Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: H56202482M
Compliance #: H56202990C

Date Concluded: July 25, 2025

Name, Address, and County of Licensee Investigated:
Minnesota Veterans Home
5101 Minnehaha Avenue South
Minneapolis, MN 55417
Hennepin County

Facility Type: Nursing Home

Evaluator's Name: Lissa Lin, RN
Special Investigator

Finding: Substantiated, individual 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 alleged perpetrator (AP) neglected the resident when she failed to follow the facility's medication administration policy and gave him 20 times the prescribed morphine amount. The resident died.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated for AP1 and inconclusive for AP2. AP2 struggled to transcribe the liquid morphine order and asked AP1 for help. While AP2 did contact the on-call provider at least once to clarify the resident's liquid morphine order, she relied on AP1 for help with the liquid morphine transcription instead of contacting the on-duty nurse supervisor who offered to help with the order. AP1 prepared and administered liquid morphine but failed to follow the facility policy and procedure for medication administration. AP1 also failed to immediately report the medication error to her supervisor and the provider. AP1 also failed to accurately report the medication error to the provider once she realized she gave 100 milligrams (mg) of morphine instead of 5 mg.

The investigator conducted interviews with facility staff members, including nursing staff. The nurse manager declined an interview. The investigator contacted the resident's family member.

The investigation included review of resident records, death record, facility internal investigation, facility incident reports, personnel files, staff schedules, and related facility policy and procedures.

The resident lived in a nursing home. His diagnoses included stroke, diabetes, dementia and atrial fibrillation. The resident required staff assistance with bathing, dressing, grooming and hygiene. Staff administered medications. He used a wheelchair for ambulation. The resident was able to communicate some of his needs and was generally alert and oriented with intermittent confusion.

Review of the internal investigation records indicated one evening the resident's family members visited him and reported to staff the resident was struggling to breathe.
A staff member checked the resident's vial signs and raised the head of his bed. He notified AP2, who was the evening shift nurse. Staff members continued to monitor the resident. His oxygen saturation levels were low and other vital signs unstable. AP2 asked the evening nurse supervisor for assistance; they contacted the on-call provider for oxygen and hospital orders. The resident's family members did not want him sent to the hospital; they returned to the facility and spoke with the on-call provider, requesting comfort cares instead. The provider agreed and gave a phone order for morphine 20 mg/1 milliliter (mL), give 5 mg (0.25mL) every hour PRN (as needed).

AP1 arrived for the overnight shift. AP2 asked her if she could help with the morphine order since she was unsure of what to do. AP1 agreed to help her. They called the provider back to clarify the order. AP2 wrote the liquid morphine order on a form. AP1 helped her type the order into the resident's electronic record.

Meanwhile the overnight nurse supervisor had arrived for her shift and received shift report. She was updated the resident had a change of condition. When the resident's morphine order was released by the pharmacy and ready, the overnight nurse supervisor brought the medication to the unit. She signed the morphine handoff to AP1 and asked both AP1 and AP2 if they needed help. Neither answered. She told AP1 and AP2 to call if they needed anything.

AP1 logged the medication into the narcotic record and went to prepare the liquid morphine. AP1 drew up five 1 mL full syringes and emptied them into a medication cup. AP1 did not confirm the order with another nurse before giving the liquid morphine to the resident. Investigation records indicated AP1 thought she knew the order, that 5 mg was the same as 5 mL and miscalculated the dose. About 15 or 20 minutes later, AP1 "fixed" the title of the order in the computer because it was wrong. (The morphine brought to the unit was 20 mg/1 mL, not 20 mg/5 mL.)

About an hour later, the overnight nurse supervisor went to AP1 and questioned her about the order. AP1 realized her error and told the overnight nurse supervisor the resident received 20 mg of morphine instead of 5 mg. AP1 still did not realize she had given the resident 100 mg of morphine. The overnight night supervisor contacted the on-call provider. AP1 notified the family of the medication error. The on-call provider instructed the nurses to monitor the resident and hold any further morphine.

AP1 said about two hours later she realized the significance of her medication error. She called the on-call provider to update him on the resident's condition but did not let the provider know she had administered 100 mg of morphine instead of 20 mg as reported to him earlier.
The resident's family declined to send the resident to the hospital. The resident died just before 3:00 a.m.

