MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
Crystal Care Center
3245 Vera Cruz Avenue North
Crystal, MN 55422
Hennepin County

Report #: H5289042

Date: November 8, 2013

Date of Visit: September 24, 2013
Time of Visit: 8:15 a.m. – 3:30 p.m.

By: Lindsey Krueger, R.N., Special Investigator

Type of Facility: ☒ Nursing Home ☐ HHA ☐ Home Care Provider/Assisted Living
☐ SLF ☐ ICF/IID ☐ Home Care
☐ Hospital ☐ Other: _____

☒ Facility Self Report ☐ Complaint

Allegation(s): **It is alleged** that neglect occurred when a resident consumed other resident's food in the dining room and choked.

An unannounced visit was made at this facility and an investigation was conducted under:

☐ Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
☑ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
☐ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
☐ Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
☐ Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
☐ Federal Regulations for EMTALA (42 CFR Part 489)
☐ State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)
☑ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
☐ State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
☐ State Licensing Rules for Home Care (MN Rules Chapter 4668)

☐ State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
☑ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
☑ State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☐ Abuse ☑ Neglect ☐ Financial Exploitation was:

◉ Substantiated ○ Not Substantiated ○ Inconclusive based on the following information:

Based on a preponderance of evidence, the allegation of neglect is substantiated. The facility was aware that the resident had behaviors of eating food off of other resident's plates prior to his/her choking. The facility failed to provide appropriate supervision for this resident knowing that s/he was sitting next to another resident with a different textured diet.

The resident resided at the facility for 24 hour nursing care related to cognition impairment. S/he had an order for a mechanical soft textured diet, which includes all meat being ground. The resident did have previous known behaviors of eating, or attempting to eat, inedible objects. When interviewed, eight staff, including the unit manager, stated that they were aware the resident had the additional behavior of eating, or attempting to eat, food off of other resident's trays in the dining room. The facility did have care plan interventions in place for the resident's behaviors of eating inedible objects, but no interventions were in place directing staff what to do to keep the resident safe when s/he displayed the behavior of eating other resident's food.

Set-up in the dining room at the facility consisted of square tables with a possibility of four resident's sitting around the table. The residents are not arranged by diet and it is very possible for them to be sitting next to someone with a different diet order. On the day of the incident the resident was in the dining room sitting at his/her normal seating arrangement. After the meal had been served the resident was noticed to be choking by a family member present in same area of the dining room. This family member alerted the facility nurse who immediately started the Heimlich maneuver on the resident. Two nurses were unable to dislodge the food from the resident, emergency personnel were called and s/he was transported to the emergency room. The resident had emergent surgery and a serving size piece of chicken was removed from his/her throat. The resident returned to the facility the next day.

It was found, through interviews, that the resident was served his/her correct diet texture for lunch, but that the resident took a piece of chicken off of another resident's plate which was a regular textured diet, who was sitting right next to him/her, and attempted to eat the chicken. When interviewing staff working on the resident's unit the day of the incident, all four staff stated that they were sitting, or were in other areas, and were unable to see the resident while s/he was eating lunch.

Interview with the unit manager revealed that staff should have been sitting in a place where they could see the resident, that way they would be able to watch what s/he was eating and make sure s/he did not attempt to eat another resident's food.

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ individual(s) and/or ☒ facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

Even though the facility was aware the resident takes food from other resident's plates, the resident was not provided adequate supervision during meal times. The facility failed to minimize the resident's risk of choking during meals.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) – Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: ☒ Yes ☐ No If no, specify: _____

(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) – Compliance Not Met
The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: _____

(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557). No state licensing orders were issued.

State Statutes Chapters 144 & 144A – Compliance Met

The facility was found to be in compliance with State Statutes for Chapters 144 & 144A. No state licensing orders were issued.

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

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

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect
"Neglect" means:

(a) 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.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

☒ Medical Records	☒ Care Guide
☐ Medication Administration Records	☒ Treatment Sheets
☒ Facility Incident Reports	☒ Physician Progress Notes
☐ ADL (Activities of Daily Living) Flow Sheets	☐ Laboratory and X-ray Reports
☒ Physician Orders	☒ Social Service Notes

☒ Nurses Notes ☐ Meal Intake Records

☐ Activities Reports ☐ Weight Records

☐ Therapy and/or Ancillary Services Records ☒ Assessments

☐ Skin Assessments ☒ Care Plan Records

Other pertinent medical records:

☒ Hospital Records ☐ Ambulance/Paramedics ☐ Medical Examiner Records ☐ Death Certificate

☐ Police Report

Additional facility records:

☒ Resident/Family Council Minutes ☐ Personnel Records/Background Check, etc.

