern for continued weakness, other signs for increased fluid within the brain related to congestive heart failure and ordered additional laboratory tests. The visit note however was not completed and provided to the facility until five days after the visit.

The resident's progress notes indicated two days after receiving the NP's orders, the resident presented with breathing changes and the NP ordered supplemental oxygen and a weight recheck (for increased fluid). The resident's weight had increased 3.5 pounds from her hospital discharge and the NP ordered a change to her Lasix (water pill). A week later, the NP discontinued the resident's other antipsychotic medication (Haldol), which had started in the hospital. Four days later, the progress note indicated the resident had a rapid decline and changes in the past 24 hours, including requiring three staff for assistance due to inability to stand and the facility staff sent the resident to the hospital.

The resident's discharge summary indicated she had a rapid decline and was sent to the hospital. The resident passed away at the hospital.

During an interview, a member of management said resident became extremely agitated during a group activity. When resident was asked to leave, she became physically aggressive towards a staff member. The member of management said the resident had dementia and a history of verbal aggression, but the resident was not physically aggressive in the past. Staff sent her to the hospital for evaluation for the change in condition. At the hospital she was diagnosed with a urinary tract infection. The member of management stated upon return to the facility, she admitted to the locked memory care unit, which family approved. The resident received one bath a week. The member of management stated staff were instructed to assist with additional showers upon resident request or as needed. The member of management was unsure why staff did not document the resident's bath on the service record. The member of management stated later after returning from the first hospitalization, the resident had a significant change in a 24-hour period and sent back to the hospital for the second hospitalization.

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

Action taken by facility:
The facility moved the resident to memory for increased care assistance. The facility followed orders received by the resident's NP. After a significant change in status, the facility sent the resident to the hospital for a second admission. The facility made changes to management staff to ensure timely communication to families and ensure nursing processes are carried out accurately and timely.

Action taken by the Minnesota Department of Health:
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32676	A. BUILDING: _____ B. WING _____	C 03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW SENIOR COMMUNITY AT	12016 ULYSSES STREET NE BLAINE, MN 55434

(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 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: #HL326769127C/#HL326761580M and #HL326761406C/#HL326762341M On March 26, 2024, 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 89 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL326769127C/#HL326761580M, tag identification 1620, 2320 and 2360. The following correction order is issued for #HL326761406C/#HL326762341M, tag identification 1760.	0 000	Minnesota Department of Health is documenting 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 is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings 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.	
01620 SS=G	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 1 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to measure and assess a resident for proper sling size selection for one of one resident (R1) who used a full body mechanical lift. R1 fell from a mechanical full body lift and sustained a hip fracture. 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	01620		

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01620	Continued From page 2 issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included hip fracture, obesity, neuropathy, chronic pain, anxiety, and stroke. R1's service plan dated April 17, 2023, indicated R1 used a mechanical full body lift with assistance of two staff for all transfers. R1's 90-day nursing assessment dated November 20, 2023, indicated R1 required total assistance with transfers utilizing two staff with a "Hoyer" lift (mechanical full body lift). R1's weight was 230 pounds and height was 55 inches as of April 13, 2023. Under section, "Assistive Devices," the assessment indicated R1 used a wheelchair, mechanical lift, and bed rails. The assessment failed to include the assessed size of sling R1 required for the full body mechanical lift and indicate which straps of the sling were required to be applied to the lift for safe and proper use. R1's care plan dated February 8, 2024, indicated R1 used a size large sling for a Hoyer life with two staff during transfers. R1's care plan failed to include what color straps to utilize when connecting the sling to the mechanical lift. A photograph provided by the licensee of the sling used showed a maroon color binding on the sling. The EZ Way brand sling sizing chart indicated the size and weight designations were estimates and basic guidelines. A proper fit would depend on other weight measurements including height and	01620		

