Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints
Investigative Public Report

Maltreatment Report #: HL32193002M
Compliance #: HL32193001C

Date Concluded: February 18, 2021

Name, Address, and County of Licensee Investigated:
Mercy Housing
7601 10th Avenue South
Richfield, MN 55423
Hennepin County

Name, Address, and County of Housing with Services location:
Mercy Home Health LLC
3055 Old Highway 8, Suite 101H
St. Anthony, MN 55418
Hennepin County

Facility Type: Home Care Provider

Investigator's Name: Jill Hagen, 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) failed to provide adequate supervision to the client when the AP left the client unsupervised with a knife. The client stabbed herself in the chest and later died at a hospital.

Investigative Findings and Conclusion:
Neglect was substantiated. The alleged perpetrator was responsible for the maltreatment. The client's assessment directed staff to supervise the client with sharp objects and lock all sharp objects when not in use due to the client's suicidal ideations. The AP used the bathroom leaving the client unsupervised in the dining room with a knife on the kitchen countertop. During that time, the client stabbed herself in the left chest below the clavicle, lacerating or causing a deep cut to her heart. The client died the same day at the hospital.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. In addition, the investigator contacted law enforcement. The investigation included a review of the client's medical record, hospital record, ambulance

report, the licensee's policies and procedures regarding client safety and maltreatment, staff training, and the AP's personnel file.

The client's medical record indicated the client had diagnoses including Asperger's syndrome, or a neuro-development disorder causing significant difficulty with social interactions and non-verbal communication, major depression, epilepsy or seizures, panic attacks, and borderline personality disorders. The client had a history of suicidal ideation, physical, and verbal aggression towards others. The client communicated her needs to others. The client's service plan directed staff to assist the client with meal preparation, shopping, arranging transportation, laundry, housekeeping, and medication administration.

The client's vulnerabilities included a risk for self-harm with a history of suicidal ideation. The client verbalized four plans for self-harm; using a knife to stab herself in the heart, being hit by a car, stabbing herself with scissors, or taking an overdose of medications. The plan directed staff to lock up sharp objects including knives.

Review of the facility's internal investigation indicated one morning the client was threatening self-harm but staff were able to calm her. Later that day at the evening meal, the client sat at the dining room table while the AP was using a knife to cut up an onion. The AP left the kitchen to go to the bathroom and left the client unsupervised with the knife on the countertop. The AP returned to the kitchen after approximately one minute and found the client lying face down on the floor. Initially, the AP thought the client had a seizure, but when the AP attempted to turn the client on her back, the AP saw blood on the floor. Emergency medical personnel arrived and transported the client to a hospital.

Review of the client's hospital medical record indicated approximately 35 minutes after arrival to the hospital the client died despite resuscitative measures. The client stabbed herself below the left clavicle, or collar bone, and lacerated her heart using a six-inch serrated knife.

When interviewed, the AP stated she was aware sharp objects had to be locked to keep the client safe. When preparing the meal, the AP took a knife from the locked cupboard to cut an onion. During the preparation, the AP needed to use the bathroom. The AP told the client she would be right back and went to the bathroom. The AP left the knife on the countertop. After about one minute the AP returned and found the client face down on the floor. The AP heard the client make a "snoring" type sound and thought the client was seizing. When the AP attempted to turn the client on her side or back, she saw blood in the client's hair and the knife in the client's chest below the collar bone. At that time, the client had a pulse with "snoring" respirations. The AP called 911. The AP stated prior to leaving the client unsupervised, the knife should have been locked in the cupboard.

When interviewed, management stated the knife should be locked when not in use. Staff training included keeping the client safe by locking all sharp objects.

In conclusion, neglect was substantiated.

“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:
(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:
Management educated staff about client safety and locking all sharp objects when clients not supervised. Management educated staff on suicide and site safety.

