Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL34304001M
Compliance #: HL34304002C

Date Concluded: May 3, 2021

Name, Address, and County of Licensee Investigated:
Paradise Care Homes LLC
2501 East 24th Street
Minneapolis, MN 55406
Hennepin County

Name, Address, and County of Housing with Services location:
Paradise Care Homes LLC
7709 Unity Avenue North
Brooklyn Park, MN 55443
Hennepin County

Facility Type: Home Care Provider

Investigator'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.

Allegation(s): It is alleged the client was neglected when facility staff failed to develop and implement a safety plan for the clients' unsafe behaviors. The client started a fire in his bedroom, refused to evacuate, and died in the fire.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The client had a history of high-risk behaviors including smoking inside the facility, overdosing with illegal drugs, and threatening staff with weapons. Although the facility was aware of the client's unsafe behaviors, the facility failed to assess, develop, and implement a plan to ensure the client's safety. The client started a fire in his bedroom, refused to leave, and died in the fire.

The investigation included interviews with facility staff members, including administrative and nursing staff. The clients medical record, the facility's investigation into the fire, facility policies and procedures, staff training and education, and prior incidents were reviewed. In addition, law enforcement and the state fire marshal were contacted.

The client had diagnoses including schizophrenia, polysubstance abuse, anoxic brain injury, and Brugada syndrome (a condition caused by a disruption of the heart's normal rhythm).
The client required staff assistance with medication administration, mental health and behavior interventions, meal preparation, cues and/or assistance with mobility and transfers, dressing, grooming, bathing, toileting, shopping, and transportation. The client ambulated independently but required a wheelchair when shaky and weak.

The client's medical record indicated staff determined the client was not susceptible to abuse by others including other vulnerable adults; not susceptible to abuse others, and self-abuse.

The facility documentation indicated the client lived at the facility for approximately two years. The client had a history of overdosing on illegal drugs, smoking inside the facility, threatening staff with words and weapons, and property damage. On multiple occasions in the previous seven months leading up to the incident, the client smoked cigarettes inside the facility behind his locked bedroom door. The client refused to unlock the door and smoke outside as staff would direct. The staff instructed the client he was putting himself, other clients, and staff at a safety risk due to the high risk of fire. Despite awareness of the client's high-risk behaviors, the staff failed to develop specific safety interventions to ensure the client, other clients, and staff safety. The client continued to smoke inside the house, take illegal drugs, threaten staff, and damage property inside the facility.

Review of the facility's investigation stated the client was alone in his room and staff smelled smoke. The smoke was coming from the locked client's room. The staff told the client to come out of his room and the client refused. Staff evacuated the other clients, left the house, and called 911. When the fire department arrived, they attempted to rescue the client from the fire; however, an explosion occurred preventing the client's evacuation. The client died in the fire.

The State Fire Marshal's report indicated the client was sitting on the edge of his bed with an approximate two-foot-high column of fire directly next to him. The client was conscious, made no attempt to leave his room, and refused assistance to leave. The origin of the fire included waxed paper, cellulose, a cigarette, and pipe lighter. The client's toxicology report was positive for methamphetamine.

When interviewed, facility management stated staff had a master key to the client's bedroom door but were afraid to use the key because of the client's yelling, swearing, and threats of harm. The client could leave the facility independently to purchase cigarettes, illegal drugs, and lighters. No safety plan was developed to ensure the client's safety.

The client's certificate of death indicated the immediate cause of death was thermal (heat) injuries with inhalation of combustion products from a residential fire. Other significant conditions included recent methamphetamine use. The manner of death could not be determined. The description of how the injury occurred stated the client was found deceased after a house fire under unclear circumstances.

In conclusion, 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:
(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: Not Applicable.

Action taken by facility:
One client moved into another of the licensee’s facility, and one client discharged from the facility.