☒ Staff Time Sheets, Schedules, etc. ☒ Facility In-service Records

☒ Facility Internal Investigation Reports ☒ Facility Policies and Procedures

☐ Call Light Audits ☐ Other, specify: _____

Number of additional resident(s) reviewed: 2

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

◉ Yes ○ No ○ N/A Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s): ○ Yes ○ No ◉ N/A Specify: Facility self report

If unable to contact complainant, attempts were made on:
Date/time: _____ Date/time: _____ Date/time: _____

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation: ○ Yes ◉ No ○ N/A Specify: Impaired cognition

Did you interview additional residents: ◉ Yes ○ No

Total number of resident interviews: 3

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: 11

Physician interviewed: ○ Yes ◉ No

Nurse Practitioner interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: _____

Attempts to contact: Date/time: _____ Date/time: _____ Date/time: _____

If unable to contact was subpoena issued: ○ Yes , date subpoena was issued _____ ○ No

Were contacts made with any of the following:
☐ Emergency personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☐ Wound Care	☐ Medication Pass	☒ Meals
☐ Personal Care	☐ Dignity/Privacy Issues	☐ Restorative Care
☐ Nursing Services	☒ Safety Issues	☒ Facility Tour
☐ Infection Control	☒ Cleanliness	☐ Injury
☐ Use of Equipment	☐ Transfers	☐ Incontinence
☐ Call Light	☐ Other: _____	

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A

Were photographs taken: ○ Yes ◉ No Specify: _____

xc: Division of Compliance Monitoring - Licensing & Certification
Minnesota Board of Examiners for Nursing Home Administrators
Crystal City Police Department
Hennepin County Attorney
Crystal City Attorney

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. BUILDING _____ B. WING _____	C 10/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL CARE CENTER	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

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F 000	INITIAL COMMENTS An abbreviated standard survey was conducted to investigate complaint #H5289042. The following deficiency is issued.	F 000	Crystal Care Center Plan of Correction is a written credible allegation of substantial compliance with the Federal and State requirements for nursing facilities and/ or skilled nursing facility participating in the Federal Medicare or State Medical Assistance programs. Please note that nothing set forth in this document is to be or should be construed to be an admission by Crystal Care Center, of validity or accuracy of any of the deficiencies cited by the Minnesota Department of Health relative to the survey, certification and enforcement effort at issue. Further, please note that any and all other communication in writing or otherwise by or on behalf of Crystal Care Center are and shall be construed to be without prejudice to the right, remedies, claims, defenses of Crystal Care Center, at law and/ or equity, all of which are not waived and all of which are reserved and retained by, for and on behalf of Crystal Care Center.	11/22/2013
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to provide adequate supervision to prevent a choking episode for one of one resident's (R1) reviewed. As a result R1 took food off another resident's plate and ingested it. R1 choked on the food requiring emergent surgery to remove. Findings include: Review of R1's medical record indicates R1 was admitted to the facility on August 2, 2013 with a diagnosis of Alzheimer's dementia with behavioral disturbances. Progress note written August 2, 2013 at 8:29 p.m. states that R1 eats independently while using her hands during meals and that R1's husband indicated that finger foods might be the best fit. Progress note dated August 5, 2013 at 3:06 p.m. indicates R1's diet would be switched that same day to mechanical	F 323	See next pg. for start of F323	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ben Mirenda | TITLE: Executive Director | (X8) DATE: 11/14/2013

