*Protecting, Maintaining and Improving the Health of All Minnesotans*

# Office of Health Facility Complaints
# Investigative Public Report

**Maltreatment Report #:** HL20700043M
**Compliance #:** HL20700044C

**Date Concluded:** December 16, 2019

**Name, Address, and County of Licensee Investigated:**
Five Star Senior Living
400 Centre Street
Newton, MA 02458
Middlesex County

**Name, Address, and County of Housing with Services location:**
The Wellstead of Rogers
20600 S. Diamond Lake Rd.
Rogers, MN 55374
Hennepin County

**Facility Type: Home Care Provider**

**Investigator's Name:**
Amy Hyers, RN
Special Investigator

**Finding: Substantiated, individual responsibility**

**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: The alleged perpetrator (AP) neglected the client when she placed ear drops into the client's left eye. The client required medical intervention.

**Investigative Findings and Conclusion:**
Neglect was substantiated. The AP was responsible for the maltreatment. The AP did not follow the six rights of medication administration when she placed ear cleansing drops into the client's left eye. The client's left eye immediately became red, swollen, and painful. The client required emergency room treatment and antibiotics after the AP administered the ear drops to her left eye.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation also consisted of record review to include the client's record, the AP's employee file, facility incident reports, and facility policies and procedures.

The client was admitted to the facility for diagnoses that included dementia. She received comprehensive homecare services to include incontinence cares; transfer and mobility assistance with a mechanical lift device; grooming; bathing; dressing; assistance with a mechanical soft diet and thickened liquids; and medication management services according to a service plan. The client had an order to receive cleansing ear drops requiring three drops in both ears once daily, four days per month.

One day, the AP approached the client in a common area and tilted the client's head back to instill medicated drops into the client's left eye. Review of the facility's internal investigation notes indicated a visitor in the facility and a facility staff member witnessed the AP placing drops into the client's left eye, and the client immediately complained of pain. The AP stopped after placing the drops into the client's left eye, did not place any in her right eye, and charted having given ear drops to the client as ordered.

Review of an incident report indicated the client experienced redness and swelling to her left eye and expressed complaints of pain. The next day, a staff member reported the symptoms to a nurse. When the nurse reviewed the client's medication administration record (MAR), however, it only contained medicated drops intended for the ear. The nurse contacted poison control and was directed to send the client to the emergency room for treatment.

The client returned several hours later from the emergency room with new orders for antibiotic eye drops to be administered three times daily for three days.

Review of the AP's employee record indicated the AP was trained on medication administration, including eye drops and ear drops. The training included the six rights of medication administration. The facility suspended the AP during an internal investigation and required the AP to re-take the medication administration training prior to administering medications again.

During an interview, a staff member said she observed the AP approach the client in a common space, tip the client's head back, and administer a drop into her eye. The staff member reported the client said, "Ow! It hurts, it burns!" The AP ceased the drop delivery. The staff member said the AP stopped after only one eye, and the client's response. Later in the day as the client continued to complain about discomfort, the staff member asked another staff to check on the client.

During an interview, the nurse said she learned about the incident the day after it occurred. She said a visitor in the facility and a staff member both observed the AP place drop(s) into the client's left eye, and the client then complain of pain. The nurse called poison control and per their direction, the nurse sent the client to the emergency room for evaluation. The nurse believed the AP knew at the time something was wrong, but did not report it to the nurse. She stated, "She only gave it to one eye, yet went back and charted she gave it in the ears." The nurse said to make an error in the route of administration for a medication was not acceptable.

During an interview, the AP said that was a very busy day for her. She had not done anything like that before, and did not know how it happened. She affirmed she received the six rights of medication administration training, and believed she confirmed the route prior to administration. She said, "I really thought they were eye drops." The AP stated she was responsible for the medication delivery of the entire unit, and it was a busy time and busy day; some days were just harder. She stated, "It was an accident. I can't pretend I didn't do it." She said what happened scared her.

The client was deceased at the time of the investigation, and the client's family had no comments to add regarding the incident.

In conclusion, neglect was substantiated. The AP did not follow proper medication administration procedure when she placed cleansing ear drops into the client's left eye, which caused the client eye pain, emergency treatment, and antibiotic administration.

