Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306992520M
Compliance #: HL306991612C

Date Concluded: August 8, 2024

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

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Erin Johnson-Crosby, 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 staff failed to notice a change in condition and delayed medical treatment requiring hospitalization.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Facility unlicensed staff recognized when the resident had a significant change in condition and the resident was sent to the emergency room for further evaluation.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident record(s), hospital records, ambulance records, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures Also, the investigator observed staff and resident interactions.

The resident resided in an assisted living facility. The resident's diagnoses included chronic kidney disease, bladder spasms and re-current urinary tract infections. The resident's service plan included assistance with morning and evening cares, bathing, transferring, medication administration, toileting, and catheter care. The resident's assessment indicated the resident was orientated to person, place, and time, but would be forgetful and confused at times.

The resident's medical record indicated the resident was seen in urgent care for a urinary tract infection (UTI) and started on an antibiotic. The note indicated the resident should have good hydration and directed to follow up with the provider if the condition was not improving in two days.

Three days after the urgent care visit, unlicensed staff contacted the on-call nurse and informed her the resident was agitated during lunch and when staff attempted to administer medications later that day, the resident was lying in a chair with his eyes closed, mumbling, and was not making sense. Staff were worried about transferring the resident because they did not think the resident was able to stand. The on-call nurse told staff to call 911 for lift assistance if needed and to monitor the resident throughout the night and update her as needed.

Two hours later, staff called the on-call nurse again to inform her that the resident had not ate or drank all day and they were concerned because the resident had a history of going septic (system blood infection) with UTIs. The on-call nurse reviewed the resident's records and the resident was transferred to the hospital for further evaluation.

Hospital records indicated the resident had a significant urological history and had been hospitalized for repeatedly for urinary tract infections. The resident was admitted to the hospital for urosepsis (systemic infection that begins in the urinary tract). The resident was treated with intravenous (IV) antibiotics, spent seven nights in the hospital and returned to the facility.

During an interview, unlicensed personnel (ULP) said when they went to administer the resident's medications the resident was mumbling, was not making sense, and could not keep his eyes open which was not normal for the resident. About two hours later, the ULP called another staff member for further direction as she did not agree with the on-call nurses' direction to monitor the resident.

During an interview, another ULP stated she received a phone call from staff working at the facility after they did not agree with the on-call nurse instructions to monitor the resident. The ULP told the staff member to call the on-call nurse back and have the nurse read the resident's chart.

During an interview, the on-call nurse stated she had never worked at the facility and was not familiar with the resident's baseline condition. The on-call nurse stated she should have initially reviewed the resident's chart more thoroughly and should have contacted the resident's family

and when she was contacted a second time by staff and read the resident's chart, she sent the resident to the hospital for further evaluation.

During an interview, the resident said he had been to the hospital so many times for urinary tract infections that he did not remember this specific 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: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
No action taken.

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

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 05/22/2024

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

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0 000	Initial Comments ******ATTENTION****** HOME CARE PROVIDER/ASSISTED LIVING PROVIDER 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: #HL306991612C/#HL306992520M On May 22, 2024, 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 36 residents receiving services under the provider's Assisted Living license. The following correction order is issued/orders are issued for #HL306991612C/#HL306992520M, tag identification 1760, 2320.	0 000		
01760 SS=D	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	01760		

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01760	Continued From page 1 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 interview and record review, the licensee failed to ensure medications were administered as prescribed for one of one resident (R1). The licensee also failed to follow-up on medication administration practices when R1's medication was out of stock for nine days. R1 had increased pain during the time the medication was unavailable. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause 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). The findings include: R1's diagnoses included chronic kidney disease, heart failure, bladder spasms, and chronic urinary tract infections. R1's undated, unsigned, service plan indicated	01760		

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01760	Continued From page 2 R1 required assistance with morning and evening cares, bathing, behavior support, reassurance checks, transferring with one assist, wound care, toileting, and medication administration. R1's change in condition assessment dated February 15, 2024, indicated R1 had intermittent bladder spasms, causing moderate to severe pain and required medications for relief. The assessment noted the licensee managed R1's medications and coordinated refills. The facility nurse or on-call nurse would communicate with the ordering provider. The assessment indicated R1 was alert and oriented, but forgetful at times. R1's progress notes dated February 16, 2024, indicated the resident returned to the licensee after a skilled nursing facility stay. The note identified the resident continued to have chronic urinary tract infections (UTI). R1 was seen in the emergency department last week for another UTI and was currently on an antibiotic. R1's Medication Administration Record (MAR) dated February 2024, indicated R1 did not receive Myrbetriq (urinary antispasmodic for bladder spasms) 8 milligram (mg)/ milliliter (ml) from February 20, 2024, through February 29, 2024. The medication notes indicated Myrbetriq was not received from the pharmacy. R1 received Hycosamine 0.125 mg for bladder spasms on February 20, the medication note indicated the medication was somewhat effective. On February 29, 2024, Hycosamine 0.125 mg was administered and was somewhat effective. R1's MAR indicated on February 25, 2024, indicated R1 received tramadol 50 mg for pain. The medication note indicated R1 had severe pain and the tramadol was somewhat effective.	01760		