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 soft diet while R1 is waiting for new upper dentures to be made. R1's Individual Resident Care Plan dated August 5, 2013 indicates R1 is at risk for choking related to ingestion of medicine cups, gloves, and papers. Goal is to prevent choking episodes or injury relating to choking with specific interventions included for staff to remove or keep gloves, medicine cups, papers in safe place where R1 cannot reach. Staff are to monitor the resident and check anything in her mouth. R1's Individual Resident Care Plan dated August 14, 2013 indicates R1 needs assist with tray set-up and limited assistance with meals. Staff are to observe for changes in chewing, swallowing, and eating ability. Progress note dated September 7, 2013 at 1:06 p.m. written by Licensed Practical Nurse (LPN)-L indicated that a family member present in the dining room noticed R1 to be choking at 12:05 p.m. and alerted facility staff. Note indicates that R1 was yelling for help while holding her neck and left side. Resident appeared to be having a difficult time breathing. Heimlich maneuver was performed multiple times with only a small piece of chicken brought up. When checked, R1's oxygen saturations were 37%, oxygen was applied. R1 was transported to the hospital by emergency medical services. Hospital records dated September 7, 2013 indicate that R1 needed to have emergency surgery to remove a large (serving size) piece of chicken that had been placed in R1's mouth and swallowed. The piece of chicken was "too big to go down and got stuck." R1 was transported	F 323	Crystal Care Center will continue to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Incident involving R1 was reported to ED and MDH. An Incident Report and investigation was completed. The resident's care plans were revised to indicate the need for supervision. On 9/9/13 **"ONE STAFF MEMBER AT ALL TIMES WHEN EATING"** was on the NAR Assignment Sheet. Care plan goal to keep R1 provided with a safe environment, with interventions of: • Place settings removed after residents are done with their meal. • Escort R1 back to her room to rest when she is done eating. • 1:1 staff observation with R1 in the dining room. The Nurse Manager met with staff on 9/9/13 and again on 9/12/13 to instruct them regarding R1 supervision needs. R1 had a Speech Evaluation done on 9/10/13 with treatment until 9/20/13. She was placed on Nutritional Risk and reviewed on 9/9/13 by the Nutritional Risk IDT and by the Quality of Life Rounds on 9/9/13.	11/22/2013

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F 323	Continued From page 2 back to the facility on September 8, 2013. Facility schedule dated September 7, 2013 indicates that three nursing assistants were scheduled for the 7:00 a.m. - 3:30 p.m. shift along with one LPN for R1's unit. Interview with nursing assistant (NA)-C on September 24, 2013 at 2:10 p.m. revealed that she was working on September 7, 2013 during the day shift and did not witness R1 choking as NA-C was sitting in a different area of the dining room and was not facing R1. NA-C indicated that s/he observed that R1 did get a mechanical soft diet during lunch. NA-C stated that s/he was aware that R1 would pick food off of other residents' trays and eat it and would take R1 out of the dining room if s/he noticed this behavior. Interview with NA-B on September 24, 2013 at 3:00 p.m. indicated that s/he was working on September 7, 2013 during the day shift but was not sitting in the same section as R1 during lunch, and did not observe R1 eat another resident's piece of chicken. NA-B stated s/he was aware that R1 would attempt to eat other residents' food and if s/he noticed this behavior would attempt to remove R1 from the dining room. Interview with NA-M on October 9, 2013 at 1:57 p.m. revealed that s/he was working on September 7, 2013 during the day shift and was unable to see R1 during lunch as s/he was sitting on the other side of the dining room. NA-M indicated that s/he observed that R1's food was untouched and assumed she picked a piece of chicken off of her neighbor's plate. NA-M stated that s/he was aware from others that R1 would pick food off of other residents' trays but did not	F 323	Nurse Manager spoke with R1's spouse to inform him of her plan of care. He expressed understanding and agreement. R1's dentures have been replaced. Residents with the potential to be affected by the same deficient practice were determined to be those residents on diets with altered consistencies. A nutritional assessment and an oral assessment were done upon admission and quarterly and as needed. No other residents were identified to be affected by the same deficient practice. To assure that the deficient practice will not reoccur, all nursing and dietary employees will attend a mandatory in service on 11/20/13 on Altered Diet Consistencies and the Signs and Symptoms of Choking, given by All employees complete the CCC Choking Procedure and Staff Responsibilities training upon hire. Facility will repeat the training annually.	11/22/2013

