Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:
Copperfield Hill – The Lodge
4020 Lakeland Avenue North
Robbinsdale, Minnesota 55422
Hennepin County

Report #: HL20297049

Date: September 27, 2013

Date of Visit: August 21, 2013
Time of Visit: 10:00 a.m. – 2:00 p.m.

By: Lisa Jacobsen, R.N., Special Investigator

Type of Facility: ☐ Nursing Home ☐ HHA ☒ Home Care Provider/Assisted Living
☐ SLF ☐ ICF/IID ☐ Home Care
☐ Hospital ☐ Other: _____

☒ Facility Self Report ☐ Complaint

Allegation(s): **It is alleged** that neglect occurred when a client was not adequately assessed prior to readmission from a detox center and once admitted his safety was not properly monitored. The facility was aware of his history of suicide ideations and that he was scheduled to be transferred in two days to an inpatient 30 day treatment center, yet he was able to obtain narcotics and alcohol sufficient to commit suicide.

An unannounced visit was made at this facility and an investigation was conducted under:

☐ Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
☐ Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
☐ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
☐ Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
☐ Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
☐ Federal Regulations for EMTALA (42 CFR Part 489)
☐ State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)

☐ State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
☐ State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
☑ State Licensing Rules for Home Care (MN Rules Chapter 4668)
☐ State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
☑ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
☑ State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☐ Abuse ☑ Neglect ☐ Financial Exploitation was:

◉ Substantiated ○ Not Substantiated ○ Inconclusive based on the following information:

Based on a preponderance of evidence neglect is substantiated when the facility failed to provide supervision to the client with a known history of suicidal ideation when he was drinking alcohol. The client died from committing suicide from a drug overdose.

The client had diagnoses of schizophrenia, depressive disorder, alcohol abuse and a history of two suicide attempts with drug overdoses. The client was alert and oriented and able to make his needs known and received assistance with medication administration, reminders to go to meals and housekeeping and laundry services.

Approximately one month after the client was admitted to the facility, the client was dropped off at the hospital by a friend due to auditory hallucinations that told the client to kill her/himself. The client was placed on a 72 hour hold and was admitted. Hospital records indicated the client had a plan to kill her/himself by an intentional medication overdose and the client stated that when s/he drank alcohol, it was harder for her/him to deal with her/his auditory hallucinations that told the client to kill her/himself. Eight days later, the client was discharged back to the facility. Behavioral discharge planning instructions indicated symptoms to report were "increased difficulties thinking, mood getting worse, increased voices, thoughts to harm yourself, thoughts to harm others, urges to use alcohol."

Approximately three weeks after returning to the facility, the client was admitted to the hospital and again placed on a 72 hour hold due to intoxication and suicidal thoughts. Five days after admission to the hospital, the client was discharged back to the facility. The discharge summary indicated the plan was for the client to return to her/his alcohol day treatment program.

Five days after returning to the facility, the client was admitted to detox from the emergency room. Two days after admission to detox, the client was discharged back to the facility. Detox Center discharge instructions indicated the client was to attend AA (alcoholic anonymous) meetings and to "stay sober".

Prior to each of the client's hospital admissions, staff did not know where the client was. Staff called the case manager, various hospitals etc., to check to see if the client was admitted somewhere.
The day the client was discharged back to the facility from detox, a discussion was held with the client about

transferring to an inpatient treatment program for alcohol abuse and the client's case manager would work on placement into a program.

Two days after discharge from detox, a meeting was held with the client and administrative staff to discuss a behavior contract that outlined the following: The client would not smoke in her/his apartment; The client would sign in and out when s/he left the facility; The client would not engage in any drinking or possessing alcohol at the facility and the client would consistently pay a realistic sum of money on a payment plan to cover her/his debt at the facility. The contract indicated that if the client did not follow any of these items that s/he would be given a 30 day eviction notice.

Two days after the meeting, staff attempted to wake the client up to give the client her/his evening medications and the client could not be woken up. Police and emergency personnel were summoned and the client was pronounced dead at the facility after rescue attempts were made.

The Medical Examiner's report indicated the Manner of Death as a "Suicide." The immediate cause of death was, "Mixed drug toxicity (methadone, ethanol, hydromorphone, diazepam and citalopram)." It could not be determined where the client obtained the narcotic medications, methadone and hydromorphone or the diazepam. The client took the antidepressant citalopram on a daily basis.