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
Hennepin County Attorney
Richfield City Attorney

Richfield Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H32193	A. BUILDING: _____ B. WING _____	C 01/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERCY HOME HEALTH LLC	3055 OLD HWY 8 ST ANTHONY, MN 55418

(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****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, the Minnesota Department of Health issued a correction order(s) pursuant to a 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: On January 21, 2021, the Minnesota Department of Health initiated an investigation of complaint #HL32193002C/#HL32193001M. At the time of the investigation, there was one client receiving services under the comprehensive license. The following correction orders are issued for #HL32193002C/#HL32193001M, tag identification 0265, 0325, 0805, and 2015.	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 investigators ' 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 licensing order follow-ups. 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." 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).	
0 265 SS=J	144A.44, Subd. 1(a)(2) Up-To-Date Plan/Accepted Standards Practice	0 265		

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0 265	Continued From page 1 Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (2) receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards and person-centered care, to take an active part in developing, modifying, and evaluating the plan and services; This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to provide services according to accepted medical, nursing, and health care practices when facility staff failed to implement a suicide safety plan for one of one client (C1) reviewed with a history of suicidal ideation. Staff failed to implement C1's suicide safety plan and left C1 unattended with a knife. C1 stabbed herself in the chest and died from a laceration to the heart. This practice resulted in a level four violation (a violation that results in 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). Findings include: Review of C1's medical record indicated C1's diagnoses included Asperger's syndrome, a neurodevelopment disorder characterized by significant difficulty in social interactions and	0 265		

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0 265	Continued From page 2 nonverbal communication, major depression, epilepsy or seizures, anxiety with panic attacks, and borderline personality disorder. The licensee admitted C1 on September 1, 2020. C1 was her own guardian. Review of C1's service plan dated September 3, 2020, indicated C1 required staff assistance with meal preparation, shopping, arranging transportation, laundry, housekeeping, and medication administration. Review of C1's Vulnerability Assessment/Abuse Prevention Plan dated September 3, 2020, indicated C1's vulnerabilities included a risk for self-harm with a history of suicidal ideation. The assessment directed staff to monitor C1 for concerns of self-abuse. Review of C1's Safety Plan for Suicidal Ideation dated December 12, 2020, indicated the rational for developing the suicidal plan included C1's intense suicidal ideation. The plan indicated C1 expressed numerous intruding thoughts of self-harm with four distinct plans which included: C1 planned to use a knife to stab herself in the heart; stab herself with scissors; run in front of a car; or take an overdose of over-the-counter sleep medications. Staff interventions included locking up sharp objects. C1's progress noted dated January 5, 2021, at 2:00 p.m. indicated C1 told staff she was having repeated suicidal thoughts with a plan of running out in front of a car. Staff redirected C1 and contacted C1's psychiatrist and arranged a call with the suicide hotline. C1's progress note dated January 5, 2021, indicated C1's psychiatrist requested staff to have	0 265		

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0 265	Continued From page 3 C1 transported to a hospital for a safety evaluation. C1 refused to be seen at that time. C1's progress note dated January 6, 2021, at 4:00 p.m. indicated C1 complained of anxiety and requested to be transported to the hospital. At 8:46 a.m., the ambulance transported C1 to the hospital. C1's progress note dated January 8, 2021, at 5:30 p.m. indicated C1 returned to the licensee's residence from the hospital. C1's progress note dated January 9, 2021. at 8:00 a.m. indicated C1 continued to request returning to the hospital but stated, "They don't help me there." Staff told C1 she was safe and loved. C1 went to bed. C1's progress note dated January 10, 2021, at 10:00 p.m. indicated when staff prepared C1's breakfast, C1 threatened to harm herself using her earrings. Staff redirected C1. After breakfast, C1 left with family to attend church. Upon return to the house, C1 appeared happy and excited. Later, C1 requested to contact the suicide hotline. Staff requested C1 have her evening meal prior to the calling the suicide hotline. C1 sat at the dining room table while staff used a knife to cut up an onion. Staff left the kitchen to use the restroom leaving the knife on the kitchen counter. When staff returned, C1 was face down on the kitchen floor. Staff attempted to turn C1 on her side and observed the knife and blood on the floor. Staff called 911. At that time, staff determined C1 was breathing with a pulse. The ambulance transported C1 to the hospital. Review of C1's hospital medical record dated January 10, 2021, at 6:24 p.m., indicated C1	0 265		

