Protecting, Maintaining and Improving the Health of All Minnesotans

Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL33645001M
Compliance #: HL33645002C

Date Concluded: January 2, 2020

Name, Address, and County of Licensee Investigated:
Salams Care Residential LLC
2240 Ide Court
Maplewood, MN 55109
Ramsey County

Facility Type: Home Care Provider

Investigator's Name:
Amy Hyers, 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 facility neglected to provide supervision and monitoring necessary for the client's health and safety.

Investigative Findings and Conclusion:
Neglect was substantiated. The facility was responsible for the maltreatment. The facility failed to initiate interventions and provide adequate supervision to prevent ongoing self-harm and suicide attempts made by the client. The client sustained numerous self-inflicted injuries, which included the client hammering two nails into her skull with a shoe. She required hospitalization, surgical removal of the nails from her skull, and weeks of intravenous antibiotics.

The investigation included interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff, and the client's external care team members. The investigator conducted observations of the facility and reviewed records, including the client's facility records, facility incident reports, facility policies, and the client's hospital records.

The client received comprehensive homecare services for diagnoses that included borderline personality disorder, post-traumatic stress disorder, seizure disorder, disruptive mood dysregulation, and an intellectual disability. She received full medication management services daily; assistance with dressing, grooming, and bathing as needed; and mental health management as needed according to a care plan.

A home health aide care plan indicated facility staff were supposed to manage the following mental health management services for the client on a daily basis as needed: wandering; orientation issues; anxiety; repetitive behavior; agitation; self-injurious behavior; verbal aggression; and physical aggression daily. Staff were instructed to provide the client with reorientation, de-escalation, calming, and redirection.

A vulnerability assessment indicated the client demonstrated self-abusive behaviors. The prevention plan indicated the client should be visible to staff and at an “observable range” at all times.

Review of the client’s medical records indicated she had a well-known history of self-harm. Four months prior to the nail insertion incident, the client required surgical removal of an uncoiled key ring from her right leg. Six days later, she returned to the hospital due to insertion of a bobby pin into her right lower shin the night before. The hospital notes depicted, "She is supposed to be on a one-to-one observation at her group home, however this is unlikely happening given her recurrent self-harm and suicide attempt/gesture."

Review of several facility progress notes indicated the client was able to lock herself in her bedroom or the bathroom on multiple occasions; several instances of banging her head against the wall; striking and punching fellow clients and staff; and jumping out of her second floor bedroom window. One progress note indicated the client’s behaviors escalated "to the point we [staff] couldn't control her."

Weeks prior to the nail incident, review of a hospital operative note indicated the client was scheduled for surgery for a right tibia foreign body removal of six objects. The client had placed four paperclips and two pieces of a ball point pen into her right tibia. The hospital notes further depicted, "We also discussed her postoperative need for elevated care and restriction from such objects." The postoperative plan included the following, “She may need different group home setting to strongly restrict access to foreign bodies and prevent self-injurious behavior."

Approximately one week later, the client was sent back in the hospital. The client was noted as crying, hysterical, and stating she was hopeless. A social worker note indicated the facility was unable to take the client back. "They report [she] punched the staff and now staff is afraid to return. After social worker further discussed [the client] and conversed with the group home, it seems the group home is not equip to take care of [her]. [She] jumped out a window and they

barricaded the window to prevent this happening again. The staff reports that they are not trained in crisis or intervention and that they are only set up for housing and food."

Review of the client's hospital discharge notes indicated that a facility staff member told the social worker that staff had struggled with the client for three days prior to her hospitalization; they did not feel they could handle her; they did not have any crisis intervention skills or training; and there were no behavioral interventions available to them. The staff member said all they do could was provide housing and food, and there were no other therapeutic interventions in place at the facility. Regardless, the client returned to the facility and had ongoing complaints of headaches and facial swelling. At times, a pus-like discharge could be seen from a wound on her forehead. A facility progress note written by facility staff indicated, "Staff will check on her every two hours." The client locked herself in her room again after multiple requests to see a physician for flank and kidney pain. The client called 911 herself and went to the emergency department. She was discharged with medication to treat a urinary tract infection.

