

**MALTREATMENT INVESTIGATION MEMORANDUM**  
**Office of Inspector General, Licensing Division**  
**Public Information**

*Minnesota Statutes, section 626.557, subdivision 1 states, "The legislature declares that the public policy of this state is to protect adults who, because of physical or mental disability or dependency on institutional services, are particularly vulnerable to maltreatment."*

**Report Number:** 202303175

**Date Issued:** March 20, 2024

**Name and Address of Facility Investigated:**

**Disposition:** Inconclusive

Beauterre Recovery Institute  
2480 S. County Road 45  
Owatonna, MN 55060

**License Number and Program Type:**

1075930-SUD (Substance Use Disorder)

**Investigator(s):**

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**Suspected Maltreatment Reported:**

It was reported that a vulnerable adult (VA) was not provided medical care when s/he had an adverse reaction to suboxone, a distended stomach, and a lack of bowel movement tracking. On March 17, 2023, the VA was found on a floor, was transported to an emergency room, and passed away around 7 a.m.

**Date of Incident(s):** March 17, 2023

**Nature of Alleged Maltreatment Pursuant to Minnesota Statutes, section 626.557, subdivision 9c, paragraph (b), and Minnesota Statutes, section 626.5572, subdivision 15, and subdivision 17, paragraph (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 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 which is not the result of an accident or therapeutic conduct.

### Summary of Findings:

Pertinent information was obtained during a site visit conducted on April 21, 2023; from documentation at the facility and/or law enforcement records; and through six interviews conducted with facility staff persons (P1-P3), a facility medical doctor (MD), a health care professional (HCP), and a family member (FM). An attempt to interview the VA's roommate (R) was not successful.

The VA's diagnoses included diabetes, lung adenoma carcinoma status post partial lobectomy (lung cancer), and alcohol and opioid use. The VA enjoyed gardening and loved animals.

The VA's *Individual Abuse Prevention Plan* stated that s/he was not susceptible to any form of abuse.

The facility's *Program Abuse Prevention Plan* stated that residential services were provided to individuals diagnosed with a substance use disorder. Staffing at the facility varied according to the time of day. (For the purposes of this investigation, from 11 p.m. to 7 :30 a.m., the program was supposed to be staffed with two paraprofessionals and one licensed practical nurse or trained medication aide. Information showed that at the time of the incident, two paraprofessionals and one trained medication aide (TMA/P3) were working. The TMA was considered a "nurse" when referred to by P1 and P2.) All staff persons were awake during the overnight hours.

Facility information showed that on March 2, 2023, the VA was admitted to the facility from a hospital. The facility's *Critical Incident Report* stated that on March 17, 2023, just prior to 4 a.m., a staff person (determined to be P1) heard a call for help from a second-floor hallway. P1 found the VA on the floor in front of his/her room. The VA complained of shortness of breath and requested oxygen. There were no obvious injuries and the VA denied hitting his/her head. P1 notified P3 who immediately responded to the area and called 9-1-1. The VA was administered his/her inhaler and an ambulance arrived at approximately 4:25 a.m. The VA was able to get on a stretcher and was transported to a local hospital. That same morning the facility was notified that the VA passed away at 7:04 a.m.

A tour of the facility was used to determine the distance between the VA's room and a desk where staff persons were located at the time of the incident. It took this investigator approximately 15 seconds to walk the distance at a normal pace. The VA's room was not visible from the desk as it was around a corner and almost to the end of the hallway.

According to a *Coroner's Case Note*:

- In mid-February 2023, the VA was hospitalized for depression and suicidal ideation. The VA was discharged directly to the facility.
- On March 2, 2023, the VA was admitted to the facility. Prior to the VA's admission, s/he was prescribed Eliquis (used to prevent blood clots). While at the facility, the VA was also prescribed ibuprofen "which is contraindicated to take with Eliquis." The VA started taking ibuprofen on March 7, 2023, and took a total of five doses during his/her stay at the facility.
- On March 14, 2023, the VA started suboxone for his/her chronic back pain. That same day, the VA

complained of abdominal pain, vomited several times, and was given Zofran to help with the nausea/vomiting. Later that evening, around 8 p.m. the VA said that s/he was feeling better. However, around 9 p.m., the VA reported feeling dizzy and lightheaded and a check of his/her oxygen showed it was at 85%. The VA sat down for a few minutes and his/her oxygen came back up to 93%. No other issues were reported the night.