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F 323	Continued From page 3 state any specific intervention that would be done when this behavior was observed. Interview with LPN-L on October 10, 2013 at 9:45 a.m. revealed that s/he was working on September 7, 2013 during the day shift and was not present in the dining room at the time R1 began choking. LPN-L was notified of R1 choking by another resident's family member who was coming down the hall to find him/her. LPN-L stated that s/he immediately had R1 sit down in the hall by the nurses station and attempted the Heimlich maneuver. LPN-L asked an aide to run and call registered nurse (RN)-D/Supervisor. LPN-L stated that LPN-A also attempted the Heimlich maneuver on R1 after s/he was unsuccessful. R1 was "gasping for air", oxygen was checked and was "very low, 30 something." 911 was called and oxygen was administered via nasal cannula (liter flow unknown). LPN-L stated that s/he was aware that R1 would pick food off of other resident's trays but did not state any interventions that were to be done if this behavior was observed. LPN-L stated that it is facility policy to have at least one staff, either a nurse or aid in the dining room area while the residents' are eating. LPN-L stated that because the three aids were in the dining room s/he went to another resident's room in an attempt to get them to join the other residents for lunch, thus why s/he was not present when the choking began. Interview with LPN-A on September 24, 2013 at 3:20 p.m. revealed that s/he was working on a different unit on the same floor as R1's unit. LPN-A stated that s/he was made aware of R1 choking when an aide from R1's unit came running to get him/her. LPN-A stated s/he ran down to the unit's nurses station where R1 was	F 323	Residents on altered consistency diets will be reviewed weekly at the IDT meetings to ensure that none of them experience difficulty with swallowing. Results will be reported to QA monthly for three months. Random audits for Dining Room Observation will be done weekly by the Nurse Managers at all three meals with reports given to the DON. The DON will report the results of the audits to QA for three months to make certain that the corrective action is achieved and sustained. Corrective action will be completed by 11/22/13.	11/22/2013

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F 323	Continued From page 4 and observed LPN-L to be attempting the Heimlich maneuver on R1. LPN-A stated that R1 was "gurgling" and s/he attempted the Heimlich maneuver on R1 but was unable to get anything up. LPN-A stated that at that time RN-D came to the floor, 911 was called, and RN-D checked R1's oxygen level . Oxygen was applied at that time via nasal cannula (liter flow unknown), paramedics arrived right afterwards and R1 was taken to the emergency room. LPN-A stated that s/he was not familiar with R1 as s/he does not normally work on her unit. Interview with RN-D on September 24, 2013 at 2:00 p.m. revealed that s/he was aware of R1 choking when they received a phone call from a nursing assistant on the floor where R1 was. RN-D stated s/he went up to the unit and and observed the Heimlich maneuver being attempted on R1. RN-D stated that R1 did respond to her name and was gasping for air and 911 was called. R1's oxygen level was checked, it was noted to be 37%, oxygen via nasal cannula (liter flow unknown) was applied and R1's oxygen level came up to 100%. RN-D stated that after oxygen had been applied the paramedics arrived at the facility and transported R1 to the emergency room. RN-D stated that s/he was aware of R1 picking food off of other residents' trays previous to this incident and did notify staff on the unit of these behaviors. RN-D stated that if these behaviors were observed from R1 that s/he would attempt to remove R1 from the dining room. Interview with LPN-I/Nurse Manager on October 15, 2013 at 2:50 p.m. revealed that they, along with staff on the unit, were aware that R1 would pick food off of other resident's trays in the dining	F 323		

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F 323	Continued From page 5 room and attempt to eat the food. LPN-I stated that staff needed to monitor R1 during meals along with being aware of what she was eating, watching what she was eating, and to make sure R1 did not "get into anyone's food." LPN-I stated s/he was unsure if anyone was watching R1 during the lunch meal. LPN-I confirmed that there was no care plan interventions in place prior to R1 choking for R1's behavior of picking food off other residents' trays and attempting to eat it. R1's Individual Care Plan did not indicate that R1 was at risk for choking due to the known behavior of picking food off of other resident's trays and attempting to eat the food. R1's Care Plan did not direct staff to be present and watching R1 during meals, which could have prevented the behaviors that led to R1's choking.	F 323		

Minnesota Department of Health

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	00255	A. BUILDING: _____ B. WING _____	C 10/24/2013

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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: A complaint investigation was initiated to investigate case #H5289042. The following correction order is issued.	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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	Continued From page 1	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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/RULES.	
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00255	A. BUILDING: _____ B. WING _____	C 10/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL CARE CENTER	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

