Protecting, Maintaining and Improving the Health of All Minnesotans

Health Regulation Division
Investigative Public Report

Maltreatment Report #: H5223199M **Date Concluded:** September 1, 2021

Name, Address, and County of Licensee Investigated:

Bayview Nursing and Rehab Center
1412 West 4th Street
Red Wing, MN 55066
Goodhue County

Investigator Name: Shannan Stoltz, RN
Special Investigator

Facility Type: Nursing Home

Finding: Not Substantiated

Nature of Visit:
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.

Allegation(s):
It is alleged: Neglect occurred when a facility staff member administered the wrong dose of a medication to the resident, four separate times, over the course of a 12-hour period.

Investigative Findings and Conclusion:
Neglect was not substantiated. While a facility licensed practical nurse did administer the wrong dosage of medication to the resident, documentation indicated there was no residual effect to the resident, and the medication error did not cause the residents death.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation also included interviews with the client's primary care provider, a registered nurse from an outside hospice agency, and family members. The investigation included a review of facility and hospice medical records, and a review of facility policies and procedures.

The resident's medical record was reviewed. The resident's medical diagnoses included diabetes, chronic kidney disease, and anemia. The resident's care plan indicated she received services for hospice/comfort cares related to an end-stage disease process, medication management, and assistance with activities of daily living.

The resident moved into a facility due to an end-stage disease process. Less than two weeks later, the resident admitted to hospice and started on 5 milligrams (mg) of morphine, every four hours. When the pharmacy fulfilled this order for the facility, they provided 2.5 mg morphine tablets on "medication (med) cards". Three days later, the residents hospice physician increased her morphine to 10 mg every four hours. The order also indicated the 2.5 mg tablets could be used-up prior to the usage of the 10 mg tablets. The pharmacy sent the facility med cards with 10 mg tablets of morphine, which upon facility receipt, the facility stored the 10 mg morphine tablets with the 2.5 mg morphine tablets. Later that day, a facility evening shift licensed practical nurse (LPN-B) misread/mistook the 10 mg med card for a 2.5 mg medication card and gave the resident four 10 mg tablets (total of 40 mg), instead of four 2.5 mg tablets (for a total of 10 mg). LPN-B repeated this same medication error three more times over the next 12 hours, and the resident received a total of 160 mg of morphine, instead of the prescribed 40 mg of morphine. After facility staff discovered the medication error, they notified the hospice agency. Hospice ordered Narcan for the resident (medication used to treat a narcotic overdose), and facility staff administered it to the resident. A hospice registered nurse (RN) also responded to the facility to perform a full assessment, which found the resident still suffered from pain, and that the morphine overdose had had no residual effects. The resident continued to receive the morphine dose of 10 mg every four hours, with no further incident, until the resident died four days later.

The resident's Hospice Physician Order indicated, "Morphine Solutab Tablet 10 MG Give 10 mg by mouth every 4 hours for pain/SOB [shortness of breath] (may give four 2.5mg tabs)".

The resident's Medication Administration Record indicated, "Morphine Solutab Tablet 10 MG Give 10 mg by mouth every 4 hours for pain/SOB (may give four 2.5mg tabs)".

The resident's facility progress notes indicated the resident had an oxygen (O2) saturation level of 37-42% after the medication error. Facility staff gave the resident oxygen and 15 minutes later the residents O2 level recovered at 86%.

The resident's hospice progress notes indicated the hospice RN responded to the facility and completed a full assessment of the resident, two hours after the morphine overdose. The notes indicated the resident returned to baseline, but still appeared to be in pain, so the hospice RN ordered facility staff to give the resident another dose of morphine.

The facility's Medication Error Report & Analysis indicated LPN-B stated, "I was thinking the card was 2.5 mg to give 4 doses, not knowing the card of morphine was 10 mg to give 1 dose."

During an interview with LPN-B, she stated she made a serious mistake. LPN-B stated that she read the physician's order to give four tablets, she read the morphine med card which indicated the same information, and she then pulled four 10 mg morphine tablets from the med card because,

“In my mind, at the time, it made sense”. LPN-B also stated that “I understand what I did, but don’t understand and don’t know why I did it”, and “In my mind the dosage was the same”. LPN-B stated, “I’m so sorry I did this. I’m so careful now”. LPN-B stated she had received her LPN license three weeks before the medication error occurred.

