

Protecting, Maintaining and Improving the Health of All Minnesotans

# Office of Health Facility Complaints Investigative Public Report

Maltreatment Report #: HL33645003M Date Concluded: February 7, 2020

**Compliance #:** HL33645004C

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 and 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 facility neglected to provide supervision and monitoring for the client when staff left the client walking outside in cold weather without adequate winter attire.

## **Investigative Findings and Conclusion:**

Neglect was substantiated. The facility and the alleged perpetrator (AP) were responsible for the maltreatment. The facility had only one staff member (the AP) assigned to continuously supervise three clients diagnosed with multiple mental health conditions. When one client left the facility unaccompanied and improperly dressed, the AP went after the client and left the other two clients alone. The AP then left the eloping client to return to the facility, and failed to report the incident to the nurse or called 911 for assistance. The police later returned the client to the facility.

The investigation included interviews with facility staff members, including nursing staff and unlicensed staff; interview with law enforcement; observation of the clients and facility; review of the client's record; and review of the facility's policies and procedures.

The client received comprehensive home care services for diagnoses that included obsessive-compulsive disorder, schizoaffective disorder, and Type II diabetes. He received daily assistance with bathing, hygiene, grooming, and dressing and full medication management according to a service plan. A home health aide care plan indicated staff were supposed to manage the client's following mental health elements: orientation issues as needed, anxiety, repetitive behavior, agitation, verbal aggression and physical aggression.

The client's individual abuse prevention plan indicated the client lacked the ability to identify potentially dangerous situations and had a lack of self-preservation skills (ignores personal safety). Specific measures staff were supposed to utilize to minimize the risk of abuse included "constant supervision, cuing, and reminders."

The investigator observed that the facility is a split-level house. There is a security system that is enabled by entering a code on the key-pad. If the security system is enabled and the front door opens, a loud alarm will sound. It is not an industry specific secured unit that keeps clients safe by prohibiting their exit through a locked door.

One night, the client was outside at approximately 10:00 p.m. walking through the snow on unplowed streets approximately three blocks from the facility. The temperature at the time was 9 degrees Fahrenheit with 6 mile per hour winds.

The client flagged down a police officer who was out on patrol in the area. He asked the officer to help him find his scarf. The client was attempting to walk back to a fast food restaurant he was at earlier, in search of his lost scarf; the distance from the facility to the restaurant was approximately 1 mile each way. The officer provided the client with a ride back to the facility.

During an interview, the AP (who was the staff member on-duty at the time the client left the facility) said the client and another off-duty staff member returned from an outing to the fast food restaurant. The AP stated he went to provide services to another client when the client left the facility. The AP went outside after the client and walked with him for approximately 1.5 blocks leaving two other clients at the facility alone who also required continuous supervision to preserve their safety. The AP said the client was not supposed to be outside unattended because "he can be confused about what happens." The AP returned to the facility where, he said, he left two other clients who also required constant supervision. He did not attempt to call the nurse or call 911 as required by facility policy. He stated the client then returned with police.

During an interview, the off-duty staff member said the AP called him to ask if he could take the client out for fast food. Although he did not begin his shift until 11:00 p.m., the off-duty staff member went to the facility to take the client out to eat. The staff member said he returned with the client, brought the client inside the facility, and then left to go purchase some groceries. The staff member said when he returned for the start of his shift, he heard about the client's attempt

to go back and find his scarf. The staff member stated it was "a little bit cold, but not snowing" at the time the client would have left the facility on his own.

During an interview, the responding police officer said he was out on normal patrol when he saw the client "zig-zagging" and stumbling through the street. He stated the street remained unplowed from the snowfall the day before. He recognized the client from previous calls and knew the client was a vulnerable adult who struggled with mental health issues including delusions. The client asked the officer to help him find his scarf at a destination approximately 1 mile away. The officer shook the client's hand. The client was not wearing gloves, was cold to the touch and shaking. The officer said the client was wearing a light-weight windbreaker type jacket, light weight athletic pants, and tennis shoes. The client told the officer staff were aware of his departure from the facility. When the officer brought the client back to the facility, the AP told the officer he went with the client initially, but then returned because he was cold; the AP let the client continue on his own. The AP was unaware of how long the client was outside. The officer said the client was approximately 0.3 miles from the facility when he picked the client up. The officer said the client did not seem to be aware of how cold he was stating, "He was locked in on finding his scarf."

During an interview, the nurse said he was very upset about the incident. He did not receive any notification from staff at the time, and learned about the incident several days later. He further said there was no documentation in either an incident report or in the client's record about the incident. He said the client, who is a vulnerable adult with mental health concerns, should not have been outside in the elements unattended. The nurse said the AP told him he did not call the nurse because "there was nothing clinical or life threatening."

