Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL240324961M **Date Concluded:** December 3, 2024
Compliance #: HL240326582C

Name, Address, and County of Licensee Investigated:
EagleCrest
2955 Lincoln Dr. North
Roseville, MN 55113
Ramsey County

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

Evaluator's Name: Michele Larson, RN
Special Investigator

Finding: Substantiated, facility 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), unknown facility staff member, verbally abused the resident when they yelled and made an inappropriate comment to the resident.

In addition, the facility neglected the resident when they failed to provide toileting services according to the resident's care plan and failed to administer the resident's eye medications according to physician orders.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Facility staff failed to correctly administer the resident's prescribed glaucoma (increased pressure in the eye due to fluid build-up) eye drops and over-the-counter artificial tears for eye dryness by not waiting five minutes between administration of the two eye drops. As a result, the resident's eye pressures became

dangerously high. There was not a preponderance of evidence facility staff failed to provide the resident with toileting services according to her care planned needs.

The Minnesota Department of Health determined verbal abuse was not substantiated. It could not be determined there was an incident of verbal abuse toward the resident by facility staff.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The resident's family member was interviewed. The investigator contacted the resident's eye doctor. The investigation included review of the resident's facility record, eye clinic record, personnel files, staff schedules, and related facility policy and procedures. Also, the investigator observed staff interaction and cares with the resident.

The resident resided in an assisted living memory care unit. The resident's diagnoses included impaired cognition, glaucoma (chronic eye disease that can lead to poor vision or blindness), and macular degeneration (eye disease affects central vision.) The resident's service plan included assistance with personal cares, escorts, toileting, and medication administration. The resident was independent with transfers and mobility even though she was legally blind. The resident was able to follow simple commands and made herself understood. The resident used a four-wheeled walker for mobility.

The resident's medication administration record indicated the resident was prescribed Latanoprost (used to treat elevated eye pressure) one drop to both eyes every evening, and artificial tears one drop to both eyes three times per day. Staff were directed to wait five minutes in between administration of the eye drops. In addition, the record indicated five dates with red circles around staff initials for Latanoprost. A legend at the bottom of the page indicated red circles indicated the medication was either "declined or skipped" and directed staff to review a note for the reason. In the medication notes section, next to the corresponding date and time staff documented the Latanoprost was not available or, the Latanoprost medication was not supposed to be on Marigold Chickadee (another unit of the facility) indicating it was unclear if the resident received the Latanoprost. In addition, prior to the resident' eye appointment, there were five days staff administered the resident's prescribed Latanoprost and artificial tears one after the other without waiting five minutes between administration as prescribed by the resident's provider.

Review of the resident's eye provider's note indicated the resident's family member brought the resident to see her eye doctor after the resident complained of worsening vision. The visit note indicated the resident stated she could no longer read, write, or see people. The resident's family member stated one week earlier while looking at the resident's camera footage placed in the resident's room, the family member saw staff administer the resident's Latanoprost and artificial tears back-to-back with no wait time in between the two drops. Measurements at the appointment indicated the resident's eye pressures were dangerously high. The resident's provider prescribed an additional glaucoma eye drop (dorzolamide-timolol; one drop to both

eyes twice a day) to reduce her eye pressures. The provider discontinued the resident's artificial tears.

During an interview, the resident's eye doctor stated he normally does not see eye pressure spikes like the resident had unless the eye drops were not administered or administering different eye drops one right after the other without waiting five minutes in-between administration of the two eye drops. The eye doctor stated the resident could have lost her eyesight if her eye pressures remained at the dangerously high level they were measured at during the resident's appointment. The resident's eye doctor stated it was unlikely the resident's eye pressures would spike that high if she missed one dose or if her eye drops were incorrectly instilled one time stating, "It was more likely multiple times within a few weeks."

