Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H15192521M
Compliance #: H15195564C

Date Concluded: April 29, 2024

Name, Address, and County of Licensee Investigated:
Mayo Clinic Hospice
906 College Way
Redwing, MN 55066
Goodhue County

Facility Type: Hospice

Evaluator's Name:
Jana Wegener, RN, Special Investigator

Finding: Substantiated, individual responsibility

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 resident was neglected when the alleged perpetrator (AP) failed to provide timely care, monitoring, and safe medication administration services for the resident during a diabetic emergency and administered Morphine to the resident in error. The resident died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The AP was responsible for maltreatment. The AP failed to provide interventions when the resident was having a seizure and had a critically low blood sugar of 29. In addition, the AP administered 5 times the resident's prescribed dose of morphine in error. The resident died.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family member. The investigation included review of the resident record(s), death record, hospice records, facility internal investigation, hospice investigation summary, facility incident reports, personnel

files, law enforcement report, related policy and procedures, and previous federal investigation documentation.

The resident resided in an assisted living facility with diagnoses including severe protein-calorie malnutrition, adult failure to thrive, Diabetes Mellitus Type 2, and hypoglycemia.

The resident's admission assessment and service plan indicated the resident was oriented, made her own decisions, was easily understood, and able to make her needs known. The assessment indicated the resident had no history of seizures.

The resident's facility medication orders included glucose oral tablet chewable 4 gram with instructions to give 4 tablets every hour as needed for low blood sugar, and glucagon emergency injection kit 1 mg with orders to inject as needed for hypoglycemia.

The resident's hospice plan of care and medication list included orders for the oral glucose chewable tablet but did not include orders for the resident's glucagon emergency injection for low blood glucose.

The resident's facility progress notes indicated the morning of the incident the resident had shortness of breath and anxiousness, and the facility unlicensed personnel (ULP) were instructed by hospice to administer ½ a tablet of morphine. The resident went back to bed and did not eat breakfast. The note indicated the resident had low blood sugar of 105, and staff were instructed to hold the resident's insulin. The progress notes indicated the resident's family arrived to take the resident out of the facility. Family reported the resident began having a seizure in the car and brought the resident back to the facility around 12:00 p.m. A ULP checked the resident's blood sugar when she arrived back at the facility and reported to hospice the residents blood sugar was 29.

A facility investigation indicated the resident did not eat breakfast and had low blood sugar prior to leaving the facility. The investigation indicated camera footage reviewed by the facility showed the resident was alert, interacting, and smiling at other residents as she left the facility. The investigation indicated the resident's family reported the resident began having seizure activity in the car and notified the facility they were bringing the resident back. The facility investigation included staff interviews which identified the resident was unconscious, unable to hold up her head, and having seizures when the family returned to the facility with the resident. The facility investigation indicated the AP gave a verbal order for ULP staff to administer 4 tablets of Ativan for seizure activity X2. The ULP dispensed the medication, and handed the crushed tablets to the AP who administered it to the resident. The AP requested the second dose of Ativan and again the ULP dispensed the medication, and handed the crushed tablets to the AP who administered it. When the ULP returned to the medication cart she identified she had crushed and given the AP Morphine in error instead of Ativan as ordered, and immediately reported the medication error to the AP.

The resident's hospice orders, and visit notes the morning of the incident indicated ULP staff reported to the AP the resident had low blood sugar. A hospice visit note indicated the AP arrived at the facility at 12:30 p.m. and rechecked the resident's blood sugar, which was 24. The AP documented a facility ULP crushed glucose tablets and mixed them with orange juice and attempted to give them to the resident, however, the resident was unconscious with ridged body, clenched teeth, non-reactive pupils, and involuntary rapid eye movement consistent with seizure activity. The documentation indicated the AP reported the resident's condition to the provider who gave orders for Ativan 2 mg every 5 minutes, X2 for seizure activity. The AP administered the first dose of Ativan at 1:00 p.m. and the second dose at 1:15 p.m. The documentation indicated the ULP reported crushing morphine instead of Ativan in error. At 1:22 p.m. the AP updated the provider of the medication error, and received another order to give the second dose of Ativan, which was given at 1:30 p.m. The documentation indicated there was resolution of seizure activity noted. The AP documented the resident's respiratory rate at that time was 26, with no additional monitoring of the resident's respiratory rate/effort documented following the morphine medication error. At 1:29 p.m. the AP documented the resident's blood sugar was 27. At 2:02 p.m. the resident's blood sugar was 24. At 2:22 p.m. the resident was given one dose of glucagon by facility staff. At 2:35 p.m. the resident's blood sugar was 37. At 3:09 p.m. the resident's blood sugar was 52, with no additional blood sugar monitoring or interventions for the resident's low blood sugar documented.