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01620	Continued From page 3 girth of the resident. The size chart indicated the fabric of one leg seam to the other should be the same width as the resident's hip to the other hip. The size guide also included a maximum distance from the resident's tailbone to base of the neck for each sling size. The document indicated the color coding referenced the binding color of the sling. The color maroon indicated a size large. R1's record failed to include measurements of R1's tailbone to base of her neck and measurements from her hip to the other hip. R1's progress notes dated January 20, 2024, indicated R1 fell from a full body mechanical lift while unlicensed personnel (ULP)-A and ULP-B attempted to transfer R1 from the wheelchair to the bed. ULP-A and ULP-B reported R1 fell from the side of the sling and landed on her left side. Staff sent R1 to the hospital. R1's hospital record indicated she admitted on January 20, 2024, for a displaced and impacted left hip fracture. She required surgical repair of the hip and was hospitalized for 17 days, discharging on February 6, 2024. R1's progress note dated February 10, 2024, indicated R1 returned to the licensee, but discharged to a skilled nursing facility four days later for higher level of care. The licensee internal investigation dated January 20, 2024, indicated R1 leaned out of the sling towards her right side and landed on her left hip. ULP-B's statement in the internal investigation indicated after lifting, R1 started leaning on her right side. Before ULP-B and ULP-A could stop her, R1 was already on the floor. The lift was	01620		

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01620	Continued From page 4 inspected and functioning properly. The internal investigation failed to include confirmation of what size sling was utilized, the strap colors used and verification the straps were connected correctly at the time of the incident, although a nurse was present. During an interview on March 28, 2024, at 10:40 a.m., ULP-B said during the transfer ULP-A operated the remote lift while she moved R1's wheelchair. R1 fell while ULP-B was turned around moving the wheelchair. ULP-B said she never saw R1 fall out of the sling. During an interview on March 28, 2024, at 11:35 a.m., ULP-A said R1 leaned to her right side and they adjusted her to the center. When ULP-A raised her up, she fell out. During an interview on March 28, 2024, at 12:18 p.m., licensed assisted living director (LALD)-C said mechanical lift re-education was completed only with ULP-A and ULP-B after the incident. The licensee policy titled Requests for Assistive Equipment, dated March 2017, indicated assistive equipment is implemented based on the Safety Risk Assessment and failed to include direction on assistive equipment assessment when a resident requires a devices rather than requests one. TIME PERIOD CORRECTION: Seven (7) Days	01620		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the	01760		

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01760	Continued From page 5 resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to transcribe provider's orders correctly for one of two residents (R2). R2 received an anti-psychotic medication for 10 days after it was discontinued. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2's diagnoses included Alzheimer's disease, depression, and fractured femur. R2's service plan dated January 30, 2024, indicated R2 received assistance with medication administration and behavioral interventions. R2's hospital discharge summary dated January	01760		

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01760	Continued From page 6 30, 2024, indicated R2 should stop taking QUEtiapine (anti-psychotic) 25 milligram tablet. R2's February 2024 medication administration record indicated QUEtiapine Fumarate 25 milligram tablet was administered February 1, 2024, through February 10, 2024. During an interview on April 9, 2024, at 9:00 a.m., licensed assisted living director (LALD)-C stated she was unaware of the medications R2 was prescribed upon hospital return but said she would look into it. An email on April 9, 2024, sent from LALD-C at 10:16 a.m., indicated the former director of nursing (DON)-D completed the medication reconciliation. The medication was manually entered into the electronic system as prescribed by the provider at the hospital who signed R2's hospital discharge orders. The licensee's Electronic Medication Administration Record policy dated November 2022, indicated the nurse supervisor enters the orders into the electronic medication administration record when orders are received and ensures orders are transcribed accurately. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02320 SS=I	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in	02320		

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02320	Continued From page 7 sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff were competent to use of a full body mechanical lift for one of one resident (R1) reviewed. R1 fell from a mechanical full body lift and sustained a hip fracture. The licensee failed to retrain unlicensed personnel (ULP) on safe and proper use of the mechanical lift and during demonstration, the sling was attached to the mechanical lift incorrectly. This had the potential to affect all residents who required a mechanical lift for transfer. In addition, the licensee failed to ensure staff competency on how to use and responded to resident call lights in a timely manner. This had the potential to affect all 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: Mechanical Full Body Lift ULP-A's record titled ULP Skills/ Competency Testing Checklist dated June 26, 2023, indicated ULP-A completed training on mechanical lifts by demonstration.	02320		