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2 830	Continued From page 2 This MN Requirement is not met as evidenced by: Based on record review and interviews the facility failed to provide adequate supervision in addition to developing a comprehensive care plan to prevent a choking episode for one of one resident's (R1) reviewed. As a result R1 took food off another resident's plate and ingested it. R1 choked on the food requiring emergent surgery to remove. Findings include: Review of R1's medical record indicates R1 was admitted to the facility on August 2, 2013 with a diagnosis of Alzheimer's dementia with behavioral disturbances. Progress note written August 2, 2013 at 8:29 p.m. states that R1 eats independently while using her hands during meals and that R1's husband indicated that finger foods might be the best fit. Progress note dated August 5, 2013 at 3:06 p.m. indicates R1's diet would be switched that same day to mechanical soft diet while R1 is waiting for new upper dentures to be made. R1's Individual Resident Care Plan dated August 5, 2013 indicates R1 is at risk for choking related to ingestion of medicine cups, gloves, and papers. Goal is to prevent choking episodes or injury relating to choking with specific interventions included for staff to remove or keep gloves, medicine cups, papers in safe place where R1 cannot reach. Staff are to monitor the resident and check anything in her mouth.	2 830		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 830	Continued From page 3 R1's Individual Resident Care Plan dated August 14, 2013 indicates R1 needs assist with tray set-up and limited assistance with meals. Staff are to observe for changes in chewing, swallowing, and eating ability. Progress note dated September 7, 2013 at 1:06 p.m. written by Licensed Practical Nurse (LPN)-L indicated that a family member present in the dining room noticed R1 to be choking at 12:05 p.m. and alerted facility staff. Note indicates that R1 was yelling for help while holding her neck and left side. Resident appeared to be having a difficult time breathing. Heimlich maneuver was performed multiple times with only a small piece of chicken brought up. When checked, R1's oxygen saturations were 37%, oxygen was applied. R1 was transported to the hospital by emergency medical services. Hospital records dated September 7, 2013 indicate that R1 needed to have emergency surgery to remove a large (serving size) piece of chicken that had been placed in R1's mouth and swallowed. The piece of chicken was "too big to go down and got stuck." R1 was transported back to the facility on September 8, 2013. Facility schedule dated September 7, 2013 indicates that three nursing assistants were scheduled for the 7:00 a.m. - 3:30 p.m. shift along with one LPN for R1's unit. Interview with nursing assistant (NA)-C on September 24, 2013 at 2:10 p.m. revealed that she was working on September 7, 2013 during the day shift and did not witness R1 choking as NA-C was sitting in a different area of the dining room and was not facing R1. NA-C indicated that s/he observed that R1 did get a mechanical soft	2 830		

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2 830	Continued From page 4 diet during lunch. NA-C stated that s/he was aware that R1 would pick food off of other residents' trays and eat it and would take R1 out of the dining room if s/he noticed this behavior. Interview with NA-B on September 24, 2013 at 3:00 p.m. indicated that s/he was working on September 7, 2013 during the day shift but was not sitting in the same section as R1 during lunch, and did not observe R1 eat another resident's piece of chicken. NA-B stated s/he was aware that R1 would attempt to eat other residents' food and if s/he noticed this behavior would attempt to remove R1 from the dining room. Interview with NA-M on October 9, 2013 at 1:57 p.m. revealed that s/he was working on September 7, 2013 during the day shift and was unable to see R1 during lunch as s/he was sitting on the other side of the dining room. NA-M indicated that s/he observed that R1's food was untouched and assumed she picked a piece of chicken off of her neighbor's plate. NA-M stated that s/he was aware from others that R1 would pick food off of other residents' trays but did not state any specific intervention that would be done when this behavior was observed. Interview with LPN-L on October 10, 2013 at 9:45 a.m. revealed that s/he was working on September 7, 2013 during the day shift and was not present in the dining room at the time R1 began choking. LPN-L was notified of R1 choking by another resident's family member who was coming down the hall to find him/her. LPN-L stated that s/he immediately had R1 sit down in the hall by the nurses station and attempted the Heimlich maneuver. LPN-L asked an aide to run and call registered nurse (RN)-D/Supervisor. LPN-L stated that LPN-A also attempted the	2 830		