During an interview, the administrative nurse stated a red circle around staff initials meant the resident's Latanoprost was either declined, not administered, or administered by a "different person," stating "If it shows up on my screen that I'm supposed to give a medication and somebody else gives it then I would document declined because I did not give the medication." The administrative nurse stated staff who actually administered the resident's Latanoprost should be the one who documented if it was administered or not. The administrative nurse stated floor nurses were supposed to perform weekly audits on staff's medication documentation and follow-up with any issues regarding their documentation. The administrative nurse stated it was easy to determine whether oral medications were administered because oral medications were popped out of bubble packs, but stated it was difficult to know with eye drop administration, stating "With eye drops you really don't know if it was given."

During an interview, the resident's family member indicated at the time of the occurrence she talked to an on-duty nurse when she saw on video staff administering the resident's eye drops with no break between administration of the two eye drops. The resident's family member indicated the on-duty nurse confirmed staff were to wait five minutes between administration of the two different eye drops. The family member stated she became concerned and took the resident to the eye doctor when the resident said her vision worsened.

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

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.

"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.

Abuse: Minnesota Statutes section 626.5572, subdivision 2.
"Abuse" means: …
(b) Conduct which is not an accident or therapeutic conduct as defined in this section, which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to, the following:
(1) hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult;
(2) use of repeated or malicious oral, written, or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
No action taken by the facility

Action taken by the Minnesota Department of Health:
The responsible party will be notified of their right to appeal the maltreatment finding.

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

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

cc:
The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities
Ramsey County Attorney
Roseville City Attorney
Roseville Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24032	A. BUILDING: _____ B. WING _____	C 10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLECREST	2955 LINCOLN DRIVE ROSEVILLE, MN 55113

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL240326582C/#HL240324961M On October 11, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 115 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL240326582C/#HL240324961M, tag identification 1760 and 2360.	0 000	Assisted Living Provider 144G. Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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01760	Continued From page 1	01760		
01760 SS=G	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medications were administered as prescribed for one of one residents (R1) with records reviewed. Licensee staff incorrectly administered R1's prescribed glaucoma (increased fluid pressure in the eyes) eye drops and over-the-counter dry eye tears causing R1's eye pressures to dangerously increase, with the potential of R1 losing her eyesight. In addition, the licensee failed to develop a medication documentation system that accurately reflected who administered medications or if medications were actually administered. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was	01760		

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01760	Continued From page 2 issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: According to a Cleveland Clinic online article, high intraocular pressure (IOP) can cause loss of vision if left untreated. Cleveland Clinic. (2022, December 19). Ocular Hypertension. http://www.my.clevelandclinic.org. R1's medical record was reviewed. R1 was admitted to the licensee's facility on October 17, 2022. R1's diagnoses included but were not limited to glaucoma (group of eye diseases that damage the nerve in the back of the eye), macular degeneration (eye damage to the retinal nerve), and impaired cognition. R1's care plan dated May 16, 2024, indicated R1 required assistance personal cares, medication administration, meals, and toileting. R1 used a four-wheeled walker for mobility. R1's assessment dated May 16, 2024, indicated R1 required assistance with all routes of medication administration including eye drops. Facility nurses were responsible for weekly review and management of R1's medications. R1 was independent with transfers and walking even though she was legally blind. R1 was able to follow simple commands and make herself understood. R1's individual abuse prevention plan (IAPP) dated May 16, 2024, indicated R1 was at risk to being abused due to her advanced age, and multiple diagnoses.	01760		

