Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL218719165M
Compliance #: HL218716844C

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: 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 alleged perpetrator (AP), a staff member, abused the resident when the AP shook the resident by her shoulders and scolded her after the resident was found soiled with urine.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined abuse was inconclusive. Due to conflicting information provided, it could not be determined whether the alleged incident did or did not occur. The AP denied the allegation and there were no witnesses or camera footage of the alleged incident. In addition, there was no evidence of bruising and changes in the resident's mood or behavior.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records, facility internal investigation, and personnel files. Also, the investigator observed the resident and staff interactions with the resident.

The resident resided in an assisted living memory care unit. The resident's diagnoses included dementia and anxiety. The resident's service plan indicated the resident required assistance with toileting three times daily, was incontinent of urine, and oriented to person and place.

The facility investigation indicated when interviewed, the resident stated the AP came into her room and found the resident sitting on the couch, urine soaked. The AP was upset with the resident, shook the resident back and forth by her shoulders, and scolded the resident for being soiled. The AP did not change the resident's incontinent brief. When facility staff interviewed the AP, the AP said when she went into the resident's room, the resident was soiled. The AP said the resident was shaking because the resident was scared. The AP changed the resident's incontinent brief and placed a pad on the resident's couch. The AP denied being aggressive.

During an interview, unlicensed personnel (ULP) stated the resident told the ULP that she was scared. The ULP stated the resident told her the AP shook her because the resident was incontinent of urine on the couch. The ULP stated the resident said the AP grabbed the resident by her shoulders, shook her, and told the resident "We don't do that shit here." The ULP stated the resident demonstrated how the AP grabbed her on both sides of her upper shoulders. When the ULP checked the resident's skin, there were no marks or bruising on either shoulder. The ULP reported the alleged incident to leadership. The ULP stated after leadership spoke to the resident, the resident appeared "very calm" because the resident was told the AP was not coming back to work with her. The ULP stated, during the timeframe of the alleged incident the resident's dementia had progressed with more incontinent episodes. The ULP stated whenever the resident was incontinent, the resident would come out of her room crying, requiring staff reassurance.

During an interview, a nurse stated after the alleged incident, the resident was checked for injury. The resident did not have any injury or bruising. The nurse stated the resident appeared "ok" afterwards because she knew the AP was not coming back to work with her.

During an interview, leadership stated the facility investigated the incident. The staff member who worked after the AP's shift said when she checked on the resident, her incontinent brief was dry and there were no changes in the resident's behavior. Leadership stated there was no witnesses or camera footage of the alleged incident. Leadership stated the resident appeared visibly upset and fearful when staff spoke with her. Leadership stated the AP denied the allegation, denied yelling at the resident, and stated she changed the resident's incontinent brief. Leadership stated the AP had vulnerable adult training, abuse prevention, and training on resident care.

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;
(3) the solicitation, inducement, and promotion of prostitution as defined in section 609.322; and
(4) criminal sexual conduct in the first through fifth degrees as defined in sections 609.342 to 609.3451.
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;

Vulnerable Adult interviewed: No. Declined an interview.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: No. Did not respond to subpoena.

Action taken by facility:
The facility conducted an internal investigation. The AP was no longer employed by the facility.

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		