- On March 15, 2023, the VA's pain medication was changed to Subutex (buprenorphine) to see if s/he tolerated that better than suboxone. The VA received Subutex 1 milligram (mg) at supper time and another 1 mg dose later in the evening. There was no further documentation regarding whether it was helpful for the VA's back pain or whether s/he had any further complaints of nausea or vomiting.
- On March 17, 2023, around 1:30 a.m., the VA was vomiting and complained of "significant" abdominal pain. The VA complained of stomach cramping and his/her "stomach was very distended." The VA asked a roommate to get a "nurse;" however, a TMA (trained medication aide, determined to be P3) came and obtained vital signs and noted the VA's abdomen was "very distended and [s/he] was in pain." [P3] asked the VA about his/her last bowel movement but did not document the answer. "There was no documentation that any licensed nurse or medical staff person came to evaluate [the VA], nor that [s/he] was offered to be sent to the ER [emergency room] to be evaluated for [his/her] significant symptoms." The VA's blood pressure was 129/73, oxygen was 96%, pulse was 67, and temperature was 97.2 degrees Fahrenheit.

At 2:34 a.m., the VA was administered ondansetron 4 mg (for nausea and vomiting).

At 4 a.m., an unidentified staff person (determined to be P1) heard the VA call for help. The VA was on the floor and complained of shortness of breath and requested oxygen; however, the facility did not have oxygen on site. Albuterol, one of the VA's prescribed medications, was available; however, it was not offered despite the VA's congestive obstructive pulmonary disease/asthma diagnosis. There were no apparent injuries from the VA's fall, and s/he denied hitting his/her head. An unidentified staff person (determined to be P3) called 9-1-1 and an ambulance arrived at 4:25 a.m. With assistance, the VA stood and got onto a stretcher. The VA was short of breath so emergency medical staff (EMS) gave "rescue albuterol inhaler" and left for the hospital at 4:30 a.m.

At the hospital, the VA was administered Narcan. The VA had copious amounts of brownish emesis and his/her stomach was "very tight." The VA was unresponsive and in cardiac arrest shortly after 5 a.m. and s/he was intubated and cardiopulmonary resuscitation was able to return the VA to spontaneous vitals, but then after another 45 minutes vitals were lost again. Attempts to return the VA's vital signs were not successful and the time of the VA's death was 7:04 a.m.

- The VA's preliminary cause of death was:
  1. Atherosclerotic and hypertensive cardiovascular disease (plaque build-up in the arteries) with abdominal aorta severe atherosclerosis (a common cause of abdominal aortic aneurysms) and coronary artery atherosclerosis (plaque buildup that narrows the arteries).
  2. Distal segment of rectum with ischemic/necrotic changes (degenerative condition from lack of blood

flow) and perforation with ascites (a condition where fluid collects in spaces in the abdomen causing abdominal pain, swelling, nausea and vomiting) and fecal matter in the abdomen.

The FM provided information that was the same or similar to the *Coroner's Case Note* and further stated that s/he saw the VA shortly after his/her death and observed the VA's "stomach was so distended [s/he] looked nine months pregnant." The FM described the VA as "small" and "thin" and "for this to be ignored was shocking."

P1, P2, P3, the HCP, and/or facility documentation provided the following information:

- An evaluation on March 7, 2023, stated there was a conversation with the VA about the use of suboxone; however, that was held off at the time "due to constipation issues." The VA was advised to increase fluid intake and continue Senna as prescribed, and Colace as needed for constipation. In addition, the VA's *Medication Administration Record (MAR)* showed that fiber/psyllium was prescribed four times per day for constipation beginning March 9, 2023.
- P1 and P2 each stated they worked overnight hours and did not have a lot of contact with the VA prior to the overnight on March 16, 2023.
- The facility's *Rounds Sheet* showed that observation of all residents was conducted hourly and their whereabouts were documented. On the evening of March 16, 2023, between 4 and 11 p.m., hourly checks showed that the VA was observed on the phone, awake in bed, at the front desk, active in his/her room, and/or in a community recreation room.
- P2 conducted hourly rounds at midnight, 1, 2, and 3 a.m. Documentation on the *Rounds Sheet* showed that at midnight the VA was awake in his/her bed. At 1 a.m. P2 documented an "N" for the VA (the code on the bottom of the sheet identified that as being with a nurse). At 2 a.m. the VA was awake in his/her bed. P2 believed around that time P3 mentioned that the VA was not feeling good and had eaten "bad Mexican food or something" the previous evening. At 3 a.m., an "N" was again documented. P2 recalled only one conversation that night with the VA about his/her roommate (R) moving to another room. Each time P2 checked on the VA, the VA was on his/her side facing "away" so P2 did not see the VA's stomach. The VA did not complain of pain when P2 did any of the hourly checks.
- P1 started work at 10 p.m. on March 16, 2023, and heard "in passing" that the VA ate some Mexican food prior to P1's arrival. P1 was aware that night that the VA was not feeling well, previously complained about stomach issues possibly related to constipation, and had a recent medication change. P1 believed that around 1 a.m. (on March 17, 2023) the R requested to move to another room because the VA was "sick," and the R was not able to sleep.