During an interview with unlicensed personnel and trained medication administrator (TMA), she stated that she has passed medications for 10 years. The TMA stated that when the facility’s morning shift licensed practical nurse (LPN-C) found the resident displayed non-verbal signs of pain, LPN-C instructed the TMA to give the resident a 10 mg dose of morphine. The TMA stated that when she pulled the morphine med card, she realized there was a medication error and alerted LPN-C, who then alerted the hospice agency. The TMA stated that although she had been a TMA for 10 years, she understood why the medication error occurred. In the TMA’s opinion, the error occurred due to the morphine medication cards (10mg and 2.5 mg) being stored together, and the confusing medication order that indicated the resident could be administered four tablets. The TMA also stated that she understood the reasoning behind the wording of the medication order, which was to use up the 2.5 mg tablets so as not to waste medication.

During an interview with LPN-C, she stated that during her morning COVID screening, she felt the client displayed non-verbal signs of pain. LPN-C stated she requested the TMA administer an as needed dose of morphine, but the TMA then notified LPN-C of the morphine medication error. LPN-C stated she contacted hospice and followed their directions for immediate resident care, alerted facility administration, and then closely monitored the resident until the hospice RN arrived. LPN-C stated, “I can totally see how the PO [physician’s order] could be confusing”. LPN-C stated she was the person who told LPN-B about the medication error, and that LPN-B was upset to learn of the error.

During an interview with the hospice RN, she stated the resident was, “very sick, in a lot of pain, and her prognosis was very bad”. The hospice RN also stated, “I don’t feel the med [medication] error had anything to do with the client’s passing”, because the resident died “approximately 4 or 5 days after the med error”.

The facility provided an email, which was between the resident’s primary care physician (PCP) and the facility’s director of nursing (DON), in which the PCP wrote, “[DON Name], I did talk to the ME’s [Medical Examiner] office. I decided that since she [resident] survived to require further doses of narcotic, that the med error had no role in her death. I did not address it on the death certificate for that reason”.

During an interview with the resident’s PCP, he stated, “The morphine overdose had nothing to do with [residents] death”. The PCP also verified the email between himself and the DON as authentic and legitimate.

During an interview with the resident’s family member stated he was not angry or upset at the nurse or facility for what happened, and it was an honest mistake. He stated the resident was in a lot of pain and this event did not change her outcome.

In conclusion, 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.

Action taken by facility:
Updated and implemented new training thresholds and requirements, as well as medication placement.

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

Action taken by the Minnesota Department of Health:
The facility was found to be in 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

Or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

cc: The Office of Ombudsman for Long-Term Care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245223	A. BUILDING _____ B. WING _____	C 04/06/2021

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F 000	INITIAL COMMENTS On 4/5/21, through 4/6/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5223192C (MN00071384 & MN00071389), with a deficiency cited at F760. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to administer Morphine, a narcotic medication, as prescribed by the physician for 1 of 3 residents (R1) reviewed for medication administration. This deficient practice resulted in actual harm when R1experienced an adverse	F 760	F760 1.Medication administration audits have been completed on multiple residents no errors have been found. 2.Medication Error policy and procedure has been reviewed and revised as of April	4/26/21

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

Electronically Signed | 04/22/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 760	Continued From page 1 drug reaction with an increased heart rate, labored breathing with periods of apnea (temporary cessation of breathing), decreased oxygen saturations, fixed pupils, and required Narcan (medication used to treat a known or suspected narcotic overdose). Findings include: R1's admission Minimum Data Set (MDS) assessment dated 3/17/21, indicated R1 was diagnosed with cancer. In addition, the MDS indicated R1 had moderately impaired cognition, experienced frequent pain and received scheduled and as needed (PRN) pain medication. Orders dated 3/26/21, indicated R1 was ordered Morphine Solutab 10 mg (milligrams) take one tablet by mouth every four hours and may repeat every hour PRN for pain or shortness of breath. The order further indicated "May give four 2.5 mg tabs." A Facility Reported Incident (FRI) dated 3/29/21, at 12:20 p.m. included, on 3/26/21, R1's morphine order was increased to 10 mg every four hours scheduled and every one hour PRN for pain (previous morphine order was 5 mg every four hours). The new morphine order indicated "May give 4, 2.5 mg tabs [to equal 10 mg] to use up current supply." The pharmacy had delivered 10 mg tablets after the new morphine order was obtained and licensed practical nurse (LPN)-A, who had worked a double-shift on 3/28/21, through 3/29/21, administered four 10 mg morphine tablets (40 mg total) to R1 at 4:00 p.m.and 8:00 p.m. on 3/28/21, and at 1:00 a.m. and 4:00 a.m. on 3/29/21. The FRI indicated R1 was noted to slip into an unconscious state,	F 760	2021 3.Bay View's Orientation process for nursing staff has been reviewed by management and revised to include an updated LPN/RN training checklist, increased length of time spent training to floor/units and follow up by Director of Staff Development or Designee prior to completing training process. All nursing staff will require a completed check list that is reviewed and approved by the Staff Development Director or Designee before completing the orientation process and transitioning to working independently. 4.EduCare Medication Administration module-Overview-1.25 hours, will be completed successfully by all facility staff that are responsible for medication administration, including LPN, RN and TMA's. Any staff not completing this module by 4/26/2021 will not be allowed to pass medication until it has been completed. New hire nursing staff will complete prior to completing their orientation process and competency will be reviewed annually. 5.Point Click Care Training Database has been purchased to allow for hands on training for nursing staff beginning in May 2021 to provide nursing staff hands on practice with our EMAR, ETAR and other documentation as needed. 6.Sedative Medication Monitoring has been added to the E-TAR to be documented each shift if resident is receiving sedating medication. 7.Medication Administration Observation Audits will be conducted 3 x per week x 4 weeks, then weekly times four weeks by	

