Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL361164022M
Compliance #: HL361167809C

Date Concluded: August 6, 2025

Name, Address, and County of Licensee Investigated:
Merrcy Care Home LLC
1609 Edgewood Ave. South
St. Louis Park, MN 55426
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Brooke Anderson, RN
Special Investigator

Finding: Inconclusive

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 facility neglected the resident when the resident was found deceased in his room from an apparent drug overdose.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was inconclusive. Although the resident's service plan was not followed, it was unable to be determined if the resident's death was a direct result of staff's failure to implement the service plan. The resident requested to sleep-in because he stayed up late and facility management was aware and approved of the resident's request. Due to conflicting information and documentation, it is unable to be determined if facility staff were aware the resident used drugs and had a prior drug overdose.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident records,

death record, facility internal investigation, facility incident reports, personnel files, staff schedules, law enforcement report, and related facility policy and procedures. Also, the investigator observed interactions between staff and residents.

The resident resided in an assisted living facility. The resident's diagnoses included type 1 diabetes and methamphetamine abuse. The resident's service plan included assistance with behavior management and safety checks to look for drug paraphernalia and to monitor for signs of drug use. The resident's assessment indicated the resident was cognitively intact.

The internal investigation indicated the morning of the incident the resident was last seen by facility staff #1 at 3:00 a.m. Facility staff member #1 did not conduct a scheduled safety check at 6:00 a.m. Facility staff #2 did not conduct a scheduled safety check at 9:00 a.m. At 11:15 a.m. facility staff #2 and #3 entered the resident's room and found him unresponsive. 911 and facility management were notified.

The police report indicated the resident was found crouched between his bed and dresser. Facility staff were instructed to lay the resident flat and perform CPR. When police entered the room, the resident was found with a lighter clutched in his right hand. Between the bed and dresser was a glass pipe and cell phone near a pool of blood. On the resident's dresser was a small container with a white substance and next to the container was a yellow straw. The police report indicated the resident had a history of daily methamphetamine use according to the resident's friend.

The death report indicated the resident died from fentanyl and methamphetamine toxicity.

During an interview, facility staff #1 stated he saw the resident at 3:00 a.m. when the resident took the dog outside. The resident told facility staff #1 he wanted to sleep and not to wake him up. A safety check was scheduled for 6:00 a.m. but that was not completed per the resident's request. Facility staff #1 stated all staff knew the resident didn't want to be bothered and wanted to sleep in that morning; however, the care plan did not indicate that.

During an interview, facility staff #2 stated the resident got mad when staff knocked on the door for safety checks. The concern was reported to facility management and facility management advised facility staff #2 to let the resident sleep until 11:00 a.m. and administer his medications at that time.

During an interview, facility staff #3 stated the resident's door was locked and after obtaining the key, facility staff #2 and #3 entered the resident's room and found him unresponsive. 911 and facility management were notified. Facility staff #3 stated he suspected the resident used drugs but was never told that by facility management.

During an interview, the facility nurse stated the resident's plan of care advised facility staff to check the resident's room for paraphernalia and observe the resident for drug use. The facility

nurse stated she was not aware facility management instructed staff to let the resident sleep in. After the incident, education was completed to staff regarding the importance of conducting safety checks.

During an interview, facility management indicated they were aware the resident used drugs and reported the drug use to the resident's medical providers and case manager.

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

Inconclusive: Minnesota Statutes, section 626.5572, Subdivision 11.
"Inconclusive" means there is less than a preponderance of evidence to show that maltreatment did or 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.

Vulnerable Adult interviewed: No. The resident was deceased.
Family/Responsible Party interviewed: No, attempts made were not successful.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
When the resident was found 911 was notified and attempts were made to resuscitate the resident.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36116	A. BUILDING: _____ B. WING _____	C 07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRCY CARE HOME LLC	1609 EDGEWOOD AVENUE SOUTH SAINT LOUIS PARK, MN 55426

(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 On July 1, 2025, the Minnesota Department of Health initiated an investigation of complaint ##HL361167809C /#HL361164022M. No correction orders are issued.	0 000		