Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL405874781M
Compliance #: HL405876116C

Date Concluded: November 15, 2024

Name, Address, and County of Licensee Investigated:
Living Hope Homes Peaceful Pines
14134 Rolling Oaks Circle Northeast
Prior Lake, Minnesota 55372
Scott County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Nicole Myslicki, 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 the resident became lethargic and less responsive after consuming a cannabis-infused edible. The resident admitted to the intensive care unit (ICU) for intubation.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility did not have knowledge the resident took a cannabis-infused edible until she became less responsive. The facility called 911 and had her transferred to the hospital. The facility notified the provider and educated the resident on safety risks associated with cannabis use, upon return from the hospital.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family. The investigation included review of the resident record, hospital record, facility internal investigation, facility incident

reports, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff supervision of residents.

The resident resided in an assisted living facility. The resident's diagnoses included lung disease, sleep apnea, and heart failure. The resident's service plan included assistance with medication administration, oxygen management daily and as needed, and safety checks twelve times per day. The resident's assessment indicated she had pain in her legs and received narcotic medication.

The resident's vital signs indicated the resident had an oxygen saturation of 94 percent in the morning prior to the incident. The resident's service delivery record indicated the facility completed all safety checks and other required tasks with the resident prior to the incident.

The resident's medication administration record (MAR) indicated the resident received hydromorphone 2 milligrams (mg) in the morning prior to the incident.

An internal investigation indicated the resident consumed a cannabis-infused edible brought by a friend, without staff knowledge. Later, staff noticed the resident appeared lethargic and unable to stand during a transfer. Staff asked the resident about her condition, and the resident told staff she consumed the edible about three hours prior. Staff updated the nurse who requested they send the resident to the hospital for evaluation. The nurse's concerns included medication interactions and possible complications due to a frequently high carbon dioxide level. At the hospital, the resident admitted to the intensive care unit (ICU) for intubation. The nurse also updated the resident's physician who stated she would not give narcotics while the resident took edibles. After the resident returned from the hospital, the nurse spoke with the resident about her provider's instructions to discontinue narcotics, educated her on edible usage increasing her risk of respiratory decline. The resident stated she had no intention to continue using cannabis unless a pain clinician approved.

A progress note in the resident's record indicated the resident returned from the hospital a few days later and received education from a facility nurse regarding the elevated risks of using cannabis products.

During an interview, an unlicensed personnel (ULP) stated he noticed the resident seemed sleepy in the middle of the day and did not want to take her medications. The ULP obtained the resident's vitals which were okay. A short time later, they were informed the resident consumed a cannabis-infused edible. The resident could not stand up or even lift her arm. The ULP became concerned because of the resident's respiratory problems. He spoke with the nurse who instructed him to call 911. Emergency medical services (EMS) arrived and brought the resident to the hospital.

During an interview, a nurse stated the resident had a history of hospitalizations related to high carbon dioxide levels which often ended up with her needing to be intubated. Staff were aware

the resident not seeming herself was an indicator of a low oxygen level but did not know the resident consumed an edible until the change of condition. Because the resident took a 500 mg cannabis-infused edible, the nurse advocated for the resident to go into the hospital. While in the hospital, her carbon dioxide level was so high, the hospital lab could not acknowledge the level, and they intubated her. The nurse updated the resident's primary provider who stated she would discontinue all narcotic medication if the resident continued to use cannabis. The resident decided she would not use cannabis products again unless a pain clinician approved it.

During an interview, the resident stated a friend brought her a cannabis-infused edible to help her pain. Facility staff did not know about the edible being brought in, and the resident consumed it without their knowledge. The resident stated shortly after she consumed the edible, she thought it started affecting her quicker than it should have. The next thing she remembered, she woke up in the hospital.

During an interview, a family member stated the resident's friend thought the cannabis-infused edibles were safe, and the resident took one. The resident's carbon dioxide level became too high, and she needed to be hospitalized. The hospital intubated the resident and gave a medication to remove the excess water from her body, to get the carbon dioxide level down. After that, she returned to her baseline and discharged back to 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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:

The facility called 911 and had the resident sent to the hospital and notified the resident's provider. Additionally, the facility completed an internal investigation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40587	A. BUILDING: _____ B. WING _____	C 10/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING HOPE HOMES PEACEFUL PINES	14134 ROLLING OAKS CIRCLE NE PRIOR LAKE, MN 55372

(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 15, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL405876116C/#HL405874781M. No correction orders are issued.	0 000		