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F 760	Continued From page 2 hospice was notified and Narcan was ordered. Review of R1's progress notes revealed: -A general note dated 3/29/21, at 6:30 a.m. indicated R1's pulse was 106, respirations were 16 and labored with 10 seconds of apnea, and blood pressure was 135/69. R1's oxygen saturations were checked five times and results ranged from 37-42%. R1 was moaning with respirations and had slight tracheal (throat) congestion. Supplemental oxygen was applied at two liters via nasal cannula. In addition, Hyoscyamine (drying agent to control excessive salivation) and morphine 10 mg was administered for comfort. A message was left for the on-call hospice nurse. -A general note dated 3/29/21, at 6:45 a.m. indicated a message was left for the on-call hospice nurse to provide an update on R1's condition. R1's respirations remained 16 and labored with 10 seconds of apnea. R1's oxygen saturation improved to 86% after administration of oxygen and morphine. -A late entry general note dated 3/29/21, at 8:05 a.m. indicated "Nursing felt that resident was having an undesirable response to the Morphine she had received." The note indicated hospice was updated on R1's condition and verbal orders were obtained to hold blood sugar checks and insulin, during the shift, as R1 was non-responsive. -A general note dated 3/29/21, at 8:25 a.m. indicated R1's hospice nurse communicated with a hospice physician regarding R1's condition. The note further indicated an order was received to	F 760	the Staff Development Director or Designee observing several staff over different shifts and units, multiple routes of administration. Results of audits will be reviewed by DON or designee and the quality assurance committee to ensure compliance.	

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F 760	Continued From page 3 administer Narcan to R1. -A general note dated 3/29/21, at 8:40 a.m. indicated Narcan was administered to R1. -A late entry general note dated 3/29/21, at 9:07 a.m. indicated R1's pulse was 89, respirations were 20 and slightly labored. No apnea was noted and R1's blood pressure was 179/67. R1's oxygen saturation was 84-86% on two liters of oxygen. R1 had slight tracheal congestion, had no response to verbal/tactile stimulation and the scheduled 8:00 a.m. dose of morphine was held. A Hospice Nursing note dated 3/29/21, indicated upon arrival to R1's room, R1 was noted to have a decreased level of consciousness, decreased reaction to sound/words, had apnea, had non-reactive pupils and was semi-comatose. During a review of the facility narcotic book on 4/5/21, it was revealed R1 received four 10 mg morphine tablets (40 mg total) on 3/28/21, through 3/29/21, at 4:00 p.m., 8:00 p.m., 1:00 a.m., and 4:00 a.m. R1 was administered a total of 160 mg of morphine which was 120 mg more than ordered. During interview on 4/5/21, at 12:06 p.m. LPN-B stated initially R1 received 2.5 mg of morphine, but the dosage increased to 10 mg on 3/26/21. LPN-B stated 3/26/21, was a Friday and the hospice nurse was unsure if 10 mg morphine tablets would be delivered by the pharmacy. LPN-B stated the hospice nurse directed the facility to use 2.5 mg morphine tablets to ensure R1 had medication available and was kept comfortable. LPN-B stated she worked the shift after the medication error occurred, assessed R1	F 760		