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.

cc: The Office of Ombudsman for Mental Health and Developmental Disabilities
Hennepin County Attorney
City of Minneapolis Attorney
Minneapolis Police Department
State Fire Marshal

Hennepin County Medical Examiner

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H34304	A. BUILDING: _____ B. WING _____	C 04/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARADISE CARE HOMES LLC	7709 UNITY AVENUE NORTH BROOKLYN PARK, MN 55443

(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 correction orders pursuant to an 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 April 15, 2021 , the Minnesota Department of Health initiated an investigation of complaint #HL34304002C/#HL34304001M. At the time of the incident, there were three clients receiving services under the comprehensive license. The following correction orders are issued for #HL34304002C/#HL34304001M, tag identification 0265, 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 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=L	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 assess, develop, and implement safety plans for one of one client (C1) reviewed with a history of unsafe smoking and use of illegal drugs in the facility, refusing to evacuate during fire drills, threatening staff, and the use of weapons. C1 started a fire in his bedroom, refused evacuation from the facility, and died in the fire. In addition, the facility's lack of assessment, development, and implementation of a safety plan for C1, placed two of two clients, C2 and C3, at risk for harm when they were in the facility when the fire started and required staff assistance with evacuation. This practice resulted in a level four violation (a violation that results in serious injury, impairment, or death), and at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). Findings include:	0 265		

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0 265	Continued From page 2 A review of the licensee's floor plan for the facility indicated there was one bedroom on the main level with a bathroom, kitchen, dining, and living room. The upper level had a bathroom and four bedrooms. Two of the bedrooms were occupied. C1's record indicated his diagnoses including schizophrenia, polysubstance abuse, anoxic brain injury, and Brugada syndrome (condition that caused a disruption of the heart's normal rhythm). C1's most recent Vulnerability Assessment/Abuse Prevention Plan dated October 17, 2019, indicated C1 vulnerabilities included short-term memory loss, poor balance, requiring a wheelchair when shaking, and cigarette smoking. The safety interventions identified were to encourage smoking cessation if C1 was willing, and for C1 to remain safe while smoking. In addition, C1 had a history of cannabis (marijuana) use with interventions including C1 may not use alcohol, chemicals, and staff are to report any use of alcohol or chemicals promptly to the nurse. The assessment indicated C1 had no known vulnerabilities to abuse from other individuals including other vulnerable adults, no risk for abusing other vulnerable adults, and was not at risk for self-abuse. C1's Resident Agreement form dated October 25, 2019, was signed by C1 and indicated staff would write up or discharge any client who violated the agreement, or any other agreement made with the facility. Breaking any rules may result in an immediate notice to vacate the premises. The rules included: - No smoking inside bedrooms or inside the home.	0 265		

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0 265	Continued From page 3 - No illegal drugs/alcohol in or around the facility. Drinking in the room and house was not allowed and clients could lose housing with the company. - No swearing or cursing in the home. No sexual comments or behaviors. - Clients must request permission for visitors to go in their personal bedrooms. - No overnight stays of guests or extended stay of long hours during the day to protect the privacy and safety of other clients. C1's care plan dated October 28, 2019, indicated C1 required assistance with medication administration, mental health and behaviors, meal preparation, cues and/or assistance from staff with mobility and transfers, dressing, grooming, bathing, toileting, shopping, and transportation. During the night, C1 required staff safety checks every two hours, and staff were directed to physically observe C1. The facility Fire Drill Response form dated April 24, 2020 at 9:10 a.m. indicated, "Most of the clients locked their door during the drill and sometimes refused to come out...". A facility Incident Report dated April 25, 2020, at 11:00 a.m. stated C1 had a hammer and knocked multiple holes in the walls. Staff told C1 his behavior was not permitted, and a repeat offence would be grounds for immediate discharge. An Incident Report dated July 30, 2020, at 11:00 a.m. indicated staff went into C1's bedroom to check on him. Staff noticed a table in C1's room that belonged in the living room. When asked why C1 took the table, C1 began yelling at staff and grabbed a knife and threatened staff stating, "If you don't leave I will stab you." The only intervention on the report indicated staff	0 265		

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0 265	Continued From page 4 immediately left C1's bedroom, contacted C1's County Case Manager (CCM)-C, and a telephone meeting was scheduled with C1. Following the incident, staff failed to develop specific measures to keep the client, other clients, and staff safe. C1's progress note dated August 4, 2020, at 3:30 p.m. indicated C1 met with the CCM-C and the facility Licensed Social Worker (LSW)-A to discuss storing knifes in his bedroom and threatening staff with the knifes. Initially, C1 refused to give up the knifes but eventually agreed to have the CCM-C secure the knifes off-site until C1 discharged from the facility. C1's progress note dated August 4, 2020, indicated at 9:00 p.m. C1 went to his room to get ready for bed. At 9:45 p.m. another client told staff he was with C1 watching television and C1 was not responsive. Staff went in the room and C1 did not respond to staff. Staff called 911 and C1 was transported to a hospital by an ambulance. C1 was admitted to the hospital due to a drug overdose. C1's progress note indicated staff were unsure what kind of drug C1 overdosed on. C1's un-timed progress note dated August 5, 2020, indicated C1 returned from the hospital following an overdose of cocaine and methamphetamine. C1 discharged from the hospital with a prescription for Narcan, a medication to reverse the effects of an opioid overdose. Despite C1's known overdose, staff failed to developed safety measures to keep C1 safe. C1's un-timed progress note dated August 5, 2020, indicated after staff discussion, the client was issued a 30-day termination of services	0 265		

