Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H51868384M
Compliance #: H51867082C

Date Concluded: April 22, 2026

Name, Address, and County of Licensee Investigated:
The Villas at Brookview
7505 Country Club Drive
Golden Valley, MN 55427
Hennepin County

Facility Type: Nursing Home

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

Finding: Substantiated, facility 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 facility neglected the resident when they failed to provide safe, accurate medication transcription and administration, resulting in a medication error.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for maltreatment. Although the facility received an unclear order, staff failed to clarify the order and transcribed the wrong dose onto the medication administration record (MAR) without completing a second check to ensure accuracy. Then staff failed to administer the right dose and gave the dose as indicated on the MAR, even though it did not match the dose ordered on the medication label. The resident received eight times the ordered amount of methadone (opioid pain medication) in error. The resident suffered respiratory depression, low oxygen levels, and decreased level of consciousness requiring Narcan (an opioid reversal drug). The resident transferred to the hospital and later died.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the hospice agency and resident's family. The investigation included review of the resident record, pharmacy records, facility internal investigation, facility incident reports, personnel files, staff schedules, related facility policy and procedures, and previous federal investigation documentation.

The resident resided in a skilled nursing facility with diagnoses including leg fracture, cancer, atherosclerotic heart disease, and congestive heart failure. The resident's assessment and plan of care indicated he received medication management and administration services from the facility. The resident utilized hospice services for end-of-life care.

A review of the provider's electronic prescription to the pharmacy included providers orders for methadone strength of 10 milligrams (mg) per milliliter (mL), with instructions to give 5 mg (0.5 mL) via gastrectomy tube once daily for pain. This order would have been on the medication bottle label provided to the facility.

A review of the hospice order form included handwritten orders for methadone liquid concentration 10 mg per mL with direction to give 2.5 mg (".4" mL) daily for pain, which was a discrepancy from the provider's order. The written dose to give 0.4 mL appeared to be written over previous writing instead of crossed out with a single line and clearly rewritten. The dose had no leading zero (0.4 mL) as would be expected with medication transcription standard of practice.

A review of the resident's MAR and order entry documentation indicated nurse #2 transcribed the methadone amount to be given of 4 mL in error and failed to include the dosage in milligrams to be administered. The MAR order transcribed by nurse #2 was an error from the hospice order form and the provider's order on the medication bottle.

A review of the resident's narcotic log indicated nurse #4 who received the medication bottle from the pharmacy entered directions to give "0.5" of methadone on the narcotic log but failed to include administration information including the ordered dose in milligrams and the amount to be given in milliliters.

A facility medication error form indicated an error in transcription occurred when a handwritten order form was provided to the facility by hospice nurse #1 with unclear writing. The hospice order form indicated the amount of methadone to administer was ".4" mL but 4 mL was transcribed into the MAR by facility nurse #2 in error.

A facility investigation indicated the error involved multiple nurses when new, unclear orders from a hospice order sheet were incorrectly transcribed by nurse #2 to the MAR and given to another nurse to be double checked to ensure accuracy. However, that did not occur, and the orders were implemented without a second nurse verifying them. The investigation indicated nurse #3 then administered the incorrect dose as directed on the MAR. The investigation

included a statement from nurse #3 who indicated she had completed checks for safe medication administration which included comparing the medication orders on the MAR with the medication label on the bottle. However, despite there being a discrepancy in the dose to administer between the MAR and the medication label, nurse #3 administered the amount indicated on the MAR without clarifying the provider's order to ensure safe medication administration was provided.

The resident's MAR indicated the resident received one dose of 4 mL of methadone.

A progress note indicated the resident received Narcan and was sent to the hospital after receiving an extra amount of methadone.

Minnesota department of health complaint survey documentation included interviews which indicated the resident was hospitalized and required a Narcan drip due to the medication error overdose of Methadone.

The resident's record of death was not available for review at the time of the investigation.

Nurse #2's personnel file included an education form following the incident which indicated the nurse transcribed unclear orders onto the resident's MAR. The form indicated nurse #2 would clarify any orders that were not clear, illegible or if the dose seemed incorrect. The form indicated nurse #2 would ensure orders were reviewed by a second nurse before being activated on the resident's MAR.

Nurse #3's personnel file included an education form following the incident which indicated whenever a discrepancy between the MAR and the medication label occurred the nurse should clarify with the ordering provider prior to administering the medication to the resident.

When interviewed, hospice leadership stated nurse #1 failed to write the order clearly and failed to include the leading zero in the amount to give (0.4 mL) which contributed to the initial transcription error at the facility. Hospice leadership indicated the facility failed to clarify the order even though the order was unclear, then transcribed to give 4 mL on the MAR in error. Hospice leadership indicated the facility implemented the order on the MAR without a second nurse checking it to ensure accuracy. Hospice leadership indicated when the provider's order on the medication label did not match the MAR facility staff gave the medication without clarifying the discrepancy.

When interviewed, facility leadership indicated the medication error could have been prevented but systemic failures occurred including failing to clarify orders that were not clear, failing to complete a double check of the orders to ensure accuracy (facility procedure for all new orders), and failing to clarify discrepancies between the MAR and providers orders on the medication label before administering the medication to the resident.

When interviewed, nurse #2 stated the facility had systems and procedures in place to identify and help prevent medication errors from occurring but they did not happen. The nurse stated after the resident received the wrong dose of the medication, he was lethargic with decreased respirations and low oxygen levels requiring Narcan to be given. The nurse stated the resident was transferred to the hospital.

When interviewed, nurse #3 stated she followed the direction on the MAR after completing checks for safe accurate medication administration.

When interviewed, the resident's family member stated the facility gave the resident an "overdose" of his methadone requiring Narcan and transfer to the hospital. The family member stated the resident required a Narcan drip for a couple of days but never recovered from the medication error and died 6 days later.

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: Not Applicable.

Action taken by facility:
When the facility became aware of the error, they assessed the resident, administered Narcan to the resident, and transferred the resident to the hospital. The facility investigated the incident, re-educated all staff to ensure practices for safe medication transcription and administration are followed to prevent recurrence.

Action taken by the Minnesota Department of Health:

MDH previously investigated the issue during a standard abbreviated survey under 42 CFR 483, Subpart B, Requirement for Long Term Care Facilities, and substantiated facility 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

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.

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies. You may also call 651-201-4200 to receive a copy via mail or email

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
Hennepin County Attorney
Golden Valley City Attorney
Golden Valley Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/16/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT BROOKVIEW	**7505 COUNTRY CLUB DRIVE , GOLDEN VALLEY, Minnesota, 55427**

(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
20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The Minnesota Department of Health investigated an allegation of maltreatment, complaint H51868384M, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557. The following correction order is issued/orders are issued for H51868384M, tag identification 21850.	20000		

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

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 **03/16/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS AT BROOKVIEW	**7505 COUNTRY CLUB DRIVE , GOLDEN VALLEY, Minnesota, 55427**

(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
20000	Continued from page 1 The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul .htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "reviewed" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	20000		
21850	Patients & Residents of HC Fac.Bill of Rights CFR(s): MN St. Statute 144.651 Subd. 14 Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This LICENSURE REQUIREMENT is NOT MET as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	21850		