Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL317866333M
Compliance #: HL317869642C

Date Concluded: March 17, 2025

Name, Address, and County of Licensee Investigated:

Eagan Pointe Senior Living
4232 Blackhawk Road
Eagan, MN 55122
Dakota County

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

Evaluator's Name: Danyell Eccleston, RN
Special Investigator

Finding: Inconclusive

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 facility over-medicated the resident with an opioid pain medication, oxycodone. The resident became unresponsive and naloxone, a medication that rapidly reverses opioid effects, was administered. The resident's last days were shortened due to the incident.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. The resident became more sedated and unresponsive after the administration of pain medication and there was an error in medication administration that caused the resident to receive an additional 5mg of Oxycodone. However, it could not be determined if the additional 5 mg of oxycodone caused the resident to become unresponsive.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted providers that were caring for the resident during the time in question. The investigation included review of the resident medical records, death record, pharmacy records, facility internal investigation, facility incident reports, staff schedules, and related facility policy and procedures.

The resident resided in an assisted living memory care unit. The resident's diagnoses included cancer. The resident's service plan included care goals to promote comfort and assist in the achievement of a comfortable, peaceful death. The resident's assessment indicated the resident was on hospice care due to a terminal cancer diagnosis.

Review of resident's facility medical record and the facility internal review indicated the resident moved to the memory care unit two days before the time in question and experienced increased pain and vomiting. At that time, a one-time 15mg oxycodone dose was administered for pain and a provider gave orders for 10mg oxycodone every four hours and hourly as needed for pain; and lorazepam, an antianxiety medication, 1mg every four hours and every two hours as needed for nausea. The day before the time in question, the resident reported to be without pain and nausea but was tired and sedated. The residents Oxycodone was decreased to 5mg every six hours and hourly as needed for pain; and lorazepam 1mg every six hours for nausea. During the early morning hours of the day in question, the staff member caring for the resident administered 10mg oxycodone rather than the scheduled 5mg oxycodone in error. That afternoon the resident was unresponsive with shallow breathing and blue tinged skin. The resident's state was a drastic change from the two days prior and naloxone was administered. Four hours later, the resident was unable to stay awake but could open her eyes intermittently, answer yes and no questions, and move her arms and legs. The resident's pain and nausea medications were discontinued and later reordered. The resident continued to receive hospice care and died eleven days later.

During interview, a nurse stated the resident lived independently prior to moving to the memory care unit. The resident moved due to increased need for assistance, especially assistance with medication management. The nurse stated she saw the resident the day the resident moved to the memory care unit, the resident had a change of condition and was very ill in the bathroom, retching and vomiting profusely. The resident's vomiting was so forceful it was causing pain and pain medication orders were increased. The nurse saw the resident again on the day in question and the resident was lying in bed, ashen in color, unresponsive to voice and touch, and did not withdraw from pain stimulation applied to fingertips. A family member of the resident expressed concern of possible over-medication, the provider was contacted and ordered naloxone. The nurse administered the naloxone and after a few minutes the resident opened her eyes and coughed. The nurse stayed with the resident and facility staff informed the nurse a medication error occurred the night before. The nurse stated the resident became more conversational over the next few days, but declined quickly and did not walk or leave her room like she did prior to moving to the memory care unit.

During interview, a second nurse indicated she conducted an internal facility review of the medication error including speaking with staff and reviewing medication orders, documentation, and bubble packs. The second nurse stated it was determined one medication error occurred when a staff member administered 10mg rather than 5mg of oxycodone during the early morning hours.

During interview, a medical provider stated a concern was voiced regarding the resident experiencing a medication error at the facility. The provider stated it was not possible to know if an extra dose of oxycodone caused the resident's sedation.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive.

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
Internal facility review of the incident and re-education of staff.

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
	31786	A. BUILDING: _____ B. WING _____	C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGAN POINTE SENIOR LIVING LLC	4232 BLACK HAWK ROAD EAGAN, MN 55122

(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 February 12, 2025, the Minnesota Department of Health initiated an investigation of complaint #HL317869642C/#HL317866333M. No correction orders are issued.	0 000		