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 #: HL244943186M
Compliance #: HL244945171C

Date Concluded: January 24, 2023

Name, Address, and County of Licensee Investigated:
Evergreen Knoll
1309 14th Street
Cloquet, MN 55720
Carlton County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name:
Jana Wegener, 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 and alleged perpetrators (AP) neglected the resident when they failed to administer the residents end of life comfort medications according to the physician orders. As a result, the resident was very agitated and in pain while dying.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The resident received end of life care with pain medication administered as prescribed. The evening prior to the resident's death the resident was administered a lower dose of Ativan (antianxiety) than prescribed, and two additional as needed (PRN) doses of Ativan during the same shift. The error was identified, and the resident continued to have restlessness and anxiety despite the correct dose being administered after the error occurred. The day the resident died the record indicated medications provided were effective and the resident was resting comfortably. The investigation identified no additional medication errors.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted hospice, and the resident's family. The investigation included a review of the resident's progress notes, medication administration record (MAR), plan of care, service agreement, service delivery record, hospice records, hospice notes, communication notes, employee records, lab/radiology report, and physician orders. In addition, observations were completed of the facility medication administration system.

The resident resided in an assisted living facility memory care unit with diagnoses including prostate cancer, heart disease, and hypertension. The resident's service plan included assistance with medication management and administration services. The resident's record indicated the resident was cognitively impaired and received hospice end of life care.

A medication error report the night prior to the resident's death indicated the resident was prescribed Ativan 1 mg scheduled every two hours, and hourly PRN (as needed). The resident was administered one 0.5mg Ativan tablet instead of two tablets for three scheduled nighttime doses. The report indicated the resident was administered two additional PRN doses of 0.5 mg Ativan during the shift.

The resident's medication administration summary notes indicated after the resident received the full scheduled doses of Ativan, he continued to be restless and anxious. The summary indicated the day the resident died he was receiving both scheduled and PRN medications for pain, anxiety, and restlessness. The summary notes indicated the medications were effective with the resident response documented as resting comfortably and sleeping.

The resident record indicated ongoing pain and anxiety medication adjustments and changes were made with hospice for management of the resident's symptoms. The resident's MAR indicated the resident was prescribed and received Haldol (antipsychotic prescribed for anxiety and restlessness) and Dilaudid (pain medication). A nurses note indicated the resident was experiencing terminal restlessness (a distressing form of delirium that sometimes occurs in dying patients). The investigation identified no other medication administration errors occurred prior to the resident's death.

When interviewed the AP's stated they worked closely with hospice and made multiple medication adjustments and changes during the end of the resident's life to help with comfort and for symptom management when he was dying. The AP's stated the resident experienced terminal restlessness, but the resident was comfortable at the end of his life.

When interviewed the resident's family member stated the resident had pain after he sustained a hip fracture a few days prior to his death. The family member stated staff did not administer the correct dose of Dilaudid pain medication the night before he died.

A review of the resident's record and radiology report indicated the resident had no fracture, and no error in administration of Dilaudid pain medication occurred.

When interviewed staff stated the resident had confusion and restlessness at the end of his life. Staff stated the resident did not appear to be in pain and was comfortable when he passed away.

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:
(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.
(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Vulnerable Adult interviewed: No, deceased
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility investigated the medication error, provided education and coaching to the staff who made the error, and collaborated with hospice services for ongoing medication changes for the resident when he was dying.

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
	24494	A. BUILDING: _____ B. WING _____	C 01/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN KNOLL	1309 14TH STREET CLOQUET, MN 55720

(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 January 10, 2023, the Minnesota Department of Health initiated an investigation of complaint HL244943186M, and HL244945171C. No correction orders are issued.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License 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 "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 letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	