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01760	Continued From page 3 R1's medication administration record (MAR) dated July 2024, indicated R1 was prescribed the following eye drops: Latanoprost (prescription used to treat glaucoma and elevated eye pressures) one drop to both eyes every evening, and artificial tears (used for dry eyes) one drop to both eyes three times per day. Staff were directed to wait five minutes in between administration of the eye drops. Review of R1's eye provider's note dated July 17, 2024, indicated R1 was seen by R1's eye medical doctor (MD)-E after R1 complained of worsening vision. MD-E's note indicated R1 stated she could no longer read, write, or see people. Family member (FM-A) stated one week earlier while looking at R1's camera footage, located in the resident's room, she saw staff administer R1's Latanoprost and artificial tears back-to-back with no wait time in between the two drops. Measurements of R1's eye pressure indicated the resident's eye pressures were dangerously high. MD-E prescribed an additional glaucoma eye drop (dorzolamide-timolol; one drop both eyes twice a day) to reduce her eye pressures. MD-E discontinued R1's artificial tears. Review of R1's July 2024 MAR indicated for Latanoprost there were five dates (July 3, 2024, July 5, 2024, July 7, 2024, July 8, 2024, and July 9, 2024) with red circles around staff initials. A legend at the bottom of the page indicated a red circle around staff initials indicated the medication was either "declined or skipped (see note)." In the medication summary notes section staff documented on those dates the Latanoprost was "unavailable" or, "Latanoprost-medication not supposed to be on Marigold Chickadee (another unit in the facility)," and "Latanoprost-medication	01760		

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01760	Continued From page 4 is not supposed to be on Marigold," making it unclear if the resident received her necessary Latanoprost. In addition, on July 6, 2024, July 10, 2024, July 13, 2024, July 14, 2024, and July 15, 2024, staff administered R1's prescribed Latanoprost and artificial tears one after the other without waiting five minutes between administration as prescribed by R1's provider. During an interview on October 11, 2024, at 12:30 p.m., FM-A stated she became concerned when R1 stated her vision worsened. FM-A stated she took R1 to see her eye medical doctor (MD)-E after she witnessed facility staff administer R1's Latanoprost and artificial tears one right after the other without waiting five minutes between administration of the two eye drops. FM-A stated MD-E was alarmed R1's intraocular pressure were extremely high in both eyes and prescribed R1 "heavy-duty" eye drops to reduce R1's high eye pressures but stated R1 developed a severe allergic reaction to the newly prescribed eye drops, stating R1's eyes swelled with a mattery discharge. In an email dated October 31, 2024, at 9:45 a.m., from FM-A to the Minnesota Department of Health investigator, FM-A indicated at the time of the occurrence she talked to an on-duty nurse when she saw on video staff administer R1's eye drops with no break between administration. FM-A indicated the on-duty nurse confirmed staff were to wait five minutes between administering the two eye drops. During an interview dated October 31, 2024, at 1:00 p.m., director of nursing (DON)-C stated she was unaware and did not recall being told about R1's eye drop incident.	01760		

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01760	Continued From page 5 During an interview on November 7, 2024, at 10:38 a.m., MD-E stated he normally did not see eye pressure spikes like R1 unless the eye drops were not administered or administering her eye drops one right after the other without waiting five minutes in-between administration of the two eye drops. MD-E stated R1 could have lost her eyesight if her intraocular pressure levels remained at the dangerously high levels he measured them at during the appointment. MD-E stated it was unlikely R1's eye pressures would spike that high if she only missed one dose or if her eye drops were incorrectly instilled one time stating, "It was more likely multiple times within a few weeks." During an interview on November 13, 2024, at 11:00 a.m., DON-C stated red circles around staff initials meant R1's Latanoprost was either declined, not administered, or administered by a "different person." DON-C stated, "If it shows up on my screen that I'm supposed to give a medication and somebody else gives it then I would document "declined" because I did not give the medication." DON-C agreed it was unclear if R1's eye drops were administered or who administered them based upon staff's medication documentation. DON-C stated facility nurses were supposed to complete weekly audits on staff medication documentation and follow-up with staff with any concerns about their documentation. DON-C stated it was easy to see if oral medications were administered because oral medications were popped out of bubble packs and initialed but stated it was difficult to know with eye drop administration stating, "With eye drops you really don't know if it was given." The licensee policy titled Assisted Living Medication Error, updated November 22, 2023,	01760		

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01760	Continued From page 6 indicated medication errors occurred when an administration of a medication was not in accordance with the prescriber's order. TIME PERIOD TO CORRECT: Seven (7) days.	01760		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		