Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306992548M
Compliance #: HL306994442C

Date Concluded: November 22, 2022

Name, Address, and County of Licensee Investigated:
Crystal Seasons Living Center ALC LLC
222 South Murphy Street
Lake Crystal, MN 56055
Blue Earth County

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

Evaluator's Name: Erin Johnson-Crosby, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Visit:
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 assisted living administrative designee/alleged perpetrator (AP) had knowledge the resident was out of medication and failed to report this concern to the nurse. This resulted in the resident missing several doses of antidepressant medications which led to hospitalization and admission to a crisis center.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility systemically failed to ensure medications were available and administered in accordance with physician orders. Several staff were aware the medication was unavailable; however, no follow-up was conducted on the availability of the medications and there was no evidence of attempts made to inform the nurse of the situation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of resident's records and

employee files. In addition, observations were made of the facility's medication administration process.

The resident resided in an assisted living facility. The resident's diagnoses included anxiety, depression, and sleep apnea. The resident's initial assessment indicated the resident had a history of anxiety, depression, and suicidal ideations. The resident also required staff assistance for medication management and administration.

The resident was sent from the facility to the emergency room (ER) twice during a 48-hour period. Initially, the resident was evaluated in the emergency room (ER) and sent back to the facility on every two-hour safety checks due to suicidal ideation. The following day, staff observed the resident crying, distraught and making statements of self-harm. The resident was transferred to the ER and later admitted to a crisis center.

Following admission to the crisis center, it was discovered the resident had not received his antidepressant medication for several days.

When facility administrative staff became aware the resident was not receiving medications as ordered, they reported the incident and began an internal investigation.

The internal investigation identified several of the resident's medications including Venlafaxine and Mirtazapine (antidepressants) were not administered, due to the medications being out-of-stock at the facility.

Review of the resident's medication administration record (MAR), indicated in the month of his hospitalization and admission to the crisis center, he missed the following medications:
- 20 doses of Prazosin (antihypertensive)
- 18 doses of Tamsulosin (urinary retention)
- 13 doses of Venlafaxine (antidepressant)

The resident's MAR that same month, indicated Mirtazapine (antidepressant) was signed out as administered. However, the facility internal investigation identified the medication was unavailable for 14 days and the resident missed several doses of the medication.

The internal investigation identified a medication omission occurred that could have contributed to the resident's hospitalization. The internal investigation revealed staff members had reported the medications being out-of-stock to a previous administrative delegee, but she did not follow up or report these concerns to the nurse.

Facility documentation, resident records and staff interviews indicated several staff documented the medications as unavailable, but no follow up was completed, no report was made to the nurse and there was no documentation of attempts to obtain the medication. In addition, the pharmacy was not contacted, no attempts were made to re-order the medication

and there was no procedure in place to audit medication availability. The missed doses of each medication were also not reported or documented as medication errors as indicated by the facility's policy.

During an interview, the previous administrative delegee stated she was not aware the resident was out of medications and if a resident was out of medications, staff should have contacted the nurse.

During an interview, a facility registered nurse (RN) confirmed the resident missed several doses of antidepressant medication. The RN indicated that not receiving this medication could have contributed to the resident's hospitalization and admission to the crisis center.

During an interview, the resident indicated his medications are helpful to him but when staff did not provide him with his medication, he became more anxious and depressed and was admitted to a crisis center.

During an interview, the resident's medical doctor (MD) stated missing Venlafaxine for more than two days in a row could cause a person to feel unwell. The MD stated missing both antidepressants (Mirtazapine and Venlafaxine) could increase depression symptoms and may have contributed to the resident's need for hospitalization.

As a result of this investigation, neglect is substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

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: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility completed medication audits and provided education and re-training to staff.

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
Blue Earth County Attorney
Lake Crystal City Attorney
Lake Crystal Police Department
Dr. Lindy Eatwell

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30699	A. BUILDING: _____ B. WING _____	C 10/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL SEASONS LIVING CENTER	222 SOUTH MURPHY STREET LAKE CRYSTAL, MN 56055

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING 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: #HL306994442C/#HL306992548M On October 13, 2022 , 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 39 residents receiving services under Assisted Living with Dementia Care license. The following correction order is issued/orders are issued for #HL306994442C/#HL306992548M, tag identification 1760, 2360.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Licensing 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.	

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01760	Continued From page 1	01760		
01760 SS=G	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were administered as prescribed for four of four residents (R1, R2, R3, R4) reviewed for omitted medications. This had the potential for harm when the licensee did not administer R1's ordered mirtazapine and venlafaxine (antidepressants) as ordered. R1 was hospitalized and admitted to a crisis center. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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).	01760		

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01760	Continued From page 2 Findings include: R1 A Minnesota Abuse Adult Reporting Center (MAARC) report dated June 29, 2022, indicated the resident was admitted to the emergency room with thoughts of self harm. The licensee identified R1 did not receive mirtazapine from June 16, 2022, through June 29, 2022. R1 also did not receive venlafaxine starting on June 24, 2022 through June 29, 2022. The report indicated a facility staff member was aware R1 was out of ordered medications but did not inform the nurse. The report indicated staff education was being completed regarding alerting a nurse of no supply of medication or low supply and auditing of the medication cart weekly to check medication supply. The licensee's internal investigation indicated mirtazapine was documented as administered, however upon review with the crisis center, medications cart audit and the pharmacy it was identified mirtazapine had not been administered as ordered. The investigation indicated multiple staff informed the previous assisted living designee of the medications being unavailable but she did not contact the nurse to report the missing medication. R1's service plan, dated July 1, 2022, indicated R1 received assistance with behavior support. R1 had a history of anxiety, depression and suicidal ideations. R1 also required medication administration. R1's June 2022, medication administration record (MAR) indicated the following medications were not administered:	01760		