During an interview, AP1 said the overnight nurse supervisor asked her to help AP2 because the evening had been hectic. AP1 said she told AP2 how to fill out the paper transcription form. AP1 said she also "walked" AP2 though entering the liquid morphine order electronically. AP1 said the electronic record did not provide a dropdown menu to select "milligrams", so she entered milliliters because she thought they are the same. AP1 did not contact the overnight nurse supervisor for help with entering the medication order and said in hindsight that was a mistake. She and AP2 called the on-call provider a few times to clarify the morphine order. AP1 said she believed she had the right amount of morphine prepared but when she looked at the amount of liquid in the medication cup, she questioned herself because it looked like much more liquid than she was used to seeing. AP1 gave the resident the morphine and documented the medication was given. AP1 said she realized the order was written wrong (morphine 20 mg/5 mL). She cancelled it and entered morphine 20 mg/1 mL. Because she cancelled the first order and entered a new order, she was now the first nurse on the new order and policy required two nurses to view the order. AP1 said she should have asked another nurse to confirm the new order but did not. The overnight nurse supervisor called AP1 with questions about the old and new morphine orders. AP1 said around 1:30 a.m. she reviewed the morphine order again and realized she should have drawn up 0.25 mL of morphine, not 5 mL. The overnight nurse supervisor came to help monitor the resident and talk with the family. AP1 said she was in disbelief and felt terrible. The resident died a few hours later. AP1 said the medication error was her mistake. Even though she was trained on giving mediations, she did not know two nurses had to review a new narcotic order. AP1 said AP2 should have known how to transcribe medication orders. AP1 said she finished her shift and went home on a suspension. She was interviewed by management and is no longer employed at the facility.

Record review indicated AP1 received training on medication preparation, medication administration, contacting physicians and transcribing telephone orders.

During an interview, AP2 said she was new to the floor the resident lived on, it was only her third shift. When the resident experienced a change in condition, she "freaked out" and asked

for other evening shift nurses to help her. AP2 said the family changed their minds several times about sending the resident to the hospital which also confused her on what to do. She had the evening nurse supervisor help her with calling the on-call provider for orders. She had never transcribed medication orders. Her training on orders was about two hours and trainers told her to ask for help when out on the floors because no one will recall everything from training. AP2 said she asked for help and was grateful when AP1 arrived for her shift and offered to help. AP1 sat next to her and told her what to type. AP2 said AP1 was calm and knew what to do. AP2 said her shift ended at 11:00 p.m. but she stayed until approximately 11:30 p.m. to catch up on tasks. AP2 said she left and did not see AP1 prepare the liquid morphine or change the order in the electronic record. She was interviewed by management and felt terrible the resident died.

During an interview, the family member said AP1 gave the resident the liquid morphine. Awhile later AP1 returned to the room and said she had given the resident 20 mg of morphine. The family member asked the overnight nurse supervisor about giving the resident Narcan (an opioid antagonist used to reverse effects of opioid overdose) but was told no. The family member said she later learned that Narcan needed to be given within 45 minutes of the overdose to work. The family member said the few hours the resident lived after the morphine overdose was “a tragedy of errors.” The overnight nurse supervisor told her the resident had received 100 mg of morphine, and a morphine order had not been signed by two nurses. The family member said she was in utter shock and disbelief and will not ever be whole again.

The on-call provider interview for the internal investigation indicated AP1 and AP2 contacted him at least three times to clarify the morphine orders. He was initially notified the resident erroneously received 20 mg of morphine but was not informed the resident received 100 mg of morphine until after the resident died. He was unable to determine if the medication error hastened the resident’s death.

The overnight nurse supervisor declined an interview.

The resident’s death record indicated the cause of death was acute morphine toxicity.

In conclusion, the Minnesota Department of Health determined neglect was substantiated for AP1.

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.

In conclusion, the Minnesota Department of Health determined neglect was inconclusive for AP2.

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.

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):
(1) AP1 followed an erroneous order, direction or care plan with awareness and failure to take action.

The facility did not direct an erroneous order, direction, or care plan.

(2) The facility was not in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

AP1 failed to follow the facility directive and/or policies and procedures.

(3) AP1 failed to follow professional standards and/or exercise professional judgement.

AP1 failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: No, deceased.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes, AP1 and AP2 interviewed.

Action taken by facility:
The facility conducted an internal investigation and AP1 is no longer employed at facility.

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
Minneapolis City Attorney
Minneapolis Police Department
Minnesota Board of Nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00233	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MN Veterans Home Minneapolis	5101 MINNEHAHA AVENUE SOUTH , MINNEAPOLIS, Minnesota, 55417

(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 #H56202482M, 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 #H56202482M, tag identification 21850.	20000		

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

Minnesota State Department of Health

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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 an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	21850		