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F 760	Continued From page 4 and notified hospice R1 had signs and symptoms of an overdose. LPN-B stated she was instructed to administer Narcan to R1. LPN-B stated it was facility policy for nurses and trained medication assistants (TMA's) to compare a medication card against an order when preparing medications. LPN-B verified no education had been provided since the medication error occurred. During interview on 4/5/21, at 12:17 p.m. LPN-G stated facility policy directed nurses and TMA's to check the Medication Administration Record (MAR) against the medication card before medications were administered to residents. LPN-G stated staff were always supposed to do the five rights when doing medication administration which included the right patient, drug, dose, route and time. During interview on 4/5/21, at 12:26 p.m. LPN-C stated she cared for R1 during the morning shift a day after the medication error occurred. LPN-C stated she had administered morphine once and another dose was administered by a TMA at noon. LPN-C stated four 2.5 mg morphine tablets were administered to total 10 mg as there was instructions to use 2.5 mg tablets. LPN-C stated during the morning shift (6:00 a.m. to 2:30 p.m.) R1 was alert and spoke to staff about her needs and had company with her throughout the shift. LPN-C stated she heard a medication error occurred; however, no training had been provided. LPN-C stated other residents at the facility were also administered morphine. During interview on 4/5/21, at 12:53 p.m. the director of nursing (DON) stated following the medication error, LPN-A was suspended pending investigation and had "Educare" on medication	F 760		

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F 760	Continued From page 5 administration. The DON stated LPN-A was put back on orientation and worked alongside another nurse because she was a brand-new nurse. The DON stated LPN-A was given a final warning and informed she could not have another medication error in the next 12 months or she would be terminated. The DON stated LPN-A was on a performance improvement plan and she was going to observe LPN-A pass medications to ensure she was completing the 6 rights (patient, medication, dose, time, route and documentation). The DON stated other nurses were to be re-trained on medication administration, however she was not sure how many nurses had completed the re-training. The DON stated she thought the nurses had until 4/11/21, to complete training. The DON confirmed one other resident received morphine 2.5 mg every four hours. During interview on 4/6/21, at 3:33 p.m. LPN-A stated during evening shift on 3/27/21, she had administered four 2.5 mg morphine tablets to R1. LPN-A stated she worked evening shift on 3/28/21, and night shift on 3/29/21, and thought she still needed to administer four tablets. LPN-A confirmed she did not realize the dosage on the medication card was 10 mg. LPN-A stated she did not realize she made a medication error until she came back to the facility on 3/29/21. LPN-A stated on the evening shift on 3/28/21, she was on orientation with LPN-F. LPN-A stated LPN-F worked the treatment cart and she administered medications alone. LPN-A stated she was on floor orientation for about four days prior to the medication error. LPN-A stated she was asked to work the night shift on 3/29/21, alone and agreed to do it. LPN-A further stated, "We are taught in school about the six rights and I just don't know	F 760		

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F 760	Continued From page 6 what I was doing, and I did not do them [six rights] when this happened." During interview on 4/5/21, at 2:11 p.m. nurse practitioner (NP)-A stated she was made aware of the medication error when she came to the facility on 3/29/21. During interview on 4/5/21, at 2:50 p.m. The consultant pharmacist stated it was a significant medication error because staff had to administer Narcan after the medication error was identified. During interview on 4/6/21, at 1:28 p.m. R1's hospice registered nurse, RN-F stated she had received a call indicating R1 had received the wrong dosage of morphine overnight. RN-F stated prior to her arrival at the facility (on 3/29/21) she had consulted with the hospice physician who gave an order for R1 to given Narcan. RN-F stated Narcan was administered approximately 20 minutes prior to her arrival and R1's oxygen saturations had improved to above 80%, but R1's pupils were pinpoint with little movement. RN-F said when she had spoken to LPN-B, she was informed R1's oxygen saturations were 37 to 42% prior to Narcan administration. RN-F stated although R1 was on hospice, prior to the medication error, R1's death was not imminent. RN-F said she'd consulted with the hospice physician who recommended administering Narcan. RN-F stated when she'd seen R1 on 3/25/21, R1 was alert and had a conversation with her. The facility's 2001 Med-Pass Inc Administering Medications policy revised April 2019, directed	F 760		

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F 760	Continued From page 7 the individual administering the medication was to check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. The facility's 2001 Med-Pass Inc Adverse Consequences and Medication Errors policy revised April 2014, indicated An "adverse drug reaction" (ADR), as a form of adverse consequences defined as a secondary and usually undesirable effect of a drug and was different from the therapeutic and helpful effects of the drug. In addition, the policy defined a "medication error" as the preparation or administration of drugs or biological which was not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services.	F 760		