Approximately one week later, the client obtained a (dull) knife, ran to her room, and locked the door. She attempted to slit her throat; however, staff were able to get into the room and intervene. The client went to the hospital via ambulance. It was reported to emergency department staff that the client had increasing suicidal ideations over the past couple days.

Review of a hospital note indicated the client was questioned about the area of swelling on her right forehead. The note indicated "[She] initially stated that she did not want to say how or why she got this. Later she stated that she injected something into her skin." Another note depicted, "[She] repeatedly states 'I want to hurt myself'." The client's physicians concluded she required psychiatric inpatient admission; however, prior to that admission a CAT scan showed the client had "two linear radiopaque foreign bodies extending from the scalp hematoma in the anterior right frontal region through the calvarium (top part of the skull) and into the right frontal lobe." The objects in the client's skull were later determined to be nails; one nail measured 4.8 centimeters, and the other was 6.2 centimeters long.

The client told the physician she inserted the nails using the heel of her shoe approximately one month prior. The operative note indicated the surgeon performed a right frontal craniectomy (a surgery that removes part of the skull) to remove two foreign bodies. The surgeon also removed a foreign body (needle) from the client's back. The client required approximately four weeks of intravenous antibiotic treatment.

During an interview, a facility nurse said, "To be at observable range at all times" according to the vulnerability assessment meant that staff always had to keep a close eye on the client. He stated the client should be in their vision at all times.

During an interview, management staff said staff were not equipped with the correct tools to keep the client safe. He said, "Our interventions were not good enough."

During an interview, a staff member said there were times when staff deferred from the constant supervision. The client occasionally held a job, and staff would wait in the workplace lobby for her. He said staff did not go into the bathroom with the client and when she slept, they left the door open and sat in a common space. He said the client closed her door when she wanted privacy.

During an interview, another staff member said the response to make when someone was suicidal was to protect them. He said the actions are to help her [the client], talk to her, and tell her she was going to be okay. There was no mention to call 911, a medical/psychological provider, or crisis intervention team.

During an interview, a member of the client's mental health team said the client required a high level of care and, at times, even needed two staff members to care for her (2:1). The team member said the facility struggled to keep staff and often had poor communication with the client's team. She further said the facility did not provide everything agreed to before the client's admission. She said they neglected to properly supervise the client. The nails were in the client's head for nearly one month. The team member said there were many times the client complained of a headache and staff did not respond. She stated she was present one time when staff brushed off the client's complaint of head pain.

During an interview, a hospital social worker said she knew the client well and had worked with her many times over several hospitalizations. The social worker said the client needed one-to-one staffing at all times as she was too high risk to be alone. The social worker said she reiterated this with facility staff every time the client was discharged from the hospital back to the facility. She said the client told her she simply went out to the garage at the facility to obtain the nails. The social worker said the client required three days in intensive care with nearly six weeks of intravenous antibiotics.

During an interview, the client said she did not feel safe at the facility because she continued to harm herself. She said when she told staff this, the stated response was, "Listen, you're going to be okay." She said she told staff she had an infection and needed an appointment. She said staff responded by saying, "You're not going to have an infection." She further said when she reported having something in her head to a nurse, the response was "You're going to be okay. You're going to be okay. You're going to be okay." She stated she felt staff had total disregard for her situation. She said that was when she took the knife; in order to evoke some action. The client went on to say there was another client at the facility in a similar situation. She said the police came to the facility often and said they cannot handle all these people hurting themselves. The client stated she was often by herself, but would feel better with someone with her at all times. She said she felt scared at the facility because she hurts herself, and the response was always, "You're going to be fine" or "You're so wonderful." She said, "I didn't have a one-to-one with me; I need that."

In conclusion, neglect was substantiated. The facility did not provide adequate supervision or initiate appropriate interventions to ensure the safety of the client.

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: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Not Applicable.

Action taken by facility:
No action taken.