The licensee's "Daily Assignment" sheets which were used by the unlicensed staff on a daily basis to direct staff as to the care needs of the clients, did not include any information for staff to be aware that the client had a history of suicide attempts and that when the client became intoxicated from alcohol, the client had increased suicidal thoughts.

Staff interviews revealed they were unaware that the client had a history of previous suicide attempts and were unaware that when the client became intoxicated from alcohol, that the client's suicidal thoughts increased. Staff indicated they were not aware of any special precautions or plan for monitoring the client's suicidal tendencies.

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ individual(s) and/or ☒ facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility is responsible for the neglect. Licensed nursing staff were aware of the client's history of suicide attempts and suicidal tendencies when drinking alcohol, but had not relayed this information to the unlicensed staff caring for the client. In addition, the facility had not developed a plan for monitoring and supervision of the client when s/he was drinking.

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.

Compliance:

State Licensing Rules for Home Care (MN Rules Chapter 4668) – Compliance Met
The facility was found to be in compliance with State Licensing Rules for Home Care (MN Rules Chapter 4668). No state licensing orders were issued.

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557). No state licensing orders were issued.

State Statutes Chapters 144 & 144A – Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☒ Yes ☐ No If no, specify: _____
(State licensing orders will be available on the MDH website.)

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated
"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect
"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.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

☒ Medical Records	☐ Care Guide
☒ Medication Administration Records	☒ Treatment Sheets
☒ Facility Incident Reports	☒ Physician Progress Notes
☒ ADL (Activities of Daily Living) Flow Sheets	☒ Laboratory and X-ray Reports
☒ Physician Orders	☐ Social Service Notes
☒ Nurses Notes	☐ Meal Intake Records
☐ Activities Reports	☐ Weight Records
☐ Therapy and/or Ancillary Services Records	☒ Assessments
☐ Skin Assessments	☒ Care Plan Records

Other pertinent medical records:

☒ Hospital Records ☒ Ambulance/Paramedics ☒ Medical Examiner Records ☒ Death Certificate

☒ Police Report

Additional facility records:

☐ Resident/Family Council Minutes ☐ Personnel Records/Background Check, etc.

☒ Staff Time Sheets, Schedules, etc. ☒ Facility In-service Records

☒ Facility Internal Investigation Reports ☒ Facility Policies and Procedures

☐ Call Light Audits ☐ Other, specify: _____

Number of additional resident(s) reviewed: 0

Were residents selected based on the allegation(s)? ○ Yes ○ No ◉ N/A Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

○ Yes ◉ No ○ N/A Specify: The client is deceased.

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s): ○ Yes ○ No ◉ N/A Specify: Facility Self-report

If unable to contact complainant, attempts were made on:
Date/time: _____ Date/time: _____ Date/time: _____

Interview with family: ◉ Yes ○ No ○ N/A Specify: _____

Did you interview the resident(s) identified in allegation: ○ Yes ◉ No ○ N/A Specify: The client is deceased.

Did you interview additional residents: ○ Yes ◉ No

Total number of resident interviews: 0

Interview with staff: ◉ Yes ○ No ○ N/A Specify: _____

Tennessen Warning given as required: ◉ Yes ○ No

Total number of staff interviews: _____

Physician interviewed: ○ Yes ◉ No

Nurse Practitioner interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: No alleged perpetrator

Attempts to contact: Date/time: _____ Date/time: _____ Date/time: _____

If unable to contact was subpoena issued: ○ Yes , date subpoena was issued _____ ○ No

Were contacts made with any of the following:
☐ Emergency personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☐ Wound Care	☐ Medication Pass	☐ Meals
☐ Personal Care	☐ Dignity/Privacy Issues	☐ Restorative Care
☐ Nursing Services	☐ Safety Issues	☒ Facility Tour
☐ Infection Control	☐ Cleanliness	☐ Injury
☐ Use of Equipment	☐ Transfers	☐ Incontinence
☐ Call Light	☐ Other: _____	