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01760	Continued From page 3 On February 27, 2024, R1 received Tramadol 50 mg for pain 7/10 and was effective and on February 29, 2024, R1 had severe pain was somewhat effective. A medication error report was requested but not provided. R1's progress notes dated February 23, 2024, indicated R1 was out of Myrbetriq and could not be sent until March 1, 2024. The resident record did not include a pain assessment or notification to R1, R1's family member, or R1's primary provider regarding the medication being out of stock. On May 22, 2024, at 12:45 p.m., R1 stated there were times the licensee ran out of his medications. R1 stated he used to count his pills to make sure he recieved all of his pills but it was too difficult to do that anymore. R1 stated when he does not receive the medications for bladder spasms he has a lot more pain. On May 22, 2024, at 1:10 p.m., unlicensed personnel (ULP)-A stated she could not remember if she notified R1's ordering provider regarding R1's Myrbetriq medication supply being out. ULP-A stated it should have been documented if she did contact R1's ordering provider. ULP-A stated at times the licensee runs out of medications usually due to insurance issues. On May 22, 2024, at 4:15 p.m., registered nurse (RN)-D stated if medications were unavailable and not administered it would be a medication error and a report should have been completed. RN-D stated some staff do not always do that. RN-D stated if a medication were not available,	01760		

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01760	Continued From page 4 the ordering provider should have been notified. On June 6, 2024, at 1:30 p.m., R1's family member (FM) stated she was not aware R1 had ever ran out of medications and would have made sure R1 received the ordered medications if she had been notified. The licensee's Medication Error Report policy, dated November 2019, indicated the licensee should document, track, and resolve medication administration errors for quality improvement and to follow proper procedures. When the medication error is found licensed nurse will instruct the staff person on what to do next. The licensed nurse will contact the prescribers and explain the medication error. The staff person involved will complete a medication error report and the report will be sent to risk management to facility nurse for further follow up. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by:	02320		

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02320	Continued From page 5 Based on interview and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards when the on-call licensed practical nurse (LPN) failed to initially respond to unlicensed personnel's (ULP) report of a change in condition and failed to contact the facility registered nurse (RN) for one of one resident (R1) reviewed. ULP had to contact the LPN a second time in order fro the LPN to respond to R1's change in condition. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause 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). The findings include: R1's diagnoses included chronic kidney disease, chronic urinary tract infections (UTI) and heart failure. R1's undated, unsigned, service plan indicated R1 required assistance with morning and evening cares, bathing, behavior support, reassurance checks, medication administration, transferring with one assist, wound care, toileting, and emptying catheter bag three times a day and change to overnight bag at night. The service plan indicated for staff to report any concerns of blood in urine/bag and any concerns with pain during cares including abdominal drainage. The service plan did not include what staff should monitor for regarding UTI or sepsis.	02320		

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02320	Continued From page 6 R1's change in condition assessment dated February 15, 2024, indicated R1 had intermittent bladder spasms, causing moderate to severe pain and required medications for relief. The assessment noted the licensee managed R1's medications. The assessment indicated R1 was alert and oriented, but forgetful at times. R1's progress notes dated February 16, 2024, indicated the resident returned to the licensee after a skilled nursing stay. The note indicated R1 had a UTI. R1 was seen in the emergency department last week for another UTI and was currently on an antibiotic. R1's record did not include monitoring for signs and symptoms of a UTI or when staff should contact the registered nurse (RN). R1's progress notes dated February 26, 2024, written by unlicensed personnel (ULP) indicated R1 complained of pain but was not able to identify where the pain was, had outbursts of yelling, and had dark/bloody urine. R1 agreed to be seen in urgent care. The record did not indicate a RN had been notified of the ULP's concerns prior to R1 being sent to urgent care. R1's progress note dated February 26, 2024, at 5:40 p.m., written by RN-D indicated R1 was seen in urgent care for a UTI and started on an antibiotic. The note indicated R1 should have good hydration and follow up in two days if not better. R1's record on February 27, 2024, and February 28, 2024, did not include follow up, monitoring, or interventions to ensure R1 was improving.	02320		

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02320	Continued From page 7 R1's progress note dated February 29, 2024, at 5:33 p.m., written by a licensed practical nurse (LPN) indicated unlicensed staff called and stated R1 currently had a UTI, was disruptive during lunch and when staff went to administer medications, R1 was lying in the chair with his eyes closed mumbling and not making sense. The staff were worried about transferring R1, "due to the state that he is in, safe in w/c (wheelchair) for now, staff feel as though resident would not be able to use easy stand." The LPN educated staff to call 911 for a lift assist if needed. The note also indicated R1 did not come to dinner and staff were going to monitor through the night and update the LPN as needed. The progress note did not indicate an assessment or notification to a RN was completed. R1's progress notes dated February 29, 2024, at 7:33 p.m., indicated that the LPN received a call from staff that R1 had not eaten all day, had not taking in much fluid, and had a history of going septic. The note indicated to have R1 come back to the hospital if not getting better. The LPN called R1's guardian for approval to send R1 to the hospital via ambulance. The ambulance run report dated February 29, 2024, dispatched at 7:43 p.m., indicated they were paged for a unresponsive male with a UTI that may have turned septic. When the emergency medical technicians (EMT) arrived R1 would not respond but would moan. The unlicensed staff informed the EMT R1 had "been like this all day," the EMT verified that R1 had been like this all day. The unlicensed staff told the EMT R1 received a pain medication at 1:30 p.m., The unlicensed staff informed the EMT, R1 usually transferred with a sit to stand (mechanical lift) but would not be able to do that.	02320		