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 Long-Term Care
Hennepin County Attorney
Maplewood City Attorney
Maplewood Police Department

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H33645	A. BUILDING: _____ B. WING _____	C 11/19/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALAMS CARE RESIDENTIAL LLC	2240 IDE COURT MAPLEWOOD, MN 55109

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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 survey. 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 November 19, 2019, the Minnesota Department of Health initiated an investigation of complaint #HL33645001M/HL33645002C. At the time of the survey, there were 3 clients receiving services under the comprehensive license. The following correction order is issued for #HL33645001M/HL33645002C, tag identification 0325.	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 surveyors' 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 follow-up surveys. 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).	
0 325 SS=J	144A.44, Subd. 1(14) Free From Maltreatment Subdivision 1. Statement of rights. A person who receives home care services has these rights: (14) the right to be free from physical and verbal abuse, neglect, financial exploitation, and all	0 325		

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0 325	Continued From page 1 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 interview and document review, the licensee failed to keep 1 of 1 client (C1) reviewed free from maltreatment when the licensee failed to initiate interventions and provide adequate supervision to prevent ongoing self-harm and suicide attempts made by C1. C1 obtained two nails and hammered them into her skull with a shoe. C1 required hospitalization, surgical removal of the nails from her skull, and one month of intravenous antibiotics. 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). The findings include: C1 was admitted to the facility on April 15, 2019, and received comprehensive homecare services for diagnoses that included borderline personality disorder, post-traumatic stress disorder, seizure disorder, disruptive mood dysregulation, and an intellectual disability. C1 received full medication management services daily; assistance with dressing, grooming, and bathing as needed; and mental health management as needed according to a care plan dated August 23, 2019.	0 325		

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0 325	Continued From page 2 A licensee progress note dated June 12, 2019 at 10:30 p.m. (five days prior to the vulnerability assessment/statement), indicated C1 called staff to show them her leg. She had scratched her leg and was bleeding. She told the staff she did something [to herself], but would not tell them what she did. Document review of a hospital operative report dated June 14, 2019 at 1:30 p.m., indicated C1 had an uncoiled key ring surgically removed from inside her right leg where C1 had placed it two days prior. A licensee progress note dated June 15, 2019, indicated C1 was screaming that she wanted to die and attempted to strangle herself with a tied article of clothing around her neck. C1 went to the hospital via ambulance and was discharged two hours later. Document review of a form titled, Abuse Prevention Plan: Vulnerability and Safety Assessment, dated June 17, 2019, indicated C1 demonstrated self-abusive behavior. The prevention plan indicated C1 should be at an observable range of view at all times. The form further indicated, "Client [C1] is considered vulnerable but there are no signs of abuse or neglect." Document review of an Emergency Department (ED) encounter dated June 20, 2019 at 2:45 p.m., indicated C1 placed a bobby pin into her right lower shin the night before. The hospital dictation also depicted, "She is supposed to be on a one-to-one observation at her group home, however this is unlikely happening given her recurrent self-harm and suicide attempt/gesture." C1 was transferred from the hospital for	0 325		

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0 325	Continued From page 3 psychiatric treatment post-operatively. Document review of a licensee progress note dated June 28, 2019, indicated C1 returned from work at approximately 2:30 p.m. and locked herself in the bathroom. Document review of a form titled, Incident Report, dated July 1, 2019 at 11:00 a.m., indicated C1 was yelling from her room. Staff attempted to check on her; however, the door was locked. A nurse was able to gain entry. C1's behaviors escalated, and C1 began banging her head against the wall. C1 pushed the nurse and attempted to jump out the (upper level) window. C1 began punching a fellow client. The report indicated C1's behaviors escalated "to the point we couldn't control her." C1 went to the hospital via ambulance. Document review of a nursing progress note dated July 1, 2019 at 12:30 p.m., indicated a female staff member went to C1's room and offered her some one-to-one time. Document review of ED dictation dated July 1, 2019, indicated, "This morning, the patient was in her room at her group home. Staff attempted to enter the patient's room, however, she would not let them because she 'wanted to do something to herself.' Patient refuses to elaborate on plan to hurt herself." Document review of hospital dictation titled, Assessment and Treatment Recommendations, dated July 5, 2019, indicated C1's outpatient care team believed C1 was on continuous one-to-one supervision at the licensee due to high risk for self-injurious behaviors.	0 325		