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02320	Continued From page 8 ULP-B's record titled ULP Skills/ Competency Testing Checklist dated December 14, 2023, indicated ULP-B completed training on mechanical lifts. The test method of demonstrated competency was blank. ULP-B's personnel record indicated new employee education was completed on December 13, 2023. R1's diagnoses included hip fracture, obesity, neuropathy, chronic pain, anxiety, and stroke. R1's service plan dated April 17, 2023, indicated R1 used a mechanical full body lift with assistance of two staff for all transfers. R1's progress notes dated January 20, 2024, indicated R1 fell from a full body mechanical lift while ULP-A and ULP-B attempted to transfer R1 from the wheelchair to the bed. ULP-A and ULP-B reported R1 fell from the side of the sling and landed on her left side. Staff sent R1 to the hospital. R1's hospital record indicated she admitted on January 20, 2024, for a displaced and impacted left hip fracture. She required surgical repair of the hip and was hospitalized for 17 days, discharging on February 6, 2024. During an interview on March 28, 2024, at 10:40 a.m., ULP-B stated she received paper training on mechanical lifts in new employee orientation. ULP-B said re-education on mechanical lifts was not completed with her after the incident. During an interview on March 28, 2024, at 12:18 p.m., licensed assisted living director (LALD)-C said mechanical lift re-education was completed only with ULP-A and ULP-B after the incident. During an interview on March 29, 2024, at 12:10	02320		

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02320	Continued From page 9 p.m., director of nursing (DON)-D stated the facility used the EZ [Way] full body lift with a sling that crosses the legs. DON-D stated they completed re-education with ULP after the incident. ULP-A's record titled Supervision of ULP dated January 24, 2024, indicated skills reviewed and trained on the hoyer lift. ULP-B's personnel record lacked education or competency evaluation completed after R1 fell from the mechanical lift. ULP-G's record titled ULP Skills/ Competency Testing Checklist dated January 31, 2024, indicated ULP-G completed training on mechanical lifts. ULP-F's record titled ULP Skills/ Competency Testing Checklist dated February 28, 2024, indicated ULP-F completed training on mechanical lifts. During an observation on April 3, 2024, at 2:40 p.m., ULP-F and ULP-G completed a mechanical full body lift demonstration. ULP-F and ULP-G attached the mesh lift sling incorrectly to the mechanical lift bar. DON-D and LALD-C were both present during the demonstration. DON-D verified the sling was attached incorrectly. The licensee Hoyer Lift policy dated November 2004, indicated two staff are required to transfer a resident with a mechanical full body lift. One person steers and operated the mechanical lift while the second person safely guides the resident's position. The policy included instruction place a mesh sling under the resident and to connect to a manual hydraulic pump mechanical	02320		

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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
02320	Continued From page 10 full body lift. The policy failed to include instruction using the EZ Way brand mechanical lift and applying the EZ Way sling (which was not a mesh sling, but a fabric cross leg sling). According to the EZ Way manufacture's mechanical lift training tutorial, if the sling is applied correctly and the lift is operated properly "there is zero percent chance" the resident would be injured during a transfer. Call Lights During an interview on April 3, 2024, at 11:30 a.m., ULP-H said she was assigned to the fourth floor. The call light system sends alerts through a program on a licensee provided iPhone. Each staff is assigned an iPhone. ULP-H gave her iPhone to the ULP-I assigned to the third floor as one phone was missing. She said if a resident pushed their call light, a staff from another floor would call her personal phone to report a resident on fourth floor requested assistance. During an interview on April 3, 2024, at 11:42 a.m., ULP-I demonstrated use of the iPhone. She said ULP-H gave her the iPhone from the fourth floor as third floor had more residents who requested assistance. ULP-I reviewed the call history log. ULP-I was unsure how long a call light had been ringing or what the calls below the current alert meant. ULP-I gave inconsistent information for clearing a call light. During an interview on April 3, 2024, at 11:55 a.m., LALD-C said more education would be provided on call light process. Per the licensee's pendant push log dated March 24, 2024 to March 26, 2024, a resident waited over 45 minutes for assistance on nine separate	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32676	A. BUILDING: _____ B. WING _____	C 03/26/2024

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02320	Continued From page 11 occasions. - March 24, 2024, call light duration 02:02:20 - March 24, 2024, call light duration 01:38:41 - March 24, 2024, call light duration 00:51:26 - March 24, 2024, call light duration 03:13:46 - March 24, 2024, call light duration 01:02:01 - March 24, 2024, call light duration 00:47:03 - March 24, 2024, call light duration 01:10:21 - March 24, 2024, call light duration 00:47:40 - March 26, 2024, call light duration 01:28:59 The licensee's undated Pendants policy indicated call lights must be answered promptly. All pendent alerts will appear on the iPhone and computer in the nurse's station on the second floor. Personnel must be aware of call lights at all times. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
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 one of two resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the	02360		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32676	A. BUILDING: _____ B. WING _____	C 03/26/2024

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02360	Continued From page 12 maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		