Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H50181481M
Compliance #: H50181603C

Date Concluded: April 11, 2023

Name, Address, and County of Licensee Investigated:
Crest View Lutheran Home
4444 Reservoir Boulevard NE
Columbia Heights, MN 55421
Anoka County

Facility Type: Nursing Home

Evaluator's Name: Michele R. Larson
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 alleged perpetrator (AP) abused a resident when she yelled and swore at the resident during cares. An unlicensed personnel (ULP) witnessed the AP yelling and swearing at the resident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was not substantiated. Although another ULP witnessed and overheard the AP scream and swear at the resident, the incident was isolated, and no harm occurred to the resident. The resident stated it was the first time the AP yelled and swore at her. The AP's words did not meet the definition of emotional abuse.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator attempted to contact the resident's family member and the AP. The investigation included review of the resident's medical record.

The resident resided in a skilled nursing facility. The resident's diagnoses included chronic obstructive pulmonary disease (COPD), traumatic brain injury (TBI), and anxiety. The resident's care plan included assistance with personal cares, supplemental oxygen, transfers, meals, and medication management. The resident did not walk and required a mechanical lift with the assistance of two staff persons for all transfers. The resident was alert and oriented to person, place, and time.

The resident's incident report indicated one morning a ULP reported to a nurse supervisor she witnessed the AP yelling and swearing at the resident while they were in the resident's room. Leadership immediately walked the AP off the property and placed on suspension pending an investigation. Leadership interviewed the resident, confirmed the story and begun an internal investigation.

The internal investigation conducted the following day and included interviews with the resident and 18 other residents who lived in the same unit. The residents completed a form with written questions. The resident indicated on the form she felt safe at the facility, but the day before she did not feel safe the way the AP spoke to her in a demanding tone and used the "F" word. The resident wrote she had no other concerns.

The resident's progress note indicated a few days after the incident she told the facility social worker she continued to feel safe.

During an interview, the ULP stated the AP appeared stressed the morning of the incident. The ULP stated that morning the resident pressed her call light several times and screamed for staff to get her up. The ULP stated when she and the AP entered the resident's room the AP yelled at the resident stating, "You fucking bitch. Fucking, shut up. We will get to you when we can. We have all these other people to get up." The ULP stated the resident was shaking and in tears. The ULP stated she got the AP to leave the resident's room. Upon returning to the resident's room, the ULP stated the resident appeared frightened. The ULP stated it took the resident a few minutes to realize she was not going to hurt the resident. The ULP stated after the AP yelled at the resident the AP went into another resident's room and proceeded to yell and swear at that resident.

During an interview, the facility nurse stated the resident told her the AP never yelled at her before the incident. The nurse stated the resident was alert and oriented and would have said something if she was not being treated well.

The resident's family member failed to return the investigator's phone calls.

The investigator attempted multiple times to reach the AP, but the AP failed to respond to the investigator's phone calls or subpoena.

The resident died one week after the investigator initiated the investigation.

In conclusion, the Minnesota Department of Health determined abuse 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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means:
(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:
(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.

Vulnerable Adult interviewed: No. The resident died one week after the investigation was initiated.
Family/Responsible Party interviewed: No.
Alleged Perpetrator interviewed: No. Multiple attempts were made to reach the AP by phone and the AP did not respond to the subpoena.

Action taken by facility:
The AP is no longer employed by the facility.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a complaint survey under federal regulations, and substantiated facility 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. You may also call 651-201-4200 to receive a copy via mail or email.

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

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
	00005	A. BUILDING: _____ B. WING _____	C 03/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW LUTHERAN HOME	4444 RESERVOIR BOULEVARD NORTHEAST COLUMBIA HEIGHTS, MN 55421

(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
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint #H50181481M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. No correction orders are issued.	2 000		

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2 000	Continued From page 1 The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	2 000		