**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.

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

**Action taken by facility:**
The employee no longer worked at the facility. The facility re-educated all staff who passed medications.

**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 651-201-4890 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.

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H20700 | A. BUILDING: _____ B. WING _____ | C 11/27/2019 |

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| THE WELLSTEAD OF ROGERS | 20600 SOUTH DIAMOND LAKE ROAD ROGERS, MN 55374 |

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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>HOME CARE PROVIDER LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>On November 27, 2019, the Minnesota Department of Health initiated an investigation of complaint #HL20700043M / HL20700044C. At the time of the survey, there were 94 clients receiving services under the comprehensive license.<br><br>The following correction orders are issued for #HL20700043M / HL20700044C, tag identification 0325 and 0810. | 0 000 | The Minnesota Department of Health documents the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. Per Minnesota Statute § 144A.474, Subd. 8(c), the home care provider must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The home care provider is not required to submit a plan of correction for approval; please disregard the heading of the fourth column, which states "Provider's Plan of Correction."<br>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to Minn. Stat. § 144A.474, Subd. 11 (b). | |
| 0 325 SS=G | 144A.44, Subd. 1(14) Free From Maltreatment<br><br>Subdivision 1. Statement of rights. A person who receives home care services has these rights: (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all | 0 325 | | |

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| 0 325 | Continued From page 1<br><br>forms<br>of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure 1 of 1 clients (C1) reviewed was free from maltreatment when staff failed to provide proper medication management services necessary for C1 to maintain her health. C1 experienced pain and discomfort when ear drops where administered to her eyes in error. C1 required an emergency room visit.<br><br>This practice resulted in a level three violation (a violation that harmed a client'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 issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>C1 was admitted to the licensee on June 18, 2013, for diagnoses that included dementia. She received comprehensive homecare services that included incontinence cares; transfer and mobility assistance with a mechanical lift device; grooming; bathing; dressing; assistance with a mechanical soft diet and thickened liquids; and medication management services according to a service plan.<br><br>Document review of C1's July 2019 medication | 0 325 | | |

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| 0 325 | Continued From page 2<br><br>administration record (MAR) included the following order: Murine Ear Solution 6.5%. Instill 3 drops in both ears one time a day starting on the 11th and ending on the 14th every month for ear wax. The medication order was dated June 6, 2019. The MAR depicted the electronic signature of unlicensed perfonnel (ULP)-E on July 13, 2019 for "PM1" signature slot.<br><br>Document review of a form titled, Incident Report Form, dated July 14, 2019, at 12:00 p.m. indicated C1 experienced redness and swelling to her left eye and expressed complaints of pain. The description of the incident indicated ULP-E was witnessed giving C1 eye drops to her left eye. However, review of C1's MAR indicated C1 was only prescribed medicated drops intended for the ear. The form indicated the medication was given via the incorrect route on July 13, 2019 at 2:21 p.m. The form further indicated the registered nurse (RN)-C contacted poison control and was directed to send C1 to the emergency room for treatment.<br><br>Document review of C1's progress notes dated July 14, 2019, at 12:00 p.m. indicated a staff member reported to RN-C that C1's left eye was red, swollen, and painful. The note further indicated a visitor and an activity staff member witnessed ULP-E administering C1 a drop in her left eye. According to the progress notes, "[C1] immediately complained of pain in left eye." Ear drops were signed off as given, not eye drops. The noted also indicated RN-C consulted poison control, notified the family and primary care provider, and sent C1 to the hospital per poison control recommendation.<br><br>A note dated July 14, 2019, at 3:42 p.m. indicated C1 returned from the hospital with a new order for | 0 325 | | |

