Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL326767303M
Compliance #: HL326767003C

Date Concluded: January 27, 2026

Name, Address, and County of Licensee Investigated:
Crest View Senior Community at Blaine
12016 Ulysses St NE
Blaine, MN 55434
Anoka County

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

Evaluator's Name: Julie Serbus, RN
Special Investigator

Finding: Inconclusive

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 AP, who is an unlicensed caregiver, abused the resident when providing personal cares caused bruising to the top of the resident's hand.

Investigative Findings and Conclusion: The Minnesota Department of Health determined abuse was inconclusive. Although an incident did occur, it could not be determined what took place due to the inconsistencies of the statements provided by the AP and resident. The resident did not require medical attention and returned to baseline.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record(s), facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed type of bed resident used and the location of the bed in her apartment.

The resident resided in an assisted living facility. The resident's diagnoses included Parkinson's Disease, chronic back pain, and anxiety. The resident's service plan included assistance with toileting, dressing, transfer, and bed mobility with assist of one staff. The resident's assessment indicated the resident was alert and oriented and able to give accurate information but not consistently. The resident could communicate needs but was also hard of hearing. The resident's side rail assessment indicated the resident had a hospital bed with bilateral ¼ bedrails she used to during repositioning in bed during cares. The medical record indicated the resident's medication included an anticoagulant (blood thinner) which increased her risk for bruising.

A concern arose during an overnight shift when it was reported that while the AP assisted the resident with bed mobility during incontinence cares the resident asked the AP to stop. Initially, the AP did not stop, and the resident pushed the AP's hand away and then the AP took hold of the resident's hand. The AP discontinued the cares at that point leaving the resident's incontinence pad not completely fastened. Later, a bruise developed on the resident's hand.

The facility task list report and signed tasks list completed record indicated the resident has a history of becoming upset during cares if the resident feels she is being rushed, for resident not to be anxious staff are to approach cares more slowly. This same document indicated resistance to toileting during the overnight. This task lists no specific check and changing time on the overnight shift, does not indicate resident is not gotten up out of bed or walked to the toilet, but that the resident is actually changed in bed, and does not specify number of staff required for the tasks.

The facility's internal investigation indicated there were conflicting narratives of what occurred. The document indicated the resident said the AP rolled her quickly from side-to-side and she asked the AP to stop. However, the AP continued so the resident grabbed and pushed the AP's hand away while the AP grasped the resident's hand while she finished placed the incontinence brief. The resident indicated the AP gave up and left the room.

The same document indicated the AP acknowledged she was having difficulty rolling the resident while changing her. The AP stated she may not have stopped immediately because she was in mid-task, however the resident's voice became very serious, and she seemed upset, so the AP stopped and left the room leaving the incontinence pad partly unfastened. The AP denied a physical struggle occurred or grasping the resident's hands.

During an interview, the AP stated the resident required assistance on the overnight shift with toileting which was completed in bed. AP stated the resident was listed as a one staff assist on the task list report [guide for cares which staff provide]. The AP stated the resident was able to help roll some from side-to-side but not all the way. The AP stated at some point mid-task the resident asked her to stop, and she tried to finish with the incontinence pad but ended up leaving it not completely closed on one side due to the resident's request and left the room. The AP stated when she exited the resident's room the second staff was outside near the room

when AP explained she had a difficult time turning the resident. AP stated task list indicated the resident was a one person assist with night changes, but a two person assist with transfers.

During an interview, an unlicensed caregiver stated the AP did tell her the resident had been combative with changing, so AP had left the room. The caregiver stated she told the AP that next time she went into change resident that they would both go in together. The caregiver stated at the time of the incident the resident was a one person assist for changing, but after that night became two persons assist for bed mobility. The caregiver stated the resident was able to turn to one side better than the other side and uses the side rails on her bed to assist with the turning. The caregiver stated the resident has been known to display behaviors especially with staff with which she is not familiar.

During an interview, a facility nurse stated the resident is heavier cares and requires assistance. The nurse stated at the time of the incident the resident was a one person assist with overnight changes in bed. The nurse stated staff do have difficulty removing the brief from under the resident. The nurse stated staff are provided direction for tasks to be completed by what is located on the Task List Report. The nurse stated since the incident the resident has requested two staff for cares for the resident's comfort. The nurse stated she made this change to the resident service plan and documented a note in the resident's progress notes.

In conclusion, the Minnesota Department of Health determined abuse was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or did not occur.

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;
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; or
(3) use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against

the will of the vulnerable adult or the legal representative of the vulnerable adult unless authorized under applicable licensing requirements or Minnesota Rules, chapter 9544.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: No, attempts to interview were unsuccessful
Alleged Perpetrator interviewed: Yes

Action taken by facility: The facility conducted an internal investigation and updated the service plan to two people for bed mobility. The AP was no longer employed by the facility.

