Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL378166404M
Compliance #: HL378169554C

Date Concluded: December 9, 2024

Name, Address, and County of Licensee Investigated:
Lindstrom Senior Living
30455 Lehigh Ave
Lindstrom, MN 55045
Chisago County

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

Evaluator's Name: Brandon Martfeld, RN BSN
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 administer the resident's pain medication according to the physician orders resulting in unrelieved pain.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the facility ran out of Morphine (opioid narcotic) for the resident, the contracted hospice services was responsible for the supply of the resident's Morphine. Facility staff requested a refill of the resident's Morphine from hospice approximately 10 hours prior to running out of the medication, however, there was confusion between pharmacies leaving the resident without Morphine for approximately 11 to 12 hours. Hospice arranged for the resident to receive hydromorphone (opioid narcotic) approximately four hours after running out of the Morphine supply. During that time, the resident was calm, unresponsive, and displayed no signs of pain.

The investigator conducted interviews with facility staff members, including nursing staff, and unlicensed staff. The investigator contacted the resident's family member and a hospice nurse. The investigation included review of the resident records, death record, hospice records, pharmacy records, staff schedules, and related facility policy and procedures. Also, the investigator observed staff interactions with residents at the facility.

The resident resided in an assisted living memory care unit. The resident's diagnoses included Alzheimer's disease and osteomyelitis (bone infection) of the right ankle and foot. The resident's service plan included assistance with dressing, assistance with repositioning in bed, and medication administration. The resident's assessment indicated the resident needed one staff member to assist with activities of daily living and had severe cognitive impairment. The resident received hospice for end of life and comfort care. The resident's assessment indicated the resident denied having pain.

Review of the resident's medication administration record indicated on the day of the incident, the resident was to receive Morphine 5 milligrams (four tablets for a total of 20 milligrams) every hour, sublingual (under the tongue) and four tablets every one hour as needed for pain and shortness of breath. In addition, the resident received Fentanyl (opioid narcotic for severe pain) patch 100 micrograms, apply two patches every 72 hours, and Lorazepam (anti-anxiety medication) 0.5 milligrams sublingual, two tablets every hour and two tablets every hour as needed for terminal agitation. The medication administration record indicated the resident did not receive Morphine for approximately 11 to 12 hours after the facility ran out of Morphine.

Hospice coordination notes indicated a facility staff member notified the hospice triage nurse to request a refill of Morphine, the night before the resident's Morphine medication ran out. The next morning a different facility staff member notified hospice triage that the resident's Morphine medication needed to be refilled. Hospice triage made the refill request to a pharmacy that was unable to fill the prescription. The hospice coordination notes indicated the hospice triage contacted a different pharmacy to refill the Morphine medication and that the refill would take two to four hours to be delivered to the facility. The hospice triage nurse then contacted a third pharmacy to have Dilaudid (opioid narcotic) eight milligrams every hour for pain, an alternate medication for Morphine, filled for the resident's pain. Because of time required to deliver the Dilaudid to the facility from the pharmacy, hospice staff arranged for the resident's family member to pick up the Dilaudid from the pharmacy. Approximately four hours after running out of Morphine medication, the resident received a dose of Dilaudid.

During an interview, unlicensed staff member stated the night prior to the resident passing away, licensed staff contacted hospice to have the resident's Morphine medication refilled. The following evening, the unlicensed staff member stated when they arrived at the facility, they were told the Morphine medication had not arrived from the pharmacy. The unlicensed staff member stated the family received a different medication from a pharmacy and was administering it to the resident. The unlicensed staff member stated a call to hospice was

placed again to check on the delivery of the Morphine medication. The Morphine medication arrived two hours after calling, and the resident received two doses prior to passing away.

During an interview, another unlicensed staff member stated the day the resident passed away, the resident ran out of Morphine. The unlicensed staff member stated facility licensed staff notified hospice of the resident not having any available Morphine. The hospice agency stated they were attempting to get more Morphine delivered for the resident. The unlicensed staff member stated the resident had other medications for pain control and comfort. The resident appeared to be comfortable and would only moan out when repositioned but calmed immediately after care was completed.

During an interview, a hospice nurse stated the resident received hospice cares for end-of-life comfort and wound care. The resident used Morphine every one hour for pain. The hospice nurse stated to refill a medication the order would be sent to a physician, the physician signed for it, the order was then sent to the pharmacy, and the pharmacy filled and delivered the medication. The hospice nurse stated the evening the resident passed away, the resident was comfortable and unresponsive to facility staff.

During an interview, a facility nurse stated the facility collaborated when hospice ordered medications between the facility, hospice, and pharmacy to ensure the resident received the right medication. The day the resident ran out of Morphine, facility staff had contacted hospice to have the Morphine refilled. The facility nurse stated usually medications arrived from pharmacy within four hours. The Dilaudid medication was ordered for the resident until the Morphine medication arrived at the facility. The resident had other pain medications and the resident's Fentanyl patch was increased the day prior to passing away.

During an interview, a family member stated the day the resident ran out of Morphine medication, they went to a pharmacy and picked up the Dilaudid medication that was ordered. The family member stated the Morphine medication arrived at the facility shortly before the resident 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 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: Not Applicable.

Action taken by facility:
The facility staff contacted the hospice agency for the Morphine medication to be refilled.

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
	37816	A. BUILDING: _____ B. WING _____	C 11/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINDSTROM SENIOR LIVING	30455 LEHIGH AVENUE LINDSTROM, MN 55045

(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 November 4, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL378166404M / #HL378169554C. No correction orders are issued.	0 000		