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0 265	Continued From page 4 arrived with a self-inflicted stab wound to the left upper chest. C1 required cardiac-pulmonary resuscitation (CPR) and intubation, or a tube into the lungs to breath. Despite multiple units of blood, resuscitation medications, a thoracotomy, (a surgery to open the chest), and attempted surgical repair of her internal injuries, C1 had no cardiac or heart activity throughout the case. C1 died approximately 35 minutes after arrival to the hospital. C1 had a left chest/clavicle puncture wound from a six-inch serrated kitchen knife causing a not survivable cardiac laceration. C1's diagnoses included a laceration of the heart with penetration into the cardiac chamber. Review of the licensee's incident report dated January 10, 2021, at 5:58 p.m. indicated C1 stabbed herself with a knife left on the kitchen counter by staff. When interviewed on February 1, 2021, at 10:32 a.m., registered nurse (RN)-A stated late August 2020, C1's case manager contacted the licensee to locate housing for C1. Initially upon admission C1 was verbally and physically abusive to staff. As time went by, C1 verbalized more suicidal ideation. RN-A stated staff should have secured the knife in a locked drawer. Review of the licensee's policy and procedure titled Clean and Safe Environment dated January 2014, stated, Ways staff can prevent injuries and accidents to tenants...know your limits...and be always alert to tenant's safety...Be alert for sharp objects and remove if indicated. Review of the licensee's policy and procedure titled Acceptance of Clients dated May 17, 2020 stated, our company shall only accept a client if it has staff, sufficient in qualifications, competency,	0 265		

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0 265	Continued From page 5 and numbers, to adequately provide the services agreed to in the Service Plan with each client and within the scope of our Comprehensive License. TIME PERIOD FOR CORRECTION: Two (2) days.	0 265		
0 325	144A.44, Subd. 1(a)(14) Free From Maltreatment Subdivision 1.Statement of rights. (a) A client who receives home care services in the community or in an assisted living facility licensed under chapter 144G has these rights: (14) be free from physical and verbal abuse, neglect, financial exploitation, and all forms of maltreatment covered under the Vulnerable Adults Act and the Maltreatment of Minors Act; This MN Requirement is not met as evidenced by: Based on interviews, and document review, the facility failed to ensure one of one clients reviewed (C1) was free from maltreatment. C1 was neglected. Findings include: On February 19, 2021, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that an individual staff person was responsible for the maltreatment, in connection with incidents which occurred at the facility. The MDH concluded there was a preponderance of evidence that maltreatment occurred.	0 325		

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0 805	Continued From page 6	0 805		
0 805 SS=F	144A.479, Subd. 6(a) Reporting Maltrx of Vulnerable Adults/Minors Subd. 6.Reporting maltreatment of vulnerable adults and minors. (a) All home care providers must comply with requirements for the reporting of maltreatment of minors in section 626.556 and the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. Each home care provider must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment for one of one (C1) record reviewed. Staff left C1 unsupervised with a knife contrary to her safety plan. C1 stabbed herself in the chest lacerating her heart and died. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients). Findings include: Review of C1's Safety Plan for Suicidal Ideation dated December 12, 2020, indicated the rational for developing the suicidal plan included C1's intense suicidal ideation. The plan indicated C1	0 805		

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0 805	Continued From page 7 expressed numerous intruding thoughts of self-harm with four distinct plans. C1 planned to use a knife to stab herself in the heart, stab herself with scissors, run in front of a car, or take an overdose of over-the-counter sleep medications. Staff interventions included locking up sharp objects. Review of the licensee's Internal Review dated January 10, 2021, at 5:56 p.m. indicated under the type of incident requiring review was the death of a person (C1) while receiving services, not reported as maltreatment. The summary of the incident indicated while eating supper, unlicensed professional (ULP)-B cut up an onion with a knife. ULP-B left the kitchen with the knife on the countertop while going to the bathroom. When ULP-B returned to the kitchen, ULP-B found C1 face down on the floor, making a "snoring" type sound. ULP-B attempted to turn C1 but noticed blood and the knife in C1's chest. C1 stabbed herself below the collar bone using the knife left in the kitchen by ULP-B. The review indicated ULP-B made an unintentional mistake when ULP-B left C1 unsupervised with a knife when she went to the bathroom. When interviewed on February 1, 2021, at 10:32 a.m., registered nurse (RN)-A stated unlicensed personal (ULP)-B unintentionally left the knife on the counter and they should have secured it in a locked drawer. Review of the licensee's policy and procedure titled Maltreatment of Vulnerable Adults Mandated Reporting not dated, indicated with suspicion or knowledge of maltreatment of a vulnerable adult, staff must report immediately (within 24 hours) to the Minnesota Adult Abuse Reporting Center (MAARC).	0 805		