Was any involved equipment inspected: ○ Yes ○ No ◉ N/A

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A

Were photographs taken: ○ Yes ◉ No Specify: _____

xc: Division of Compliance Monitoring - Licensing & Certification
Minnesota Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Medical Examiners
Robbinsdale City Police Department
Hennepin County Attorney
Robbinsdale City Attorney

PRINTED: 11/01/2013
FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H20297	A. BUILDING: _____ B. WING _____	C 09/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COPPERFIELD HILL PHASE II	4020 LAKELAND AVENUE NORTH ROBBINSDALE, MN 55422

(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 A complaint investigation was initiated to investigate case #HL20297049. The following correction order is issued. When corrections are completed please sign and date, make a copy of the form for your records and return the original to the MN Department of Health, Division of Compliance Monitoring, Office of Health Facility Complaints; 85 East Seventh Place, Suite 220, P.O. Box 64970, St. Paul, Minnesota 55164-0970.	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/Rules for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute/Rule number and the corresponding text of the state Statute/Rule 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 surveyors ' 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/RULES.	
0 030	144A.44 Subd.1(2) Up-to-date Plan/Accepted Standards Practice Subdivision 1. Statement of rights. A person who receives home care services has these rights: (2) the right to receive care and services	0 030		

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0 030	Continued From page 1 according to a suitable and up-to-date plan, and subject to accepted medical or nursing standards, to take an active part in creating and changing the plan and evaluating care and services; This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to provide care and services according to an up to date plan for one of one client (C1) reviewed. The findings included: The licensee failed to develop a plan for supervision of C1 who had a known history of suicidal ideation when s/he was intoxicated from alcohol. C1's record was reviewed. C1 was admitted to receive services from the licensee on April 11, 2013. C1's physician's order sheet dated April 12, 2013 indicated the client had schizophrenia, depressive disorder, alcohol abuse and a history of two suicide attempts with drug overdoses, with the most recent being in July of 2012. C1's service plan dated April 15, 2013 indicated C1 received assistance with medication administration two times a day, reminders to go to the dining room three times a day and housekeeping and laundry services. Hospital records were reviewed. Hospital notes indicated that on May 6, 2013 C1 was dropped off at the hospital by a friend due to auditory hallucinations telling the C1 to kill her/himself. C1	0 030		

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0 030	Continued From page 2 was placed on a 72 hour hold and was admitted. Hospital notes indicated C1 had a plan to kill her/himself by an intentional medication overdose. Hospital notes also indicated that C1 admitted that when s/he drank alcohol, it was harder for her/him to deal with her/his auditory hallucinations that told the client to kill her/himself .C1 was admitted to the hospital and was discharged back to the care of the licensee on May 14, 2013. Behavioral discharge planning instructions dated May 14, 2013 indicated symptoms to report were "increased difficulties thinking, mood getting worse, increased voices, thoughts to harm yourself, thoughts to harm others, urges to use alcohol." Hospital records revealed on June 7, 2013, C1 was admitted to the hospital and placed on a 72 hour hold due to intoxication and suicidal thoughts. C1 was discharged back to the care of the licensee on June 12, 2013. The discharge summary indicated the plan was for C1 to return to her/his alcohol day treatment program. Detox Center records were reviewed and indicated that on June 17, 2013, C1 was admitted to detox from the emergency room. C1 was discharged back to the care of the licensee on June 19, 2013. Detox Center discharge instructions dated June 19, 2013 indicated C1 was to attend AA (alcoholic anonymous) meetings and to stay sober. The licensee's progress notes indicated prior to each of the hospital admissions; May 6, 2013, June 7, 2013 and June 17, 2013, staff did not know where C1 was. Staff called the case manager, various hospitals etc., to check to see if C1 was admitted somewhere.	0 030		