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 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW SENIOR COMMUNITY AT BLAINE	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: #HL326767003C/#HL326767303M On November 19, 2025, 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 94 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL326767003C/#HL326767303M, tag identification 0450.	0 000	Assisted Living Provider 144G. 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.	
0 450 SS=D	144G.41 Subdivision 1 Minimum requirements	0 450		

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0 450	Continued From page 1 All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the utilization of person-centered planning and service delivery process when it did not individualize a care plan for resident (R1) reviewed. Additionally, the licensee failed to delegate health care activities to unlicensed caregivers by a registered nurse as required by the Nurse Practice Act when the interventions lacked specificity to direct the unlicensed caregivers and lacked individualization to identify the resident -specific needs. 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 Nurse Practice Act indicated the definition of	0 450		

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0 450	Continued From page 2 "delegation" means the transfer of authority to another nurse or a competent, unlicensed assistive person to perform a specific nursing task or activity in a specific situation. The National Guidelines for Nursing Delegation, developed by the American Nurses Association (ANA) effective April 29, 2019, indicated the licensed nurse cannot delegate nursing judgement or any activity that will involve nursing judgement or critical decision making to an unlicensed assistive person. Findings included: R1's diagnoses included Parkinson's disease, chronic back pain, and anxiety. R1's Service Plan dated July 18, 2024, indicated a registered nurse completed an assessment to determine the residents needs along with costs of provided services. The Service plan indicated the resident would receive assistance from unlicensed staff to include toileting and transfer assist of one staff, along with an ambulation program that did not specify number of staff required for this task. The service plan did not identify the resident was checked and changed on overnights in her bed nor did it include number of staff required. The service plan only indicated the resident to be toileted every two hours, again number of staff for this task not listed. This same plan indicted the resident was a transfer assist of one person. R1's Vulnerability Assessment/Abuse Prevention Plan dated October 7, 2025, indicated R1 had vulnerabilities and needed interventions for mobility, had limited range in motion in all	0 450		

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0 450	Continued From page 3 extremities and required staff to assist with activities of daily living and transfers, R1 description of vulnerability and why interventions were required were related to limited endurance/strength related to resident diagnosis of Parkinson's. Another vulnerability identified included chronic lower back pain. This nursing assessment did not indicate number of staff required for tasks. R1's tasks list report dated November 19, 2025, indicated resident becomes upset during cares if she feels she is rushed and indicated staff are to take a slower approach. R1 was resistive to toileting during the night and often would only let staff change her once throughout the night shift. A review of the task list, which unlicensed personnel were to refer to for delegation of cares, indicated it did not include when the resident was to be checked-and-changed during the overnights in bed nor the number of staff required for the task. During an interview on November 26, 2025, at 10 a.m., unlicensed personnel (ULP)-D stated she was aware R1 was changed once during the overnight shift. ULP-D stated R1 has a hospital bed that is accessible on both sides. ULP-D stated she uses a draw sheet to turn R1. ULP-D stated she does not turn R1 by holding onto her body but uses a draw sheet placed under the resident to turn her from side to side. ULP-D stated the resident uses the grab bar to assist in turning to her side by turn better to one side better than the other. During an interview on December 1, 2025, at 9:27 a.m., ULP-B stated at the time of the incident on the overnight shift of October 24th into 25, 2025, R1 was listed as a one person assist for	0 450		

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0 450	Continued From page 4 changing. R1 can roll and use her grab bars located on both sides of her bed. Except her right side it is harder to pulls towards the right. ULP-B stated the resident can be resistant during the care if she is not familiar with staff. During an interview on December 1, 2025, at 10:50 a.m., registered nurse (RN)-A stated the nursing assessment drives the service plan. RN-A stated from the service plan the tasks care record is developed which directs services the unlicensed caregivers provide to the resident. RN-A stated whenever the task care record makes a change to a task their system does not place the updated date but defaults it back to the original date of the tasks even though a change was recently updated. RN-A stated since the incident regarding R1 and a ULP was providing assistance with bed mobility, R1's service agreement was updated for R1 to be a 2 person assist per R1's request for comfort. Date of last assessment was November 18, 2025, which indicated 2 staff. RN-A stated at that time the service plan was updated along with documentation in the resident's progress notes. RN-A stated ULP's do not see either of these but provide services off of a four-page task plan. Policies and Procedures titled Contents of Service Plans, dated August 1, 2021, and last revised January 17, 2025, indicated all assisted living residents have an up-to-date service plan identifying services to be provided based on the assessment by the registered nurse and/or other licensed health professional. The service plan will include a description of the services provided, frequency of each service, and resident preferences. Staff providing services will be informed of the current written service plan via a communication method determined by the facility.	0 450		

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0 450	Continued From page 5 TIME PERIODFOR CORRECTION: SEVEN (7) DAYS	0 450		