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01760	Continued From page 3 -Prazosin (antihypertensives) 1 milligram (mg) at bed time 20 out of 28 times -Tamsulosin (urinary retention) 0.4 mg daily 18 out of 28 times -Venlafaxine (antidepressant) 150 mg daily 5 out of 28 times -Venlafaxine (antidepressant) 75 mg daily 8 out of 28 times. R1's Mirtazapine (antidepressant) was signed out on the medication administration record (MAR) as administered, but was not administered from June 16, 2022, until June 29, 2022. The resident missed 14 doses of Mirtazapine. R1's progress notes dated June 28, 2022, indicated R1 complained of left arm pain, dizziness, chest pain and demanded to go to the emergency room (ER). Facility staff had R1 transferred to the ER and when R1 returned to the licensee later that evening, R1 was placed on every 2 hour safety checks due to suicidal thoughts. R1's progress notes on June 29, 2022, indicated R1 was crying, distraught and stated that he wanted to kill himself. R1 was sent to the ER and then transferred to a crisis center. The progress note indicated the licensed practical nurse (LPN) became aware the following medications were missed Prazosin, Tamsulosin, Venlafaxine, and Cerovite after R1 reported to the crisis center he had not received his medications. R1's progress notes on July 2, 2022, indicated R1 returned to the facility following discharge from the crisis center with no changes made to his medication orders. On October 13, 2022, at 10:55 a.m., R1 stated he	01760		

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01760	Continued From page 4 did not receive his medications for multiple days which caused him to be more depressed and anxious and he had to go to the hospital then to a crisis center. On October 21, 2022, at 12:25 p.m., licensed practical nurse (LPN)-D stated she did not check the medication administration log for omitted medications and was not sure if the new LPN was checking for that either. LPN-D also stated frequently there was not a nurse in the building and the assisted living designee (ALD) would have to take phone calls and refer to the appropriate person to pass along the information. On October 21, 2022 at 3:00 p.m., unlicensed personnel (ULP)-B stated she was aware R1 was out of medications and indicated the nurse would also be able to see on the electronic medical record if a medication was not administered. ULP-B stated she was put in charge of auditing the medication cart after the errors occurred with R1. ULP-B stated she recently received training to review resident MAR's to ensure all medications were available as ordered. ULP-B stated if a medication was not administered as ordered one day it would not be considered a medication error. ULP-B was not sure what system was in place to monitor or audit resident MARs or how medication errors were reported, documented or reviewed. On October 25, 2022, at 3:00 p.m., registered nurse (RN)-C verified R1 missed several doses of medication, including antidepressants during the month of June and indicated this may have contributed to his admission to the ER and crisis center. On October 27, 2022, at 8:40 a.m., a medical	01760		

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01760	Continued From page 5 doctor (MD)-H stated R1 missing Effexor (venlafaxine) for more than two days could cause a person to feel unwell. MD-H stated missing both antidepressant medications [Effexor and Mirtazapine] could increase depression symptoms and could have contributed to the resident's need for emergency room visits and admission to the crisis center. R2 R2's face sheet indicated current diagnoses including a history of polio and dermatitis. R2's service plan dated January 4, 2022, indicated R2 received assistance with transferring, toileting, wound care and medication administration. R2's October MAR indicated the following medications were not administered: - Nystatin (antifungal) 100,000 unit/G cream apply and rub in a thin film to affected area twice daily -October 12 and 14, 2022 - Furosemide (diuretic) 40 mg 1 tab by mouth twice daily. -October 13, 2022 No medication error reports were completed regarding R2's omitted medications. R3 R3's service plan dated May 17, 2021, indicated R3 was receiving hospice services and required assistance with medication administration and ambulation. R3's October MAR indicated the following medications were not administered as ordered: -Haloperidol lactate (antipsychotic) 2 mg/ml take	01760		

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01760	Continued From page 6 0.5 ml by mouth daily -October 10, 2022 - M-PAP (pain medication)160 mg/5 mg solution taken 30 ML by mouth three times day -October 18, 2022. No medication error reports were completed regarding R3's omitted medications. R4 R4's service plan dated August 9, 2022, indicated diagnoses including anxiety, depression, multiple sclerosis, and memory loss. The service plan indicated R4 required assistance with morning and evening cares, toileting, turning and repositioning, and medication administration. R4's October 2022 MAR indicated the following medications were not administered as ordered: -Modafanil (stimulant used to treat sleep disorders) 100 mg po BID was not administered 24 out of 38 times. No medication error reports were completed regarding R4's omitted medications. On October 25, 2022, at 3:00 p.m., registered nurse (RN)-C verified R1, R2, R3 and R4 all missed medications and medication error reports were not completed. RN-C stated all medications should be administered as ordered by the physician. RN-C further indicated if a medication was not available, or a resident missed a medication, a medication error report should be completed and the pharmacy should be contacted to re-order the medications so resident's do not miss medications due to the medication being unavailable.	01760		

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01760	Continued From page 7 The licensee's Medication Error Report Policy dated November 2019, indicated when a medication error occurs, the person that found the medication error will contact the nurse and follow nurse direction in documentation of the error and ensure the medication error report is provided to the nurse for review. The licensee's undated Unlicensed Personnel Medication Administration Policy indicated staff would document all medications given or refused on the resident's MAR. Immediately upon recognition of issues with administration of medications, documentation or storage of medications unlicensed staff should contact the nurse and complete a medication report. Resident family and physician should be notified of the error if necessary. Time period for correction: Seven (7) days.	01760		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred,	02360		

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02360	Continued From page 8 and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		