The resident's hospice record indicated the AP failed to provide ongoing monitoring or interventions for the resident's low blood sugar levels, or respiratory effort/rate following a significant medication error. The AP's documentation lacked indication the family was offered and declined emergency medical services to treat the residents low blood glucose, seizure, and morphine error/overdose.

The hospice investigation indicated although the resident's seizure activity was treated, they identified concerns with management of the resident's low blood glucose. The investigation indicated the AP was coached that she should not administer medications that she did not personally prepare and could not verify.

The resident's record of death indicated the resident died the day of the incident of natural causes, with other significant conditions contributing to the resident's death including Diabetes Mellitus.

When interviewed the ULP stated when the AP asked her to get the Ativan for the resident, she had no physical order to complete the required checks for safe medication administration. The ULP stated the resident was unresponsive and unable to swallow the crushed glucose tablets effectively. The ULP stated the AP instructed her to stop trying to administer the glucose tablets because it was not safe for the resident due to decreased consciousness and seizure activity. The ULP stated the AP gave no other instructions for interventions to address the resident's low blood sugar.

When interviewed the AP stated she was not aware the facility had orders for the resident to receive injectable glucagon until about two and a half hours after staff reported the resident's blood sugar was in the 20's. The AP stated no additional monitoring of the resident's blood sugar was completed after the resident's last recorded blood sugar reading of 52, and indicated no other interventions were provided to the resident despite ongoing low blood sugar levels. The AP stated she communicated the resident's condition and low blood sugar readings to the provider who provided no additional orders for the resident's low blood sugar or the morphine overdose. The AP stated she administered crushed medications dispensed by the ULP from her verbal order. The AP stated there was no way to verify what the medication was the ULP provided that she administered. The AP stated she should have requested the ULP dispense the medication under her supervision to ensure it was accurate prior to administering it.

When interviewed hospice leadership stated the AP should have implemented interventions as a standard of care including increased frequency/ongoing blood sugar monitoring, and respiratory rate/effort monitoring after the morphine error. Leadership staff stated the AP should have provided ongoing interventions to raise the resident's blood sugar and documented the resident's response. Leadership staff stated the AP would not have needed an order to implement those interventions and indicated the record lacked indication they were provided to the resident. Leadership staff stated the resident record failed to indicate the family was offered and declined interventions for the resident's low blood sugar or morphine overdose. Leadership staff stated although the resident's verbal order was given for Ativan in an emergency situation the AP should not have administered medication's she could not verify.

When interviewed the resident's family member stated the resident's low blood sugar was not addressed timely.

In conclusion, the Minnesota Department of Health determined neglect was 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: No, deceased.

Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The hospice agency implemented protocols and education for monitoring/management of hypoglycemia rescue medications and interventions for opioid overdose following the incident. The AP is no longer employed by the hospice agency.

Action taken by the Minnesota Department of Health:
MDH previously investigated the issue during a complaint survey under federal regulations, and substantiated 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. You may also call 651-201-4200 to receive a copy via mail or email.

The purpose of this investigation was to determine any individual responsibility for alleged maltreatment under Minn. Stat. 626.557, the Maltreatment of Vulnerable Adults Act.

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.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Goodhue County Attorney
Redwing City Attorney
Redwing Police Department
Minnesota Board of Nursing

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/26/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mayo Clinic Hospice	**200 FIRST STREET SOUTHWEST , ROCHESTER, Minnesota, 55905**

(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) COMPLETION DATE
40000	Initial Comments Tag numbers have been assigned to Minnesota state Statutes for Hospice Providers. 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 Minnesota Department of Health is documenting the State Licensing Correction Orders using federal "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 surveyors' 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 Minnesota Department of Health investigated an allegation of maltreatment, complaint H15192521M in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557.	40000		
41405	HOSPICE BILL OF RIGHTS CFR(s): 144A.751 Subdivision 1 (2) (2) receive care and services according to a suitable hospice plan of care and subject to accepted hospice care standards and to take an active part in creating and changing the plan and evaluating care and services; This LICENSURE REQUIREMENT is NOT MET as evidenced by: The facility failed to ensure one of one client reviewed (C1) was free from maltreatment. The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in	41405		

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

Minnesota State Department of Health

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41405	Continued from page 1 connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	41405		