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0 805	Continued From page 8 Review of the licensee's policy and procedure titled Vulnerable Adults and Maltreatment-Communication, Prevention, and Reporting dated May 17, 2020, indicated the licensee defined maltreatment as neglect, abuse, and exploitation /theft. The licensee educated staff to report suspected maltreatment internally and to the Minnesota Adult Abuse Reporting Center (MAARC). The policy defined neglect as the absence or likelihood of absence of care or services, including but not limited to supervision necessary to maintain the physical and mental health of the vulnerable adult (VA) which a reasonable person would deem essential to obtain or maintain the VA's health, safety, or comfort considering the physical or mental capacity or dysfunction of the VA. TIME PERIOD FOR CORRECTION: Two (2) days.	0 805		
02015 SS=F	626.557, Subd. 3 Timing of Report Subd. 3.Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to	02015		

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02015	Continued From page 9 believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.	02015		

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02015	Continued From page 10 This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to report suspected maltreatment to the Minnesota Adult Abuse Reporting Agency (MAARC) for 1 of 1 client (C1) reviewed. Staff left C1 unsupervised with a knife, contrary to her safety plan. C1 stabbed herself in the chest lacerating her heart and died. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients). Findings include: Review of C1's Safety Plan for Suicidal Ideation dated December 12, 2020, indicated the rational for developing the suicidal plan included C1's intense suicidal ideation. The plan indicated C1 expressed numerous intruding thoughts of self-harm with four distinct plans. C1 planned to use a knife to stab herself in the heart, stab herself with scissors, run in front of a car, or take an overdose of over-the-counter sleep medications. Staff interventions included locking up sharp objects. Review of the licensee's Internal Review dated January 10, 2021, at 5:56 p.m. indicated under the type of incident requiring review was the death of a person (C1) while receiving services,	02015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H32193	A. BUILDING: _____ B. WING _____	C 01/21/2021

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02015	Continued From page 11 not reported as maltreatment. The summary of the incident indicated while eating supper, unlicensed professional (ULP)-B cut up an onion with a knife. ULP-B left the kitchen with the knife on the countertop while going to the bathroom. When ULP-B returned to the kitchen, ULP-B found C1 face down on the floor, making a "snoring" type sound. ULP-B attempted to turn C1 but noticed blood and the knife in C1's chest. C1 stabbed herself below the collar bone using the knife left in the kitchen by ULP-B. The review indicated ULP-B made an unintentional mistake when ULP-B left C1 unsupervised with a knife when she went to the bathroom. When interviewed on February 1, 2021, at 10:32 a.m., registered nurse (RN)-A stated unlicensed personal (ULP)-B unintentionally left the knife on the counter and they should have secured it in a locked drawer. Review of the licensee's policy and procedure titled Maltreatment of Vulnerable Adults Mandated Reporting not dated, indicated with suspicion or knowledge of maltreatment of a vulnerable adult, staff must report immediately (within 24 hours) to the Minnesota Adult Abuse Reporting Center (MAARC). Review of the licensee's policy and procedure titled Vulnerable Adults and Maltreatment-Communication, Prevention, and Reporting dated May 17, 2020, indicated the licensee defined maltreatment as neglect, abuse, and exploitation /theft. The licensee educated staff to report suspected maltreatment internally and to the Minnesota Adult Abuse Reporting Center (MAARC). The policy defined neglect as the absence or likelihood of absence of care or services, including but not limited to supervision	02015		

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02015	Continued From page 12 necessary to maintain the physical and mental health of the vulnerable adult (VA) which a reasonable person would deem essential to obtain or maintain the VA's health, safety, or comfort considering the physical or mental capacity or dysfunction of the VA. TIME PERIOD FOR CORRECTION: Two (2) days.	02015		