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0 325	Continued From page 4 Document review of an operative note from the hospital dated July 25, 2019 at 9:24 a.m., indicated C1 was scheduled once again for a right tibia foreign body removal to surgically remove six objects from her leg. C1 had placed four paperclips and two pieces of a ball point pen into her right tibia. The dictation further depicted, "We also discussed her postoperative need for elevated care and restriction from such objects." The postoperative plan included the following: "She may need different group home setting to strongly restrict access to foreign bodies and prevent self-injurious behavior." Document review of a licensee progress note dated August 5, 2019, indicated C1 was bleeding through her mouth and nose. C1 also reported to staff she felt dizzy. There were no follow-up notes indicating these symptoms were addressed. Document review of a form titled, Home Health Aide Care Plan, dated August 23, 2019, indicated staff were supposed to provide and manage the following mental health management services for C1 as needed on a daily basis: wandering; orientation issues; anxiety; repetitive behavior; agitation; self-injurious behavior; verbal aggression; and physical aggression. The instructions to staff included reorientation; de-escalation; calming; and redirection. Document review of a licensee progress note dated August 27, 2019, indicated C1 called the police that night and was transported to the hospital. C1 had locked herself in her room until police arrived at the licensee's facility. Document review of ED notes from the hospital dated August 27, 2019 at 10:10 p.m., indicated	0 325		

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0 325	Continued From page 5 "[C1] had called 911 stating that she was going to strangle herself. [C1] states that it [sic] group home staff were not listening to her." A note the following morning at 9:35 a.m. indicated C1 had been suicidal for the past three days with a plan to choke herself. Document review of a licensee nursing assessment dated August 28, 2019, by registered nurse (RN)-A indicated C1 had no open wounds, lesions, or ulcers; skin intact. Document review of a licensee progress note dated August 30, 2019 at 8:00 a.m., indicated, on two occasions, C1 said she was going to strangle herself and throw herself out the window. A second note indicated C1 did jump from the window; however, she sustained no injuries. Document review of another licensee incident report dated August 30, 2019 at 4:30 p.m., indicated C1 was angry at a male client. C1 reported the client touched her. "Staff wasn't watching / see [sic] happened at the time." Document review of a hospital crisis evaluation note dated September 1, 2019 at 3:43 p.m., indicated C1 was crying and hysterical, stating she is hopeless. A note written by the social worker at 6:02 p.m. indicated the licensee was unable to take C1 back. "They report [C1] punched the staff and now staff is afraid to return. After social worker further discussed [C1] and conversed with the group home it seems the group home is not equip to take care of [C1]. [C1] jumped out a window and they barricaded the window to prevent this happening again. The staff reports that they are not trained in crisis or intervention and that they are only set up for housing and food."	0 325		

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0 325	Continued From page 6 Document review of a hospital discharge summary note dated September 4, 2019 at 10:00 a.m., indicated the social worker discussed the situation with management staff (MS)-C. "I... called staff back stating that respite care in the ED a [sic] morning was not an appropriate intervention. [MS-C] then stated that they had been struggling with [C1] for three days, they did not feel they could handle her, that they do not have any crisis intervention skills or training and that they have had no behavioral interventions available to them. He stated that all they do is provide housing and food and that there is no other therapeutic interventions in place in this setting." Document review of a licensee progress note dated September 21, 2019, indicated C1 was agitated, swearing, and screaming. C1 left the house carrying luggage. Staff went to locate her and took her to the hospital. Document review of a hospital ED crisis evaluation note dated September 21, 2019 at 9:31 p.m., indicated C1 told the facility she was suicidal; however, C1 then reported she simply wanted to get out for a while. Document review of a hospital ED note from a second hospital dated September 26, 2019 at 5:39 a.m., indicated C1 arrived to the ED for an evaluation after a fall. C1 could not recall the fall, but reported a mild headache and dizziness. C1 was noted to have an abrasion over the right side of her forehead. A CAT Scan revealed, "Focal cortical defect in the right frontal bone which [sic] worrisome for traumatic injury with overlying scalp hematoma." C1's ED discharge diagnosis was "closed fracture of frontal bone."	0 325		