During an interview, the client's mental health care team member stated the client is under a civil commitment because he is unable to manage his own safety awareness, health concerns, and medication regime. She said the client should never go out unescorted, and further, the facility did not inform her of the incident when it happened. She said the client had previously resided in a secured unit and believed this facility was a secured unit as well. She said the client was sometimes delusional, not an accurate historian, and overall had a significant lack of safety awareness. She said he was not aware of how to dress appropriately for the weather, and he received care because he was not able to adequately do that for himself.

During an interview, the client's legal guardian was unhappy to learn of the incident. The facility did not inform her of the incident, and her expectation was the client not go out unescorted. She listed reasons such as getting lost, exploited, or hurt as possible outcomes of the client being unescorted. She further expressed her expectation that staff would monitor the appropriateness of the client's clothing choices for the season.

During an interview, the client pointed to the coat he stated he wore that night. It was a poly/rayon/wool blend pea-coat. He explained how he believed he lost his scarf and was going to try to find it. He said, "I left by myself because I wanted to look for my scarf." He said he did

not typically go out alone, but he was not frightened to do so. The client said the night he left the facility that there was snow on the roads, but it was not too cold. He also pointed to the low cut loafer type, rubber soled shoes he said he wore. He said when he saw the police officer, he flagged him down to ask for help finding his scarf. He said, "They care about me. I care about them. It is dangerous out there."

In conclusion, neglect was substantiated. The facility and the AP failed to provide the client with continuous supervision as required by his service plan which placed the client's safety at risk. The AP did not contact the nurse or 911 after the client eloped from the facility.

### 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**: Yes.

# Action taken by facility:

The facility hired a consultant who started the staff re-education process after the incident.

#### 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
The Office of Ombudsman for Mental Health and Developmental Disabilities
Maplewood Police Department
Maplewood City Attorney
Ramsey County Attorney

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H33645	B. WING		C 01/30/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	
SALAMS	CARE RESIDENTIAL	LLC MAPLEW	COURT OOD, MN 5	5109	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE COMPLETE
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	In accordance with 144A.43 to 144A.45 of Health issued a casurvey.  Determination of wherequires compliance provided at the state When a Minnesota items, failure to combe considered lack  INITIAL COMMENT On January 30, 202 of Health initiated a HL33645003M / HL survey, there were sunder the comprehendations.	Minnesota Statutes, section 32, the Minnesota Department correction order(s) pursuant to mether a violation is corrected with all requirements ute number indicated below. Statute contains several apply with any of the items will of compliance.  TS:  O, the Minnesota Department in investigation of complaint 33645004C. At the time of the 3 clients receiving services ensive license.		The Minnesota Department of Headocuments the State Licensing Coorders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Hom Providers. The assigned tag numbers appears in the far left column entity Prefix Tag." The state statute numbers the corresponding text of the state out of compliance are listed in the "Summary Statement of Deficient column. This column also includes findings that are in violation of the requirement after the statement, "Minnesota requirement is not met evidenced by." Following the survey findings is the Time Period for Corper Minnesota Statute § 144A.4748(c), the home care provider must document any action taken to comb the correction order. A copy of the provider's records documenting the actions may be requested for follo surveys. The home care provider required to submit a plan of correct approval; please disregard the head the fourth column, which states "Pelan of Correction."  The letter in the left column is use tracking purposes and reflects the and level issued pursuant to Minn. 144A.474, Subd. 11 (b).	e Care led "ID ber and statute les" sthe state This as eyors' rection. I, Subd. hply with ose w-up is not ction for ading of rovider's d for scope
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		ement of rights. (a) A person care services has these			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE TITLE