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0 265	Continued From page 5 letter. C1's un-timed Risk Agreement dated August 5, 2020, indicated C1 repeatedly ingested illegal substances, had weapons in his room, and smoked in his room. Staff informed C1 multiple times of a risk of fire. Possible consequences for C1's continued behavior included an overdose, and physical injury to C1, other clients, and staff due to a possible fire. The safety interventions included having C1 agree to follow all rules and regulations set forth prior to admission, refrain from drug use on the property, and no type of weapons. Follow-up for the evaluation was scheduled to be completed in 90 days to six months. There were no specific interventions developed to provide for the safety of C1, other clients, and staff. C1's un-timed progress note dated August 6, 2020, indicated C1 continued to smoke in his room. Staff informed C1 the behavior was not safe and requested C1 sit outside on the deck when smoking. C1 refused, locked his bedroom door, and refused to come out. A supervisor was notified. Staff failed to develop specific interventions to ensure the safety of C1, other clients, and staff. C1's un-timed progress note dated August 7, 2020, indicated C1 agreed to smoke outdoors, not in his bedroom. C1's un-timed progress note dated October 16, 2020, indicated staff found C1 with another client, C2, smoking downstairs in the facility. Staff told both C1 and C2 to smoke outside, but both clients refused. The LSW-A and C1 and C2 discussed safety concerns of smoking indoors including risk of a fire, and all the doors of the	0 265		

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0 265	Continued From page 6 house were locked with no outside air coming into the home. C1 and C2 agreed to smoke outdoors. Despite C1's continued refusal to smoke outdoors and place himself, the other clients, and staff at risk for a fire, the facility failed to develop specific measures to ensure everyone's safety. The facility's Fire Drill Response Form dated October 24, 2020, at 9:30 a.m. indicated, "We are still working with clients to unlock their doors." C1's un-timed progress note dated December 1, 2020, indicated C1 knocked holes in the kitchen wall to prove C1 could do anything he wanted and not be in trouble because he pays to live at the facility. C1's un-timed progress note dated January 25, 2021, indicated C1 woke in the morning and was aggressive. Around 10:00 a.m., staff noticed C1 opening the back door of the house to a male visitor. Staff told C1 he could not have a visitor at that time, but C1 took the visitor into his bedroom and locked the door. Staff contacted a supervisor who came to the house to talk to C1. C1 continued to refuse to unlock the bedroom door. When the supervisor tried to unlock C1's door the client yelled at the supervisor using inappropriate language. After approximately 30 minutes, C1 came out of the room alone and locked the door behind him leaving the unidentified male locked in his room. C1 refused to allow the supervisor to enter the room. C1 continued to swear at staff claiming he owned the house and could bring anyone into the house. Despite the safety risk for other clients and staff, staff failed to develop interventions to ensure the safety of C1 and the other clients living in the facility. A facility Incident Report dated February 11, 2021,	0 265		

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0 265	Continued From page 7 at 3:15 p.m. indicated a fire started in C1's room on the main level of the house. Initially smoke was coming out of C1's room and the smoke alarm went off. Staff called 911 and knocked on all the clients rooms to evacuate. C1 did not come out of his room and passed away. A second Incident Report dated February 11, 2021, at 3:30 p.m. indicated C1 started a fire in his bedroom. Staff smelled smoke and ran into the kitchen first to check for the cause. There was no fire and when staff went around the corner they saw smoke coming out of C1's room. Staff knocked on the door but C1 refused to open the door. Staff ran upstairs and evacuated C2 and C3. The fire department arrived but were not able to rescue C1 due to an explosion. The report identified the contributing factors to the fire as C1's impaired safety judgement, resistance to care, and a balance disorder. The facility's state form for reporting a vulnerable adult dated February 12, 2021 at 9:44 a.m. indicated the report was made due to C1's self-abuse. C1 was alone in his bedroom and staff smelled smoke coming from C1's room. The bedroom door was locked and staff requested C1 to come out of the room. C1 yelled at staff and refused to open the door. Staff ran upstairs and evacuated two other clients to safety. The fire department arrived and went into the house to rescue C1. An explosion occurred and the fire fighters were unable to get into C1's room. C1 passed away. Review of the State Fire Marshal Investigation Report, with a disposition date of April 19, 2021 at 1:26 p.m. indicated, C1 "was sitting on the side of his bed with an approximate two-foot-high column of fire directly next to him. Staff and another client	0 265		