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0 325	Continued From page 7 Document review of hospital ED encounter note indicated C1 arrived to the ED at 12:17 a.m. on September 28, 2019, and was discharged at 3:44 a.m. C1 was evaluated a headache. C1 also felt as though she had worsening facial swelling. Document review of a hospital ED encounter note indicated C1 was evaluated on September 28, 2019 at 10:24 p.m. for migraine. C1 was treated for pain and nausea, and then discharged back to the licensee. Document review of a licensee progress note dated October 2, 2019, indicated C1 left the licensee around 7:00 p.m. Staff drove around trying to locate her, but were unable to do so. No further information regarding the incident was documented by staff. Document review of a hospital ED encounter note dated October 12, 2019 at 9:56 p.m., indicated C1 had pus type drainage from her right frontal forehead wound. She was treated in the ED and discharged back to the facility. Document review of a licensee progress note dated October 14, 2019, indicated C1 complained that her head hurt. Staff provided her water "to hydrate" and gave her as-needed medication. C1 went to lie down in her bed. "Staff will check on her every two hours." A later note indicated staff tried to check on her; however, C1 had locked the door. C1 called police to take her to the hospital. Document review of a hospital ED note dated October 14, 2019 at 11:43 p.m., indicated C1 presented to the ED with agitation and suicidal ideation. She later reported flank and kidney pain. C1 told ED staff she had asked facility staff	0 325		

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0 325	Continued From page 8 to take her to urgent care, but they refused so she called 911. The note further indicated a call was placed to MS-C. MS-C told ED staff that C1 was complaining about pain and that she had an infection and a headache. C1 was discharged from the ED with medication to treat a urinary tract infection. Document review of a licensee progress note dated October 20, 2019, indicated C1 was admitted to the hospital. Document review of a hospital ED behavioral health note dated October 20, 2019, indicated C1 presented with increasing suicidal ideations over the past couple days. She was able obtain a knife at the licensee and had attempted to slit her throat. Licensee staff were able to open her door and intervene. A note further indicated C1 was questioned about the area of swelling on her right forehead. "[C1] initially stated that she did not want to say how or why she got this. Later she stated that she injected something into her skin." Another note depicted, "[C1] repeatedly states 'I want to hurt myself'." The ED plan noted C1 required a psychiatric inpatient admission. Document review of CAT Scan results dated October 23, 2019 at 8:02 p.m., indicated "There are 2 linear radiopaque foreign bodies extending from the scalp hematoma in the anterior right frontal region through the calvarium and into the right frontal lobe." The objects were later determined to be nails. One nail measured 4.8 centimeters, and the other nail measured 6.2 centimeters long. Document review of C1's hospital history and physical dated October 23, 2019 at 10:20 p.m., indicated C1 told the physician she inserted the	0 325		

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	H33645	A. BUILDING: _____ B. WING _____	C 11/19/2019