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0 030	Continued From page 3 The licensee's "Resident Notes" dated June 19, 2013 indicated a discussion was held with C1 about transferring to an inpatient treatment program for alcohol abuse and that C1's case manager would work on placement into a program. The licensee's "Resident Notes" dated June 21, 2013, indicated a meeting was held with C1 and administrative staff to discuss a behavior contract that outlined the following: C1 would not smoke in her/his apartment; C1 would sign in and out when s/he left the facility; C1 would not engage in any drinking or possessing alcohol at the facility and C1 would consistently pay a realistic sum of money on a payment plan to cover her/his debt at the facility. The contract indicated that if C1 did not follow any of these items that s/he would be given a 30 day eviction notice. The licensee's "Resident Notes" dated June 23, 2013 indicated staff attempted to wake C1 up to give C1 her/his evening medications and C1 could not be woken up. Police and emergency personnel were summoned and C1 was pronounced dead at the facility after rescue attempts were made. The Medical Examiner's report dated August 7, 2013 indicated the Manner of Death as a "Suicide." The immediate cause of death was, "Mixed drug toxicity (methadone, ethanol, hydromorphone, diazepam and citalopram)." It could not be determined where the C1 obtained the narcotic medications, methadone and hydromorphone or the diazepam. C1 took the antidepressant citalopram on a daily basis. The licensee's "Daily Assignment" sheets which were used by the unlicensed staff on a daily basis	0 030		

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0 030	Continued From page 4 to direct staff as to the care needs of the clients, indicated that staff were to monitor C1's behavior for any signs of alcohol use and drug use and report it to the nurse immediately In addition, the "Daily Assignment" sheet indicated that if C1 was unable to be located at meal time or medication administration time, that staff were to notify nursing, because C1 had a history of leaving community without signing out. There was no information on the "Daily Assignment" sheets related to special precautions or to be aware that C1 had a history of suicide attempts and that when C1 became intoxicated from alcohol, C1 had increased suicidal thoughts. When interviewed September 9 2013 at 3:10 p.m., Employee G/unlicensed staff indicated s/he was aware of C1's alcohol abuse, but was not aware that C1 had a history of suicidal thoughts and suicide attempts. Employee G stated the only precaution s/he was aware of was to report to the nurse if C1 was not around at scheduled meal times/medication times. When interviewed September 9, 2013 at 2:10 p.m., Employee F/unlicensed staff indicated s/he was not aware of any special precautions when taking care of C1. Employee F stated s/he was not aware C1 had a history of alcohol abuse or suicidal thoughts. When interviewed September 10, 2013 at 7:35 a.m., Employee H/unlicensed staff indicated s/he was not aware of any special precautions related to C1's substance abuse or suicide thoughts. Employee H stated s/he was not aware the C1 had a history of suicidal thoughts. When interviewed September 6, 2013, at 10:00 a.m., Employee D/unlicensed staff indicated s/he	0 030		

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0 030	Continued From page 5 was not aware that C1 had a history of suicidal thoughts or that these thoughts increased when C1 became intoxicated. When interviewed September 9, 2013 at 9:15 a.m., Registered Nurse (RN)/E indicated that prior to C1 returning from his hospitalizations, s/he would talk with the staff at the hospital to see how he was doing. RN/E stated that upon discharge, there was always a plan for C1 to attend AA (alcoholic anonymous) meetings and/or chemical dependency day treatment etc. TIME PERIOD FOR CORRECTION: Thirty (30) days	0 030		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Post Correction Order Follow-Up
PUBLIC DATA

Facility:
Copperfield Hill Phase II
4020 Lakeland Avenue North
Robbinsdale, MN 55422
Hennepin County

Report #: HL20297049

Date: January 15, 2014

Date of Visit: January 14, 2014
Time of Visit: 9:30 a.m.

By: Jolene Bertelsen/Lisa Jacobsen, R.N.
Special Investigator

Nature of Visit
An unannounced visit was made in order to follow-up one state licensing order which were issued on November 1, 2013, as the result of an investigation which had been completed on September 27, 2013.

The status of the order is as follow:
1 144A.44 Subd.1(2) - Corrected

xc: Minnesota Department of Health – Licensing and Certification

AH Form Approved
1/21/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
H20297	A. Building B. Wing	1/14/2014

Name of Facility	Street Address, City, State, Zip Code
COPPERFIELD HILL PHASE II	4020 LAKELAND AVENUE NORTH ROBBINSDALE, MN 55422

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix 00030 Reg. # 144A.44 Subd.1(2) LSC	Correction Completed 01/14/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By KL/AK	Date: 01/21/2014	Signature of Surveyor: 03002	Date: 01/14/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 7/30/2013			Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES NO