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02320	Continued From page 8 Police records indicated on February 29, 2024, at 7:43 p.m., police were dispatched for a non-responsive and possible septic resident. The healthcare worker revealed R1 had been in the current medical state "all day." R1 struggled to open his eyes, had not eaten or drank anything all day. R1 could not stand on his own and was not able to speak to the police or ambulance which was no normal behavior for R1. The record indicated five people assisted R1 to the ambulance cot and previous occasions R1 had been able to assist with transferring to the cot. The record indicated R1 had a full catheter bag and staff did not know when it was emptied last. The record indicated when R1 "goes into Sepsis, it happens fast." The body worn camera was powered off during this incident. R1's emergency department and hospital notes dated February 29, 2024, at 9:04 p.m., indicated R1 was seen for a decreased level of consciousness and alteration in mentation all day and almost no intake with previous UTI's. R1 had a significant urological history with a contracted bladder requiring a Foley catheter. On arrival R1's temperature was 101.3, pulse 105, and blood pressure of 105/50 (vital signs may be consistent with sepsis). R1 was admitted with urosepsis. R1 received intravenous antibiotics and spent seven nights in the hospital. During an interview with unlicensed personnel (ULP)-A on May 30, 2024, at 2:20 p.m., ULP-A indicated on February 29, 2024, another ULP called her after they did not agree with the on call nurse. ULP-A told the other ULP that R1 needed to be seen and to call the LPN back for further instruction. ULP-A did not call the RN and did not talk to the on call LPN.	02320		

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02320	Continued From page 9 On May 22, 2024, at 1:45 p.m., LPN-B stated she was the nurse on call on February 29, 2024. LPN-B stated she had never been to the facility and was not familiar with the residents at the licensee. LPN-B read off an Assisted Living On-Call policy on when she was required to contact a RN which included missing narcotics, transfer to emergency department (ED) or return from ED, and suspected maltreatment. LPN-B stated there were two RNs she could contact with questions but at times the RNs would not answer the phone. LPN-B stated she did not know why she didn't contact the RN on February 29, 2024, regarding R1's change in condition. On May 22, 2024, at 2:25 p.m., ULP-C stated she came into work on February 29, 2024, at 2:00 p.m., ULP-C stated she noticed R1 was not propelling his wheelchair around the room or digging through drawers which was R1's normal. ULP-C stated around 5:00 p.m., she administered R1's medication and R1 wasn't responding or making sense. ULP-C stated he woke up enough to take medications but couldn't not keep his eyes open which was not normal for him. ULP-C stated she called the on call nurse and the on call nurse told her to monitor R1. ULP-C stated she called another staff member for direction since she did not agree with the on calls nurse direction. ULP-C did not know how long she waited to call another staff member for direction. ULP-C did not remember if the day staff communicated concerns regarding R1 that day. ULP-C stated she called the on call nurse back and told her to read the nurses notes. ULP-C stated the ambulance arrived and transported R1 to the hospital. ULP-C did not recall saying R1 had been this way all day.	02320		

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02320	Continued From page 10 On May 22, 2024, at 4:15 p.m., registered nurse (RN)-D stated she checked on R1 February 27 or February 28, 2024, and seemed a bit confused, but at times R1's cognition changed. RN-D verified there was no documentation she checked on R1. RN-D told staff to monitor him. RN-D stated the on call LPN did not contact her on February 29, 2024. RN-D stated if there was a change in condition the LPN should have contacted the facility RN for further guidance. RN-D stated if the nurse on call would have read the progress notes it would have warranted follow up. RN-D stated the on call nurse should check the resident assessment for baseline information. On June 6, 2024, at 1:30 p.m., family member (FM)-E stated R1 had multiple urinary tract infections (UTI) and would need to be hospitalized for sepsis. FM-E stated the facility would call for her permission to send R1 to the hospital. FM-E stated they should not be calling me and should call 911. FM-E did not recall the incident that occurred February 29, 2024. The licensee's Assisted Living On-Call Nurse policy: LPN call revised May 2, 2024, indicated the staff were aware there is an on call RN available for back up/consultation to the LPN 24/7. LPN's are able to take call and aware that an RN is available 24 hours a day 7 days a week. LPN's will contact the RN in real time for situations including: narcotic diversion, falls with head injury, falls with significant injury, uncontrolled bleeding, CPR initiation, transfer to ED, Return from ED or hospitalization and need for additional services, and suspected abuse and maltreatment. The policy indicated if there is a change in condition the RN would be notified immediately for consultation and further review.	02320		

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 05/22/2024

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

(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
02320	Continued From page 11 A change in condition policy was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		