DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL306996808M
Compliance #: HL306992862C

Date Concluded: November 16, 2023

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

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: **Not Substantiated**

Nature of the 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 alleged perpetrator (AP) neglected a resident by administering two doses of hydromorphone at the same time prior to the resident's death.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. While the resident was actively dying a medication error did occur, however there is a lack of evidence the medication error changed the course of her dying process.

The investigator conducted interviews with administrative staff. The investigator contacted the resident's family member and hospice nurse. The investigation included review of resident's records, the AP's personnel record, facility's policies and procedures, incident reports. The investigation included an onsite visit, observations, and interactions between residents and facility staff.

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The resident resided in an assisted living facility unit. The resident’s diagnoses included heart and renal failure. The resident’s service plan included assistance with medication administration. The resident admitted to the facility from the hospital approximately ten days before her passing. The resident’s medical record indicated the plan was for the resident to stay there with hospice support until the end of her life.

On the day of the incident the resident’s medical record and the facility’s internal investigation indicated the resident was actively declining in her dying process. A family member requested medication on behalf of the resident. The resident’s medication included lorazepam (anti-anxiety) and hydromorphone (a narcotic pain medication), however the AP administered two doses of hydromorphone. The resident died just after administration of the medication.

According to the medical records, the resident's orders were as follows:

> Lorazepam 0.5 milligrams (mg) (0.25 milliliters (ml)) every four hours as needed for anxiety.
> Hydromorphone 1 mg (0.25 ml) every four hours as scheduled, and every two hours as needed for pain and dyspnea.

According to the medication administration record (MAR) the following medications were administered the morning of the incident:

> The AP administered lorazepam 0.5 mg (0.25 ml) and hydromorphone 1 mg (0.25 ml) at 8:36 a.m.
> The AP administered hydromorphone 1 mg (0.25 ml) at 10:48 a.m.
> The AP administered lorazepam 0.5 mg (0.25 ml) and hydromorphone 1 mg (0.25 ml) at 11:39 a.m.

Following the medication administration at 11:39 a.m., the resident was confirmed deceased by the attending hospice nurse at 11:40 a.m.

The next day the error was discovered during a narcotic count conducted by the staff members when a discrepancy was identified between the narcotic book and the remaining syringes in the facility. Specifically, there was a shortage of one syringe of hydromorphone and an extra of one syringe of lorazepam.

The facility’s internal investigation included a written statement by the AP which indicated she discussed what medications to provide the resident. The same document indicated the AP intended to give the resident one dose of lorazepam and one dose of hydromorphone.

During an interview, a management staff member said on that particular day, the resident was actively dying. The hospice nurse was present to replenish the medication, and at the request of the family, the AP went to the resident's apartment to administer the medication. Instead of administering the prescribed lorazepam and hydromorphone, the AP inadvertently administered two syringes of hydromorphone without realizing it. The resident passed away

shortly thereafter. The management staff initiated an internal investigation promptly, suspended the AP. She attributed the incident to a combination of factors, including the hospice nurse refilling medication, the visual similarity of medications with clear liquid, and the resident's imminent passing. However, the AP should have cross-checked the label with the MAR, which was not done. The management staff spoke with the hospice nurse, who expressed the opinion the medication did not cause the resident's death. While the medication may have contributed to a more peaceful passing for the resident, it was not the direct cause of her death. Following the incident, the facility engaged in discussions with hospice care and implemented color labeling for medications to prevent a recurrence of similar errors.

During an interview, the hospice nurse stated the resident had been under the hospice service for approximately 10 days. She stated she was present at the facility when the resident passed away. Upon arrival, she confirmed the resident was in the process of dying. In her notes, she documented the resident was comfortable during the time she was there, and the AP acted appropriately.

During an interview, the family member stated she was with the resident when she passed away. She indicated she was aware the resident would pass away that day due to her condition, and the resident did so after the AP administered the last dose of medication.

Despite multiple attempts, the efforts to conduct an interview with the AP were unsuccessful.

The AP is no longer employed at the facility.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

“Not Substantiated” means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
Neglect means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: No. The resident was deceased.
Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: No, attempts to interview were unsuccessful.

Action taken by facility:
Facility requested solutabs from hospice instead of liquid medications when possible.
Facility requested hospice to color coordinate syringes if liquid medication is needed.
All staff who pass medications were re-educated on the process, specifically regarding liquid medications.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

Minnesota Department of Health

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 **10/16/2023**

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
0 000	Initial Comments On October 16, 2023, the Minnesota Department of Health initiated an investigation of complaint HL306996808M/HL306992862C. No correction orders are issued.	0 000		

Minnesota Department of Health

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