Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL326769962M
Compliance #: HL326769902C

Date Concluded: June 24, 2025

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

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

Evaluator's Name: Lori Pokela R.N.
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 the resident was hospitalized twice after ingesting hand sanitizer.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. When facility staff observed the resident pumping the hand sanitizer into his hands then bringing his hand to his mouth, the resident was assessed, monitored, and treated. Facility staff facilitated meetings with the resident's family, medical provider(s) and the resident to develop and implement interventions for alcohol abuse.

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), hospital records, internal investigation documentation, incident reports, personnel files, staff

schedules, and related facility policy and procedures. Also, the investigator observed the facility environment and staff interaction with the residents.

The resident resided in an assisted living facility. The resident's diagnoses included cerebellar stroke syndrome (a group of neurological deficits resulting from impaired blood flow to the cerebellum, a region of the brain responsible for coordination and balance), major depressive disorder and alcohol abuse. The resident's service plan included assistance with medication management. The resident's assessment indicated the resident had a history of alcohol abuse that involved ingesting rubbing alcohol, the resident was alert and orient to person, place, and time. The resident's assessment indicated the resident was independent with all activities of daily living, including mobility, but received staff assistance with medication management and encouragement to attend facility activities.

The resident's medical records indicated the resident received outpatient counseling services for mental health concerns. The medical records indicated the resident's family reported hand sanitizer was found in the resident's room, inside snack boxes. Facility staff investigated the incidents, discussed the risks of ingesting hand sanitizer, and encouraged the resident to wash his hands with soap and water to reduce the temptation of ingestion.

The resident's medical records indicated the resident was observed by staff after pumping hand sanitizer in his hands and bringing his hands up to his mouth. Although the resident did not always admit to ingesting the hand sanitizer, facility staff investigated each incident, monitored the resident and reported the incidents to the resident's family and provider.

The facility implemented services for medication management to ensure the resident was taking his prescribed Antabuse medication (medication that would produce a sensitivity to alcohol causing symptoms such as: nausea, vomiting, dizziness, weakness and confusion). Following implementation of medication management services, the resident reported on two different occasions that he ingested hand sanitizer, felt nauseous, was vomiting and unsteady. Staff assessed the resident, reported the incidents to family and the medical provider, then transported the resident to the hospital for evaluation.

During the second hospitalization, the resident refused in-patient treatment and returned to the facility. The facility decreased access to hand sanitizer by keeping hand sanitizers only with facility staff, and facilitated meetings with the resident, family, and medical providers to schedule a psychiatric evaluation and an outpatient treatment program.

During an interview, a facility administrative nurse stated video footage was reviewed during facility investigations. The facility administrative nurse stated the video locations made it difficult to view if the resident pumped the hand sanitizer in his hands and it could not be determined if, after the resident brought his hands to his face, if he was smelling or ingesting it.

During an interview, a floor nurse recalled staff reporting the hand sanitizer missing off of a medication cart that was located in the same room the resident had been sitting. The floor nurse then interviewed the resident, who denied taking the hand sanitizer at first, but gave permission for the floor nurse to look in his room for the bottle. A bottle of sanitizer was found in the resident's closet. The resident then admitted to taking the hand sanitizer bottle and apologized. The floor nurse stated she updated the resident's provider regarding the incident.

During an interview, a facility administrative staff stated the resident like to walk around the facility independently where he had access to various hand sanitizers throughout the building. Facility administrative staff stated the resident, the resident's family, and the medical provider were agreeable to a plan that included the resident to be transported directly to a hospital inpatient treatment program if other incidents occurred.

During an interview, the resident's family member stated the resident's alcohol abuse had gone on for decades and was the reason for the resident's admission to the facility. The family member stated they completed audits of the resident's room and found hand sanitizer bottles in various places then removed them and reported the findings to facility staff. The family member stated they were grateful for the collaboration with the facility to assist the resident with the alcohol abuse concerns.

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, per family request.
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility assessed and monitored the resident after each incident, completed facility internal investigations of the incidents, reported the incidents to family and the resident's provider and implemented interventions to prevent further occurrance.

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
	32676	A. BUILDING: _____ B. WING _____	C 05/06/2025

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 On May 6, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL326769902C/#HL326769962M. No correction orders are issued.	0 000		