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0 265	Continued From page 8 (C3) attempted to put the fire out with a gallon jug of water when (C1) told them to get out. (C1) was conscious at the time. (C1) did not attempt to get out himself and refused assistance." After the fire was extinguished, C1 was found on his bedroom floor face down. The origin of the fire was identified as a cigarette, paper that included cellulose, waxed paper, a cigarette lighter, and a pipe lighter. The report established C1's blood toxicology results were positive for methamphetamine. During interview on April 16, 2021, at 2:01 p.m. CCM-C stated she worked with C1 since 2017. Prior to C1 moving into the facility in 2019, the CCM-C told facility staff C1 had a history of drug abuse and disrespect for staff. It was common for C1 to swear and be out of control. C1 lost his housing at the previous provider due to an overdose of illegal drugs. The CCM-C stated she removed all but one knife from C1's bedroom. When interviewed on April 23, 2021, at 11:03 a.m. the LSW-A stated she was familiar with C1 and worked with C1 at another residence prior to his admission. C1 usually ambulated independently but also used a wheelchair when his legs were shaky and weak. C1 had a history of drug abuse and threatening others. Staff were afraid of C1 and several had left employment due to that fear. Facility staff had a master key to unlock C1's bedroom door, however staff didn't use the key due to their fear of C1. The LSW-A stated C1 was able to leave the facility independently and could meet other people to obtain lighters, cigarettes, and illegal drugs. After the fire was discovered in C1's room, staff and C3 begged him to leave the room but C1 refused. During interview on April 23, 2021, at 11:23 a.m.	0 265		

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0 265	Continued From page 9 Registered Nurse (RN)-B stated C1's most current abuse prevention plan was completed in 2019. The facility did not complete a smoking assessment to ensure the safety of C1 and other clients in the facility. RN-B stated staff were afraid when C1 let individuals in the back door of the residence. Staff told the RN after the fire that C1's bedroom door remained shut and locked and C1 refused to leave. The facility's policy and procedure titled Risk Agreement, dated July 1, 2020, indicated the facility would honor a client's right to have choices and make decision about his or her own lifestyle, wellness activities, and other issues. The facility would make reasonable effort to foresee and prevent avoidable harm to the client. The facility's policy and procedure titled Assessments with an effective date of August 15, 2020, indicated nurses shall conduct assessments, monitoring and reassessments consistent with the Comprehensive Home Care requirements and the individualized needs of each home care client. Review of the facilities Vulnerable Adult policy and procedure, not dated, indicated personnel are required to individually assess clients to determine vulnerability to abuse or neglect, and develop a specific plan to minimize the risk of abuse and neglect to the client. The home care employee has responsibility for the following: Assessment of the vulnerability status of each client upon admission and susceptibility to abuse including self-abuse. The abuse prevention plan will be evaluated at a minimum of every 90 days or more frequently as necessary. The documentation will include results of the implementation.	0 265		

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(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
0 265	Continued From page 10 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 three clients reviewed, client 1, was free from maltreatment. C1 was neglected. Findings include: On April 29, 2021, the Minnesota Department of Health (MDH) issued a determination that neglect occurred, and that the facility 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		
0 810 SS=F	144A.479, Subd. 6(b) Individual Abuse Prevention Plan (b) Each home care provider must develop and	0 810		

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	H34304	A. BUILDING: _____ B. WING _____	C 04/15/2021

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0 810	Continued From page 11 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults and self abuse; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults, for three of three clients, C1, C2, and C3, reviewed for safety. 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, but was not likely to cause serious injury, impairment, or death), and is 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:	0 810		

