Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL218718825M
Compliance #: HL218716422C

Date Concluded: March 22, 2024

Name, Address, and County of Licensee Investigated:
Crest View on 42nd
600 42nd Avenue NE
Columbia Heights, MN, 55421
Anoka County

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

Evaluator's Name: Angela Vatalaro, 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 the resident when they failed to provide the resident supervision when the resident eloped from the facility by breaking and climbing out a window in the resident's room.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Facility staff could not anticipate the resident breaking and climbing out the window in her room. Staff immediately responded to the resident and with the assistance of law enforcement stayed with the resident until emergency medical services arrived.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's case worker. The investigation included review of the resident records, hospital records, facility internal

investigation, facility incident reports, and the law enforcement report. Also, the investigator observed the locked memory care unit and locked fenced courtyard area.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and anxiety disorder. The resident's service plan included assistance with medication management services. The resident's assessment indicated the resident was oriented to person, place, required redirection and reminders often, and walked independently without assisted devices.

The facility's investigation indicated earlier in the day, the resident was agitated and tried to "escape" out of a patio area. Facility staff provided the resident as needed medication for agitation and brought the resident to her room to calm. Approximately one hour later, the resident broke the window in her room and climbed out. Staff immediately called 911, followed the resident, and controlled traffic as the resident crossed a busy street. Staff stayed with the resident until law enforcement arrived.

The law enforcement report indicated law enforcement arrived at a gas station shortly after the facility called and found the resident surrounded by facility staff members. The resident had a laceration (cut) on her right wrist and small cuts on her left arm and wrist. The resident denied living at the facility and said she did know why facility staff were following her. The resident was transported to a hospital for an evaluation. In the resident's room, it appeared the resident used a stand to a lamp and broke her ground level window.

The resident's hospital record indicated the resident arrived at the hospital agitated and confused. The resident was evaluated by physiatry and admitted to a locked unit and placed on a 72-hour hold. The resident had superficial scratches to her right hand and left arm. The resident had a laceration on her right forearm that was closed with stiches. Seven days later, the resident discharged to another inpatient unit at a different hospital.

During an interview, unlicensed personnel (ULP) stated the day of the incident, the staff member who was working in memory care came out yelling, "help, help, I need help." The resident had just broken the window in her room, climbed out, and was running across the street. The ULP stated staff contacted 911 for assistance. The ULP and kitchen staff ran outside and controlled traffic as the resident crossed a busy street. The ULP stated at a gas station, staff stayed with the resident until law enforcement arrived.

During investigative interviews, multiple nurses stated staff were trained and provided interventions for the resident's known agitation and exit seeking behaviors. The resident had no previous incidents of breaking a window to leave. Staff interventions for agitation included redirection and distraction. At times, staff were directed to bring the resident to her room to calm. One nurse stated the resident's as needed medication for agitation increased during her stay.

During an interview, leadership stated earlier in the shift the resident was agitated and wanted to leave. Staff distracted her, shut memory care window blinds, and had the resident sit in her room attempting to calm her. While in her room, the resident broke the window and climbed out. Leadership stated the memory care staff heard the noise of the window breaking and called another staff member not in memory care for help. Facility staff members rushed outside to assist the resident. The resident had a history of agitation however, the resident had no previous attempts of breaking a window to leave the facility. Leadership stated staff interventions for the resident's agitation included distraction and at times various facility staff members provided one-on-one to calm her. These interventions had previously been effective. Leadership stated throughout the resident's stay at the facility, they also increased doses of the resident's as needed medication for agitation. The resident did not return to the facility after the incident.

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 reach and due to cognition.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
The facility staff provided medication and interventions for the resident's agitation. While the resident crossed the street, staff controlled the traffic, called 911, and stayed with the resident until law enforcement arrived.

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
	21871	A. BUILDING: _____ B. WING _____	C 02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREST VIEW ON 42ND	900 42ND AVENUE NE 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
0 000	Initial Comments On February 7, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL218714531C/#HL218717708M, #HL218716422C/HL218718825M, #HL218716844C/HL218719165M. No correction orders are issued.	0 000		