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0 325	Continued From page 9 nails using the heel of her shoe approximately one month prior. The hospital operative note dated October 25, 2019 at 10:27 a.m., indicated C1 underwent a right frontal craniectomy to remove two foreign bodies was performed. C1 also had a foreign body (needle) removed from her back. C1 required approximately four weeks intravenous antibiotic treatment after surgery. Document review of a list of police responses to the licensee from December 1, 2018 to September 22, 2019, depicted police responded 40 times to licensee; police responded approximately 14 times for incidents related to C1. During an interview on November 19, 2019 at 1:37 p.m., RN-A indicated that "to be at observable range at all times" according to the vulnerability assessment meant staff had to always keep a close eye on C1. RN-A stated C1 should be in their vision [staff] at all times. During an interview on December 13, 2019 at 10:22 a.m., MS-C said staff were not equipped with the correct tools to keep C1 safe. He said, "Our interventions were not good enough." During an interview on December 13, 2019 at 10:11 a.m., unlicensed personnel (ULP)-D said there were times when staff deferred from the constant supervision required for C1. ULP-D stated C1 occasionally held a job, and staff would wait in the workplace lobby for C1. ULP-D said staff did not go into the bathroom with C1, and when she slept, staff left the door open and sat in a common space. He said C1 closed her door when she wanted privacy. During an interview on December 13, 2019 at	0 325		

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0 325	Continued From page 10 11:10 a.m., ULP-E said the response to make when someone was suicidal was to protect them. He said staff were supposed to help her [C1], talk to her, and tell her she was going to be okay. There was no mention to call 911, a medical/ psychological provider, or crisis intervention team. During an interview on December 20, 2019 at 10:29 a.m., a member of C1's mental health team (MH)-I said C1 required a high level of care and, at times, even required two staff members to supervise her (2:1). MH-P said the licensee struggled to keep staff and often had poor communication with C1's team. She further said the licensee did not provide everything agreed to before the admission. She said the licensee neglected to properly supervise C1. She stated the nails found in C1's head were there for nearly one month. There were many times C1 complained of a headache, and licensee staff did not respond. MH-P stated she was present one time when licensee staff brushed off C1's complaint of head pain. During an interview on November 21, 2019 at 1:48 p.m., a hospital social worker (SW)-B said she knew C1 well and had worked with her many times over several hospitalizations. SW-B said C1 needed one-to-one staff supervision at all times. SW-B stated C1 was too high risk to be alone. SW-B said she reiterated C1's supervision requirements to the licensee staff with every hospital discharge back to the licensee. SW-B stated C1 told her she simply went out to the garage at the licensee to obtain the nails. SW-B said C1 required three days in intensive care with nearly six total weeks of intravenous antibiotics. During an interview on November 21, 2019 at	0 325		

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0 325	Continued From page 11 approximately 1:30 p.m., C1 requested an interpreter be included in the interview. SW-B obtained interpretive services via telephone. C1 said she did not feel safe at the facility because she continued to harm herself. She said when she told licensee staff she did that, the response was, "Listen, you're going to be okay." She said she told staff she had an infection and needed an appointment. C1 said licensee staff's response was, "You're not going to have an infection." She further said when she reported having something in her head to RN-A, the response was, "You're going to be okay, you're going to be okay, you're going to be okay." She felt the licensee had total disregard for her situation. She said that is when she took the knife in order to evoke some action. C1 went on to say there was another client at the licensee in a similar situation. She said the police came to the licensee often and say they "cannot handle all these people hurting themselves." C1 stated she was often by herself [at the licensee], but would feel better with someone with her at all times. C1 said she felt scared at the facility because she would hurt herself, and the [staff] response was always, "You're going to be fine" or "You're so wonderful." She said, "I didn't have a one-to-one with me; I need that." Licensee's policies that address suicidal and self-harming clients were requested during this investigation. MS-C provided licensee's policies that pertained to long term care facilities governed by the Centers for Medicare and Medicaid Services (CMS). The licensee is not a federally-licensed facility. Document review of an undated licensee policy titled, Abuse Prevention Plan, indicated, "The admission policy shall state there must be a reasonable expectation that the client's needs	0 325		

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0 325	Continued From page 12 can be met in the client's place of residence." It further indicated, "Effectiveness of the plan will also be documented and if client safety is not being achieved, appropriate disciplines will be notified and care conference set up to address possible alternatives including discharge to another setting." Document review of an undated licensee policy titled, Vulnerable Adult, indicated the facility is to protect those who are...vulnerable to abuse or neglect. TIME PERIOD FOR CORRECTION: Seven (7) days	0 325		