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0 810	Continued From page 12 C1's medical record indicated diagnoses including schizophrenia, polysubstance abuse, anoxic brain injury, and Brugada syndrome (condition that caused a disruption of the heart's normal rhythm). C1's most recent Vulnerability Assessment/Abuse Prevention Plan dated October 17, 2019, indicated C1 vulnerabilities included short-term memory loss, poor balance, required a wheelchair when shaking, and cigarette smoking. Staff were directed to encourage smoking cessation if C1 was willing, and for C1 to remain safe while smoking. In addition, C1 had a history of cannabis (marijuana) use. The plan directed staff not to allow C1 to use alcohol or other chemicals, and to report any use of alcohol or chemicals promptly to the nurse. The plan did not provide specific measures for staff to take to prevent C1's risk for self-abuse, the possibility of abuse from other individuals including other vulnerable adults, and risk for abusing other vulnerable adults. C1's care plan dated October 28, 2019, indicated C1 required assistance with medication administration, mental health and behavior management, meal preparation, cues and/or assistance from staff with mobility and transfers, dressing, grooming, bathing, toileting, shopping, and transportation. A facility Incident Report dated April 25, 2020, at 11:00 a.m. indicated C1 had a hammer and knocked multiple holes in the walls. Staff told C1 his behavior was not permitted, and a repeat offence would be grounds for immediate discharge.	0 810		

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0 810	Continued From page 13 An Incident Report dated July 30, 2020, at 11:00 a.m. indicated staff went into C1's bedroom to check on him. Staff noticed a table in C1's room that belonged in the living room. When asked why C1 took the table, C1 began yelling at staff, grabbed a knife, and threatened staff stating, "If you don't leave I will stab you." The only intervention on the report stated staff immediately left C1's bedroom, contacted C1's County Case Manager (CCN)-C, and a telephone meeting was scheduled with C1. Following the incident, staff failed to develop specific measures to keep the client, other clients, and staff safe. C1's progress note dated August 4, 2020, indicated at 9:00 p.m. C1 went to his room to get ready for bed. At 9:45 p.m. another client told staff he was with C1 watching television and C1 was not responsive. Staff went in the room and C1 did not respond to staff. Staff called 911 and C1 was transported to a hospital by an ambulance. C1 was admitted to the hospital for a drug overdose. The progress note indicated staff did not know what drug C1 took. C1's un-timed progress note dated August 5, 2020, indicated the client returned from the hospital following an overdose of cocaine and methamphetamine. C1 discharged from the hospital with a prescription for Narcan, a medication to reverse the effects of an opioid overdose. Despite C1's known overdose, staff failed to develop specific measures to keep C1 safe. C1's un-timed Risk Agreement dated August 5, 2020, indicated C1 repeatedly ingested illegal substances, had weapons in his room, and smoked in his room. Staff informed C1 multiple times of a risk of fire. Possible consequences for	0 810		

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0 810	Continued From page 14 C1's continued behavior included an overdose, physical injury to C1, other clients, and staff due to a possible fire. Staff interventions included C1 agreed to follow all rules and regulations set forth prior to admission, and refrain from drug use on the property, and not have any weapons. Follow-up for the evaluation was scheduled in 90 days to six months. There were no specific interventions developed to provide for the safety of C1 and other clients. C1's progress note dated August 6, 2020, indicated C1 continued to smoke in his room. Staff informed C1 the behavior was not safe and requested C1 sit outside on the deck when smoking. C1 refused, locked his bedroom door, and refused to come out. A supervisor was notified. Staff failed to develop specific interventions to ensure the safety of C1 and other clients. C1's progress note dated October 16, 2020, indicated staff found C1 and C2 smoking downstairs in the facility. Staff told C1 and C2 to go outside to smoke but both clients refused. The facility licensed social worker (LSW)-A told both C1 and C2 the safety concerns of smoking indoors, risk of a fire, and all the doors of the facility were locked with no outside air coming into the home. Eventually C1 and C2 agreed to smoke outdoors. Despite C1's continued refusal to smoke outdoors and place himself and other clients at risk for a fire, the facility failed to develop specific measures to ensure everyone's safety. C1's progress note dated December 1, 2020, indicated C1 stated he knocked holes in the kitchen wall to prove he could do anything he wanted and not be in trouble because he pays to	0 810		