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2 830	Continued From page 5 Heimlich maneuver on R1 after s/he was unsuccessful. R1 was "gasping for air", oxygen was checked and was "very low, 30 something." 911 was called and oxygen was administered via nasal cannula (liter flow unknown). LPN-L stated that s/he was aware that R1 would pick food off of other resident's trays but did not state any interventions that were to be done if this behavior was observed. LPN-L stated that it is facility policy to have at least one staff, either a nurse or aid in the dining room area while the residents' are eating. LPN-L stated that because the three aids were in the dining room s/he went to another resident's room in an attempt to get them to join the other residents for lunch, thus why s/he was not present when the choking began. Interview with LPN-A on September 24, 2013 at 3:20 p.m. revealed that s/he was working on a different unit on the same floor as R1's unit. LPN-A stated that s/he was made aware of R1 choking when an aide from R1's unit came running to get him/her. LPN-A stated s/he ran down to the unit's nurses station where R1 was and observed LPN-L to be attempting the Heimlich maneuver on R1. LPN-A stated that R1 was "gurgling" and s/he attempted the Heimlich maneuver on R1 but was unable to get anything up. LPN-A stated that at that time RN-D came to the floor, 911 was called, and RN-D checked R1's oxygen level . Oxygen was applied at that time via nasal cannula (liter flow unknown), paramedics arrived right afterwards and R1 was taken to the emergency room. LPN-A stated that s/he was not familiar with R1 as s/he does not normally work on her unit. Interview with RN-D on September 24, 2013 at 2:00 p.m. revealed that s/he was aware of R1 choking when they received a phone call from an	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 6 aid on the floor where R1 was. RN-D stated s/he went up to the unit and and observed the Heimlich maneuver being attempted on R1. RN-D stated that R1 did respond to her name and was gasping for air and 911 was called. R1's oxygen level was checked, it was noted to be 37%, oxygen via nasal cannula (liter flow unknown) was applied and R1's oxygen level came up to 100%. RN-D stated that after oxygen had been applied the paramedics arrived at the facility and transported R1 to the emergency room. RN-D stated that s/he was aware of R1 picking food off of other residents' trays previous to this incident and did notify staff on the unit of these behaviors. RN-D stated that if these behaviors were observed from R1 that s/he would attempt to remove R1 from the dining room. Interview with LPN-I/Nurse Manager on October 15, 2013 at 2:50 p.m. revealed that they, along with staff on the unit, were aware that R1 would pick food off of other resident's trays in the dining room and attempt to eat the food. LPN-I stated that staff needed to monitor R1 during meals along with being aware of what she was eating, watching what she was eating, and to make sure R1 did not "get into anyone's food." LPN-I stated s/he was unsure if anyone was watching R1 during the lunch meal. LPN-I confirmed that there was no care plan interventions in place prior to R1 choking for R1's behavior of picking food off other residents' trays and attempting to eat it. R1's Individual Care Plan did not indicate that R1 was at risk for choking due to the known behavior of picking food off of other resident's trays and attempting to eat the food. R1's Care Plan did not direct staff to be present and watching R1 during meals, which could have prevented the behaviors that led to R1's choking.	2 830		

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2 830	Continued From page 7 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and re-educate staff on policies to ensure that all residents are assessed and provided necessary care and services related to resident behaviors and to ensure that care plans are developed comprehensively. The director of nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Thirty (30) Days	2 830		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Post Correction Order Follow-Up/Federal Certification Review Report
PUBLIC DATA

Facility:
Crystal Care Center
3245 Vera Cruz Avenue North
Crystal, MN 55422
Hennepin County

Report #: H5289042

Date: December 4, 2013

Date of Visit: December 3, 2013
Time of Visit: 9:30 a.m.

By: Stephanie Richard, R.N.
Special Investigator

Nature of Visit
An unannounced visit was made in order to follow-up one federal deficiency and one state licensing order which were issued on October 29, 2013, as the result of an investigation which had been completed on October 24, 2013.

The status of the order is as follow:
1 MN Rule 4658.0520 Subp. 1 - Corrected

See Attached 2567B for status of federal deficiency.

xc: Minnesota Department of Health -Licensing & Certification Division

OHFC

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245289	A. Building B. Wing	12/3/2013

Name of Facility	Street Address, City, State, Zip Code
CRYSTAL CARE CENTER	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0323 Reg. # 483.25(h) LSC	12/03/2013	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/KL	12/24/2013	31242	12/03/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/24/2013				

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245289	A. Building B. Wing	12/6/2013

Name of Facility	Street Address, City, State, Zip Code
CRYSTAL CARE CENTER	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

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(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0164 Reg. # 483.10(e), 483.75(l)(4) LSC	Correction Completed 11/29/2013	ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4) LSC	Correction Completed 11/29/2013	ID Prefix F0226 Reg. # 483.13(c) LSC	Correction Completed 11/29/2013
ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 11/29/2013	ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 11/29/2013	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 11/29/2013
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/KL	12/06/2013	18623	12/06/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/25/2013			

OHFC
AH Form Approved
12/24/2013

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00255	A. Building B. Wing	12/3/2013

Name of Facility	Street Address, City, State, Zip Code
CRYSTAL CARE CENTER	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

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(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix 20830 Reg. # MN Rule 4658.0520 Subp. 1 LSC	Correction Completed 12/03/2013	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/KL	12/24/2013	31242	12/03/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 10/24/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO