Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL240284424M
Compliance #: HL240289297C

Date Concluded: July 17, 2023

Name, Address, and County of Licensee Investigated:
Emerald Crest of Victoria
8150 Bavaria Road
Victoria, MN 55386-9702
Carver County

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

Evaluator's Name: Lena Gangestad, RN
Special Investigator

Finding: **Not Substantiated**

Nature of the 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 a resident when the facility overdosed the resident with opioid pain medication.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility administered the resident's hydromorphone (an opioid pain medication) according to the medical provider's orders. When the resident developed symptoms of opioid side effects, the facility identified the concern and responded appropriately.

The investigator conducted interviews with administrative staff. During the investigation, despite making multiple attempts, the investigator was unable to reach the family members, nurses, and unlicensed staff members. The investigation included review of resident's records, facility's policies and procedures, incident reports, and the resident's external medical record.

The investigation included an onsite visit, observations, and interactions between residents and facility staff.

The resident resided in an assisted living memory care unit. The resident’s service plan included assistance with all activities of daily living which included hygiene, dressing, toileting, and medications. The resident’s assessment indicated he required hand on assistance with transfer and mobility.

The resident's medical records indicated pain management regimen consisted of taking one milligram (mg) of hydromorphone orally twice a day, as well as an additional one mg tablet to be taken every 8 hours as needed for pain. This medication had been consistently taken by the resident for over a month.

The resident’s incident report indicated the resident had an unwitnessed fall and was subsequently transported to the hospital for treatment. Later in the evening, the resident returned to the facility without any documented injuries or new orders from the hospital.

The resident’s electronic medical record (EMAR) indicated no pain medication was administered due to the resident’s return late in the evening. However, the following morning, an unlicensed staff member administered a scheduled dose of one mg of hydromorphone orally at 7 am, followed by another as-needed dose at 10:30 a.m.

The progress notes indicated the on-call registered nurse continued to receive updates throughout the day as the resident progressively declined and his caregivers reported shallow breathing. The registered nursed directed the resident back to the hospital at 6:00 p.m.

The hospital records indicated the resident received treatment for a narcotic overdose using Narcan (a medication which reverses the effects of opioid medications) and the resident recovered. According to the resident's hospital discharge summary, it is possible that the accumulation in the resident's system occurred due to their advanced age and kidney disease. Notably, the resident did not exhibit any signs of narcotic withdrawal at the time.

During an interview, the director of housing stated the nurse on call was notified about the resident’s unwitnessed fall, which led to the resident’s hospitalization. The resident did not spend the night at the hospital and returned to the facility later the same evening. The facility sent the resident back to the hospital the next day due increased lethargy after the resident received one as needed dose of hydromorphone, which was treated with Narcan. The diagnosis provided was a narcotic overdose, considering the resident's daily use of oral hydromorphone.

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: The resident is deceased.
Family/Responsible Party interviewed: Unable to reach.
Alleged Perpetrator interviewed: Not Applicable

Action taken by facility:
The facility investigated the incident and sent the resident to the hospital.

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
	24028	A. BUILDING: _____ B. WING _____	C 06/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CREST OF VICTORIA	8150 BAVARIA ROAD VICTORIA, MN 55386

(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 June 12, 2023, the Minnesota Department of Health initiated an investigation of complaints #HL240289297C/HL240285403M, #HL240287495C/HL240284424M and #HL240284983C/HL240283063M . No correction orders are issued.	0 000		