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0 810	Continued From page 15 live at the house. C1's progress note dated January 25, 2021, indicated C1 woke in the morning and was aggressive. Around 10:00 a.m., staff noticed C1 opening the back door of the house to a male visitor. Staff told C1 he could not have a visitor at that time, but C1 took the visitor into his bedroom and locked the door. Staff contacted a supervisor who came to the house to talk to C1. C1 continued to refuse to unlock the bedroom door. When the supervisor tried to unlock the door, C1 yelled at the supervisor using inappropriate language. After approximately 30 minutes, C1 came out of the room alone and locked the door behind him leaving the unidentified male locked in his room. C1 refused to allow the supervisor to enter the room. C1 continued to swear at staff claiming he owned the house and could bring anyone into the house he wanted. Despite the safety risk for other clients, staff failed to develop interventions to ensure safety. A facility incident report dated February 11, 2021, at 3:30 p.m. indicated C1 started a fire in his bedroom. Staff smelled smoke and ran into the kitchen first to check for the cause. As staff walked out of the kitchen they saw smoke coming out of C1's room. Staff knocked on the door but C1 refused to open the door. Staff ran upstairs and evacuated C1 and C2. The fire department arrived but were not able to rescue C1 due to an explosion. The report identified the contributing factors to the incident as C1's impaired safety judgement, resistance to care, and a balance disorder. C2's Service Plan dated October 28, 2019, indicated the client required assistance with medications, bathing, dressing, grooming, food	0 810		

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0 810	Continued From page 16 preparation, transportation, and daily behavior management. C2's Vulnerability Assessment/Abuse Prevention Plan dated, March 5, 2020, indicated C2's diagnoses included schizophrenia, bi-polar disorder, and cannabis related disorder. C2 had poor judgement often putting himself in harm and wandering away from staff and caregivers. The plan indicated C2 had no susceptibility to abuse from other individuals or vulnerable adults. C2 was at risk of abusing others due to a history of aggressive behavior. Staff were directed to monitor and intervene with any actions of abuse toward others. In addition, C2 was at risk for self-abuse due to placing himself in dangerous situations. Staff were directed to monitor C2 for concerns of self-abuse and report promptly to the nurse. The plan failed to provide staff with specific interventions to prevent C2's self abuse and abuse to other vulnerable adults. C2's progress note dated October 16, 2020, indicated the client was smoking downstairs in the facility with C1. Staff told both clients to smoke outside on the deck but they refused. Staff explained the risk of a fire with smoking inside with all the doors to the residence locked and no air coming into the home. C2 agreed to smoke outside. Following the incident, staff failed to develop specific safety interventions. C2's progress note dated February 11, 2021, indicated there was a fire at the facility. The fire department came and C2 ran across the street to a neighbor's house. Later, staff were not able to locate C2. The plan directed staff to continue to search for C2. Later that day, C2 contacted facility staff to inform them he was staying with family.	0 810		

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0 810	Continued From page 17 C3's Service Plan dated October 28, 2019, indicated C3 received assistance with medications, bathing, hygiene, meal preparation, housekeeping, laundry, and behavioral management. C3's Vulnerability Assessment/Abuse Prevention Plan dated March 14, 2020, indicated C3's diagnoses included a traumatic brain injury (TBI). The assessment indicated C3 had no known vulnerabilities to abuse from other individuals, including other vulnerable adults, and no risk for abusing other vulnerable adults. C3 was at risk for self-abuse and staff interventions included monitoring the client for concerns of self-abuse and reporting concerns promptly to the nurse. There were no specific self-abuse vulnerabilities provided or specific interventions developed to prevent self-abuse. C3's progress note dated April 24, 2020, indicated C3 continually wore the same clothes and refused to shower. C3 told staff it was over a month since he showered. The progress note indicated, "Will follow-up." C3's progress note dated June 14,2020, at 8:00 a.m. indicated the client was upset and refused staff assistance. Another client was in the bathroom and C3 started knocking and continued knocking on the bathroom door. When the other client left the bathroom, C3 went in and slammed the door. After using the bathroom, C3 slammed the bathroom door leaving a hole in the wall behind the door. C3 continued to be aggressive toward staff and other clients that day. C3's progress note dated August 22, 2020, indicated C3 contacted the LSW-A stating he was	0 810		

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0 810	Continued From page 18 angry with staff and another client. C3 stated the LSW-A needed to come to the facility or "something will happen." C3 refused to take his medications and threw his meal in the garbage. Review of the facility's policy and procedure titled Vulnerable Adults and Maltreatment-Communication, Prevention, and Reporting, with an effective date of August 1, 2020, indicated the facility staff would develop an individualized abuse prevention plan for each home care client. The plan would include the clients susceptibility to abuse another individual, the client's risk of abusing other vulnerable adults, and actions, measures, or approaches for staff to take in order to minimize the risk of abuse to the client and other vulnerable adults. When appropriate, the plan would also address the issue of client self-abuse. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 810		