P1 recalled seeing P3 in the VA's room two times when P1 passed by the VA's room prior to 4 a.m. P1 started hourly rounds at 4 a.m. and at approximately that same time, P1 responded to the VA's call from the hallway for assistance. The VA was on his/her back "laying calmly on the floor" with a hand on his/her stomach. P1 observed that the VA's stomach was "bloated" and "very distended;" however, since P1 did not have daily contact with the VA, s/he did not have "good knowledge" of what the VA's stomach looked like "on a normal day." P1 felt the VA's stomach and it "felt firm." P3 arrived at the area and an ambulance was called. When the EMS arrived, one walked on each side of the VA as the VA got on a

gurney with the VA "holding [his/her] own weight."

- P3 began his/her shift on March 16, 2023, at 10 p.m. and the VA was in his/her room when P3 arrived. P3 said that s/he was considered "part of the nursing team."

Around 1:30 a.m., the R went to P3's office and said that the VA was "moaning and groaning and asking for nursing." P3 went to the VA's room and took his/her vitals. The VA was "actively vomiting" and said s/he ate Mexican food that s/he had delivered earlier. The VA's stomach was a "little bloated" and s/he said s/he had to "poop;" however, when s/he sat on the toilet, his/her feet went numb because the toilet was low to the ground. Although s/he did not document the conversation, P3 believed the VA told him/her that s/he had a bowel movement the previous day.

P3 was in and out of the VA's room from 1:30 until 2:45 a.m. During that time P3 brought the VA ondansetron/Zofran (for vomiting), a toilet riser, and talked with the VA. The VA sat up for a while and then laid down and "started getting comfortable" on his/her right side, facing a window (with his/her back towards the door).

At approximately 4 a.m., P1 told P3 that the VA was on the floor in the hallway outside of the VA's room. P3 went to the hallway and the VA said that s/he tried to go to the bathroom and was having trouble breathing; however, the VA was able to talk. P3 immediately called 9-1-1. While on the phone with 9-1-1, P3 was asked if the VA had asthma. (There was no information in the VA's hospital record or intake information that indicated that diagnosis. However, on March 8, 2023, the VA was prescribed Albuterol Sulfate, two puffs as needed. Documentation showed the inhaler was not needed, requested, or administered until the time of the incident on March 17, 2023.) P2 retrieved the VA's inhaler and two "breaths" were administered from the inhaler. P3 sat on the floor behind the VA and rubbed his/her back while waiting for the ambulance to arrive. When EMS arrived, the VA was able to answer questions and was then transported to the hospital.

- A facility HCP stated that resident bowel movements were not documented/tracked. On March 14, 2023, the VA was prescribed suboxone that caused nausea and vomiting. Ondansetron/Zofran was prescribed for the VA's vomiting and nausea that resulted in "some improvement." The suboxone was discontinued and the order was changed to Subutex.

The HCP saw the VA in the afternoon on March 16, 2023, and observed the VA "laughing and smiling," and appeared to "feel good" because s/he stopped vomiting. When asked what s/he observed about the VA's physical appearance, the HCP said that s/he saw "no difference" in the VA's abdomen that day compared to other days.

The HCP said that residents were sent to the hospital "whenever they request," when there is a change in vital signs, or when symptoms were not manageable.

