Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL330235386M
Compliance #: HL330237388C

Date Concluded: January 8, 2025

Name, Address, and County of Licensee Investigated:
Virginia Carefree Living
421 10th Street South
Virginia, MN 55792
St. Louis County

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

Evaluator's Name: Barbara Axness, 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 two unlicensed personnel (ULP) failed to follow medication administration procedures and gave the resident an incorrect dose of Oxycodone (an opioid pain medication). The resident suffered an overdose and was hospitalized.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident suffered an overdose and was treated in the hospital due to a medication error, the error was an isolated incident, and the resident returned to their baseline health condition. Facility staff identified the error shortly after it occurred and provided appropriate monitoring, administered Narcan (a medication to reverse opioid overdoses), updated the resident's responsible party, and contacted emergency services.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the primary care provider and the

case manager. The investigation included review of the resident record, hospital records, facility internal investigation documentation, facility incident reports, personnel files, staff schedules, and related facility policies and procedures. Also, the investigator observed medication administration at the facility and the resident's medications.

The resident resided in an assisted living facility. The resident's diagnoses included osteoarthritis and chronic pain. The resident's service plan included assistance with medication administration. The resident's assessment indicated the facility recently began management of the resident's medications.

The resident's medication administration record (MAR) included an order for Oxycodone extended release/Xtampza (narcotic pain medication) extended release 18 milligrams (mg) take one tablet by mouth every 12 hours. The resident also had an order for Oxycodone 5 mg every six hours as needed (PRN) for pain. The MAR indicated the medication being despite out of stock, the resident's Oxycodone 5 mg PRN dose was marked as administered at 6:01 p.m. the night prior to the overdose and again at 12:54 a.m. the morning of the overdose. The resident's 18 mg Oxycodone dose was marked as administered at 8:00 a.m. the morning of the overdose.

The medical record indicated that a nurse was reviewing the medication dashboard when she noticed the resident was given PRN doses of Oxycodone but she recalled that the PRN doses were not available, as they were pending refill from the pharmacy. The resident's MAR identified that three doses of the 18 mg extended-release Oxycodone were given, two of those doses were in error and documented as 5 mg PRN doses. The most recent dose was given at 8:42 a.m. and a nurse assessed the resident at 9:15 a.m. The resident was noted to be in a "catatonic" state and had a slow heart rate and slow respirations. The resident initially declined being sent to the emergency room. The responsible party agreed to honor the resident's wishes to decline treatment in the emergency room. A facility nurse administered Narcan and an improvement in vital signs was noted but the resident began to hallucinate and convulse. The resident continued to decline going to the emergency room, but the facility nurse elected to have the resident transported to the emergency room for further evaluation.

Hospital records indicated the resident was evaluated for an accidental opioid overdose. The resident returned to the facility two days later.

Employee records for the two staff who administered incorrect medication doses were reviewed, and both had received training on medication administration practices.

During an interview, the facility registered nurse (RN) stated she reviews the electronic medical record when she comes to work in the morning, and she knew the resident's PRN dose was pending refill so the resident should not have had any PRN doses administered. The RN stated she was not in the building that morning, so she called the nurse that was there and had her check the medication card and check on the resident. The RN stated once they realized the resident was given too much Oxycodone, they began to monitor symptoms and eventually sent

the resident to the emergency room. The RN stated the resident had an order for PRN Narcan so it was available to administer in the event of an overdose.

During an interview, another facility nurse stated she was in the building when the RN called her to go check on the medications and the resident. The nurse stated she noticed the resident was bed bound and had some abnormal vital signs. The nurse stated she knew the resident had an order for Narcan and it was administered immediately as they suspected she was experiencing an opioid overdose.

During an interview, one of the unlicensed staff who administered the incorrect dose of medication stated he had been working a 12 or 16 hour shift and his other coworker, who also administered an incorrect dose, told him the resident could get the Oxycodone at 12 a.m. The staff stated he was in a rush, wasn't paying attention and didn't look at the dose before he administered the pill.

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 identified the medication error shortly after it occurred. Facility staff administered Narcan, updated the responsible party, and called emergency medical services. The facility also filed a MAARC report. All staff were retrained on medication administration, administration of Narcan, and identifying signs and symptoms of overdose.

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
	33023	A. BUILDING: _____ B. WING _____	C 12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIRGINIA CAREFREE LIVING	421 10TH STREET SOUTH VIRGINIA, MN 55792

(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 December 4, 2024, the Minnesota Department of Health initiated an investigation of complaint #HL330235386M/#HL330237388C. No correction orders are issued.	0 000		