DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL336133584M
Compliance #: HL336135926C

Date Concluded: February 16, 2023

Name, Address, and County of Licensee Investigated:
The Sanctuary at St. Cloud
2410 20th Avenue Southeast
St. Cloud, MN 56304
Sherburne County

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

Evaluator's Name: Jill Hagen, RN, Special Investigator

Finding: Substantiated, facility 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.

Initial Investigation Allegation(s):
The alleged perpetrator (AP), a facility staff, neglected a resident when the AP administered superglue into both of the residents' eyes instead of eye drops. The resident required treatment at a hospital.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The facility was aware the AP required additional training regarding medication administration and proper identification of medication labels. However, facility staff failed to ensure the AP was trained and competent to administer medications. The AP was scheduled independently to administer resident medications and dispensed superglue into the resident's eyes instead of eye drops.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigation included review of the resident's medical record,

hospital record, AP's personnel file and training, facility policy and procedures for medication administration and vulnerable adult, and photographs of both the superglue and eye drop bottles.

The resident resided in an assisted living memory care unit. The resident's diagnoses included diabetes, anxiety, and previous cataract surgery. The resident's service plan included staff assistance with medication administration including eye drop administration. The resident was able to make her needs known to staff.

The resident's provider order included Refresh Optive Gel eye drops, one drop to both eyes four times a day for dry eye.

The facility incident report indicated one morning the AP reported she administered superglue to each of the resident's eyes instead of the ordered eye drops. Initially, the resident's eyes were "stuck closed", and the resident had complaints of burning and stinging to both eyes. The nurse used a warm cloth to open the resident's eyes and administered Refresh eye drops to remove the chemical. The eye drop container was located on the kitchen table in a black mess bag with the superglue also on the table but clearly marked superglue. The containers were approximately the same shape and size. The nurse arranged for an evaluation of the resident at a local hospital.

The resident's hospital record indicated the resident had red eyes with mild burning and irritation. The resident was administered numbing eye drops which provided relief and the redness gradually improved. The resident discharged back to the facility the same day with provider orders for an antibiotic eye drop, warm compresses to the eyes for comfort, and a follow-up appointment with an eye doctor.

Review of the pictures taken of the superglue and Refresh eye drop containers indicated both bottles were similar in size however, the superglue had a bright red cap with a yellow label that said, "superglue." The Refresh eye drop container was aqua blue and clearly labeled Refresh Optive Gel drops.

The AP's personnel filed indicated the new employee competency training occurred approximately two weeks before the incident. The AP's training record indicated the AP required further training and competency checking for medication administration. The record indicated the AP needed to slow down, follow the seven rights of medication administration including the right time, right amount, right resident, right medication, right route, right dose, and checking expiration dates of the medication. In addition, the AP required additional training on following the specific instructions included on every resident's medication administration record for specific medication. The training document indicated nurse leadership needed to plan and monitor the AP on-site for educational experience for skills marked as failed/incomplete and deem the AP competent in areas of concern prior to the first assignment.

The facility failed to provide evidence of additional training to the AP until after the AP dispensed superglue into the resident's eyes.

During interview, the nurse stated the cooperate office staff completed all training for new employees including medication administration and communicate any concerns to the facility through an email. Facility staff missed the message from the cooperate office directing the facility provide the AP additional medication administration training, The nurse stated the AP received three days of orientation with a mentor dispensing medication to residents. The first day the AP independently dispensed medication to residents was the day of the incident. The nurse stated the first time the facility became aware of the AP's need for continued training for medication administration was following the incident during a review of the AP's training record. The nurse stated the AP immediately notified the nurse of the error and the nurse quickly responded and provided for the resident's needs.

During an interview, the AP stated she just completed medication administration training and had worked with a staff one time on each floor before being assigned to work alone. The AP stated she asked the resident the location of the eye drops and was told the drops were on the resident's table. The AP picked up the bottle of superglue and dispensed the glue into the resident's eyes without checking the label on the container. The AP stated the initial medication administration training completed by the facility was inadequate. The AP stated the second medication administration training provided by the facility to the AP following the incident, was more complete. The AP stated she learned to slow down when administering medications, read all labels, and ask for clarification of the nursing staff with any concerns with medication administration.

During an interview, the resident stated the morning of the incident was the first time the AP gave her medications and eye drops without another staff present and the resident told the AP to slow down. The resident stated after the superglue was put in the resident's eyes they were glued shut. The resident preferred the AP no longer provide care for the resident and stated she felt safe living at the facility.

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.

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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
Following the incident, the facility updated communication between the cooperate office and facility regarding employee education. An email and voicemail along with an attached training sheet for each employee is delivered to pertinent staff including the director of nursing services and the executive director. The facility provided training to the AP including the rights of medication administration and provided additional one to one staff mentoring to the AP for medication administration. The facility recommended the resident and the resident’s family change the storage of the eye drops from the resident’s room to a locked medication cart, however; the resident and family declined the recommendation.

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
Sherburne County Attorney
St. Cloud City Attorney
St. Cloud Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33613	A. BUILDING: ___ B. WING ___	C 02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SANCTUARY AT ST CLOUD	2410 20TH AVENUE SE SAINT CLOUD, MN 56304

(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 LICENSING 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: #HL336135926C/#HL336133584M On February 1, 2023, the Minnesota Department of Health initiated a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 105 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL336135926C/#HL336133584M, tag identification 2360.	0 000	Minnesota Department of Health is documenting the State Licensing 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.	
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical,	02360		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Minnesota Department of Health

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02360	Continued From page 1 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 1 of 1 residents 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. No plan of correction is required for this tag.	02360	No Plan of Correction (PoC) required. Please refer to the public maltreatment report (report sent separately) for details of this tag.	