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| 0 325 | Continued From page 3<br><br>antibiotic eye drops to be administered three times daily for three days. At that time, C1 denied discomfort but stated her vision was still a little blurry.<br><br>Document review of an orientation checklist indicated ULP-E was trained to medication administration, including eye drops and ear drops on February 19, 2019.<br><br>Document review of a medication assistance and administration knowledge assessment dated February 8, 2019, included a question checking ULP-E's knowledge of the six rights of medication administration.<br><br>Document review of a form titled, Notification of Investigatory Suspension, dated July 15, 2019, indicated ULP-E was suspended pending internal investigation results. The form indicated ULP-E was observed by a visitor and staff member administering (ear) drops into C1's left eye.<br><br>During an interview on November 27, 2019, at 12:05 p.m., activity aide (AA)-A stated she observed ULP-E approach C1 in a common space, tip C1's head back, and administer a drop into C1's eye. AA-A said C1 said, "Ow, it hurts, it burns". ULP-E ceased the drop delivery. AA-A said ULP-E stopped after only one eye and C1's response. Later in the day as C1 continued to complain about discomfort, AA-A asked another ULP to check on C1.<br><br>During an interview on December 6, 2019 at 12:01 p.m., RN-C said she learned about the incident the day after it occurred. She said a visitor in the facility and a staff member both observed ULP-E place drop(s) into C1's eye, and C1 complained of left eye pain. RN-C called | 0 325 | | |

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| 0 325 | Continued From page 4<br><br>poison control and per their direction sent C1 to the emergency room for evaluation. RN-C believed ULP-E knew at the time something was wrong, but did not report it to RN-C. She stated, "She only gave it to one eye, yet went back and charted she gave it in the ears." RN-C said to make an error in the route of administration for a medication was not acceptable.<br><br>During an interview on December 9, 2019, at 9:28 a.m., ULP-E said that was a very busy day for her. She said she had not done anything like that before, and did not know how it happened. She affirmed she was taught the six rights of medication administration and believed she confirmed the route prior to administration. She said, "I really thought they were eye drops." She stated she was responsible for the medication delivery of the entire unit, and it was a busy time and busy day; some days are just harder. She stated, "It was an accident. I can't pretend I didn't do it." She said what happened scared her.<br><br>Document review of a policy titled, Abuse, Neglect, and Exploitation Prohibition and Prevention Program, last revised on September 1, 2019 indicated, neglect is the failure of the community, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Neglect may be intentional or unintentional.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) Days | 0 325 | | |
| 0 810 SS=D | 144A.479, Subd. 6(b) Individual Abuse Prevention Plan | 0 810 | | |

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| 0 810 | Continued From page 5<br><br>(b) Each home care provider must develop and implement an individual abuse prevention plan for each vulnerable minor or adult for whom home care services are provided by a home care provider. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults or minors; the person's risk of abusing other vulnerable adults or minors; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults or minors. For purposes of the abuse prevention plan, the term abuse includes self-abuse.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview, and record review, the licensee failed to ensure an individual abuse prevention plan was complete for 1 of 1 clients (C1) reviewed to include statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.<br><br>This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The Findings include: | 0 810 | | |

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| 0 810 | Continued From page 6<br><br>C1 was admitted to the licensee on June 18, 2013, for diagnoses that included dementia. She received comprehensive homecare services that included incontinence cares; transfer and mobility assistance with a mechanical lift device; grooming; bathing; dressing; assistance with a mechanical soft diet and thickened liquids; and medication management services according to a service plan.<br><br>Document review of an assessment of C1 dated March 28, 2019, indicated C1 had some cognitive impairments as evidenced by mild confusion and memory loss. C1 would not be able to vocalize whether or not eye drops were a part of her medication regimen.<br><br>Document review of C1's vulnerability assessment indicated C1 had vulnerabilities of orientation, inaccurate information, and mental health. There were no interventions listed to help prevent maltreatment associated with these vulnerabilities.<br><br>During an interview on November 27, 2019 at 11:49 a.m., registered nurse (RN)-B stated she was unsure why no interventions were documented. She said there should be.<br><br>Document review of a policy titled, Resident Assessment and Re-Assessment Process, dated April 1, 2019, indicated as assessment is performed by a registered nurse...within five days of the initiation of comprehensive health services. The assessment includes client vulnerability. There was no policy directly related to individual abuse prevention plans. | 0 810 | | |

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| 0 810 | Continued From page 7<br>TIME PERIOD FOR CORRECTION: Twenty-One (21) Days | 0 810 | | |