The MD provided the following information:

- An inhaler was prescribed (March 8, 2023) to be used “as needed” for the VA’s “lung disease.”
- Prior to March 17, 2023, the VA was prescribed senna, Colace, and psyllium to prevent constipation. There was no information that the VA was not having regular bowel movements or that s/he reported to staff persons any concerns about constipation.
- The MD had no information regarding the March 17, 2023, incident until after the incident; however, there was a “low threshold” for sending residents to an emergency room.
- Prior to the overnight shift on March 16-17, 2023, the VA was “fine and engaged,” was “not in distress” and did “not look any different.” When P3 was aware that the VA complained about pain, P3 assessed the VA “right away,” talked to the VA, and felt s/he was stable because the VA was going to “try to get some sleep.”
- When asked about using the VA’s inhaler for shortness of breath, the MD did not believe an inhaler would help “unless [the VA] was wheezing.” The MD stated that “a more likely scenario” was that the VA had shortness of breath because s/he was in pain or if his/her abdomen was distended, the VA’s diaphragm may have been compressed.

The VA’s *Medication Administration Record (MAR)* and/or *Physician’s Orders* showed:

- On March 11, 13, 14, and 15, 2023, fiber/psyllium 400 mg was administered for constipation four times per day, and three times per day on March 10, 12 and 16, 2023.
- On March 5, 7, 8, 9, and 10, 2023, Senna 8.6 mg was administered for constipation “as needed” one time per day.
- On March 6, 7, 8, and 10, Milk of Magnesia was administered for constipation “as needed.”
- On March 7, 8, 11, 12, and 16, 2023, ibuprofen 600 mg was administered “as needed” one time per day.
- On March 13, 2023, suboxone was prescribed and first administered on March 14, 2023.
- On March 14, 2023, suboxone was discontinued in the evening. Subutex (1 mg twice per day) was ordered and first administered on March 15, 2023.

Prior to the VA’s admission to the facility, the VA was at a hospital. The VA’s hospital records showed blood pressure readings of 157/90 and 147/77, and stated the VA complained of back pain and ongoing constipation.

Information showed that staff persons were trained regarding the facility’s policies and procedures and the Reporting of Maltreatment of Vulnerable Adults Act.

**Conclusion:**

Information showed that on March 14, 2023, the VA was administered suboxone for chronic back pain. When the VA complained of abdominal pain and vomiting, Zofran was administered. Later that same evening, suboxone was discontinued and Subutex was prescribed and administered on March 15, 2023.

On March 16, 2023, the HCP saw the VA in the afternoon and said the VA was "laughing and smiling," and appeared to "feel good" because s/he stopped vomiting. The HCP said there was no difference in the VA's abdomen compared to other days. Hourly checks that evening documented that the VA was observed throughout the facility and engaged in various activities.

Although the VA exhibited nausea and vomiting prior to March 17, 2023, it was believed to be related to the administration of suboxone since the vomiting stopped when that was discontinued and replaced with Subutex. On March 17, 2023, vomiting started again at approximately 1:30 a.m. The VA told P3 that s/he ate Mexican food earlier and felt like s/he had to "poop." At 4 a.m., the VA called for assistance and P1 found the VA on the floor in the hallway outside of his/her room. P3 also went to the hallway and then immediately called 9-1-1. The VA was taken to an emergency room where cardiac arrest required resuscitation that was not successful the second time and the VA passed away.

The VA's preliminary cause of death was determined to be atherosclerotic and hypertensive cardiovascular disease and distal segment of rectum with ischemic/necrotic changes and perforation with ascites and fecal matter in the abdomen.

Given that the VA had multiple medications prescribed for ongoing constipation, that when s/he requested "nursing" on March 17, 2023, P3 spent over an hour with the VA, that P3 observed the VA's stomach was "a little bloated," and brought the VA a toilet riser, administered Zofran, and took the VA's vitals that were within a normal range, that at 4 a.m. when the VA was on the floor and had trouble breathing 9-1-1 was immediately called, and that it was unknown what effect if any sooner medical care would have had, there was not a preponderance of the evidence whether there was a failure to provide the VA with care that was reasonable and necessary to obtain or maintain the VA's health and safety.

It was not determined whether neglect occurred (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 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 which is not the result of an accident or therapeutic conduct).

**Action Taken by Facility:**

The facility completed a death report and provided copies to the Ombudsman's office as well as the Department of Human Services. The facility also completed an internal review and determined that policies and procedures were adequate and were followed and there was no additional training needed.

**Action Taken by Department of Human Services, Office of Inspector General:**

No further action taken.