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	by: Based on interview licensee failed to prospect for three of the reviewed. Staff failed re-direction or intersupervision for C1 to the cold, at night, illustration Staff had to choose	ent is not met as evidenced and document review, the rovide services to ensure client hree clients (C1, C2, C3) ed to provide proper vention and ongoing when he walked outside into -dressed for the elements. e between direct supervision of pervision of the remaining two ide the facility.				
	violation that harmed not including serious or a violation that has serious injury, impa- issued at a widesprare pervasive or rep	ed in a level three violation (a ed a client's health or safety, is injury, impairment, or death, as the potential to lead to airment, or death) and was read scope (when problems present a systemic failure that potential to affect a large clients).				
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0 265	according to a serving 2019. C1 signed the 2020.  Document review of Aide Care Plan-Custoff, 2019, indicated perform the following with C1:  -manage orientations—manage anxiety—manage repetitive—manage repetitive—manage agitation—manage verbal agg—manage physical admitisty potentially of lacked self-preserves safety). The IAPP is measures staff were minimize the risk of "constant supervisions" C2 was admitted to and received complete for diagnoses that is injury, mild mental redisorder, organic pediabetes. The investor service plan from the provided.  Document review of the provided.	dedication management ice plan dated August 12, e service plan on January 25, if a form titled, Home Health stomized Living, dated August staff were supposed to a mental health management in issues as needed behavior gression iggression if a form titled, Individual Plan (IAPP), dated November C1 possessed the inability to langerous situations and action skills (ignores personal indicated the specific e supposed to utilize to a buse to C1 included on, cuing, and reminders."  The facility on April 15, 2019, rehensive home care services included a traumatic brain retardation, organic delusional ersonality disorder, and Type II stigator requested C2's included in the facility, but one was not in the facility, but one was not included included in the facility, but one was not included included in the facility, but one was not included included in the facility, but one was not included included in the facility, but one was not included in the facility, but one was not included in the facility, but one was not included in the facility included in the f				
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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0 265	inability to care for self-preservation sk and refused to take indicated the specific supposed to utilize to C2 included play Starbucks, keeping supervision, cuing,  C3 was admitted to 2018, and received services for diagnost depressive disorder personality disorder disorder, and Type medication manage independent with all (ADLs) according to November 5, 2018.  The investigator recall the investigator recall to the investigator recall to the staffing schedules; not provided.  During an interview p.m., a police office back to the facility for the cold, ill dressed approximately 9:50 (ULP)-D told the off initially, but then retall the was cold; ULP-E unsupervised.	ally abusive to others; had an self-help needs; lacked kills (ignores personal safety); a medications. The IAPP fic measures staff were to minimize the risk of abuse ing his music, taking him to him calm, and "constant and reminders."  The facility on November 5, comprehensive home care ses that included major r, anxiety, borderline r, attention deficit hyperactive II diabetes. C3 received ement services and was II activities of daily living to a service plan dated  quested the facility provide was not provided.  Quested the facility provide however, the schedules were  Ton February 3, 2020 at 2:39 or indicated C1 was brought from walking alone outdoors in for the weather at p.m. Unlicensed personnel ficer he walked with C1 curned to the facility because to let C1 continue on his own	0 265			
	_	on February 3, 2020 at 11:44 when he went to provide				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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	Standards of Practices will deliver services	f an undated policy titled, ce, indicated, "Agency staff on each client's unique and d clinical decisions"				
	TIME PERIOD FOR days	R CORRECTION: Seven (7)				
0 325	144A.44, Subd. 1(1	4) Free From Maltreatment	0 325			
	receives home care (14) the right to be to abuse, neglect, finatorms of maltreatment covers	ement of rights. A person who services has these rights: free from physical and verbal incial exploitation, and all vered under the Vulnerable Maltreatment of Minors Act;				
	by:	ent is not met as evidenced s and document review, the		No Plan of Correction (PoC) is req	juired.	

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	•	ure one of one clients free from maltreatment. C1		Please refer to the maltreatment prepared for details.	ublic	
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	of Health (MDH) iss neglect occurred, a individual staff pers maltreatment, in co					
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	adults and minors. on must comply with re	maltreatment of vulnerable (a) All home care providers equirements for the reporting minors in section 626.556 and				
	requirements for the vulnerable adults in care provider must established procedure to ensure	e reporting of maltreatment of section 626.557. Each home olish and implement a written that all cases of suspected				
	by: Based on interview licensee failed to en maltreatment was re(SA), for three of the	ent is not met as evidenced and document review, the sure an incident of suspected eported to the State Agency ree clients (C1, C2, C3) If left all three clients who				

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	violation that harmed not including serious or a violation that has serious injury, impa- issued at a widesprare pervasive or rep					
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	Abuse Prevention F 2, 2019, indicated C identify potentially of verbally and physical inability to care for a self-preservation sk and refuses to take indicated specific m to utilize to minimize which included play	If a form titled, Individual Plan (IAPP), dated December 22 possessed the inability to langerous situations; becomes ally abusive to others; has an self-help needs; lacks of tills (ignores personal safety); medications. The IAPP neasures staff were supposed the risk of abuse to C2, ring his music, taking him to him calm, and constant and reminders.				
	2018, and received services for diagnost depressive disorder personality disorder disorder, and Type medication manage independent with all	the facility on November 5, comprehensive home care ses that included major r, anxiety, borderline r, attention deficit hyperactive II diabetes. C3 received ement services and was I activities of daily living a service plan dated				
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STATE FORM 1SSF11 If continuation sheet 8 of 19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	` ′	(X3) DATE SURVEY COMPLETED	
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0 805	During an interview a.m., ULP-D said w services to C2, C1 he went outside after approximately 1.5 k not supposed to be "he can be confuse ULP-D stated he reshad left C2 and C3 required constant s.  The investigator recipertaining to the mass by the facility.  During an interview p.m., registered numotify him about the aware and question there was "nothing they did not notify the nurse was unaware SA.  During an interview a.m., an RN-G, who	on February 3, 2020 at 11:44 when he went to provide left the facility. ULP-D stated er C1 and walked with him for blocks. ULP-D said C1 was outside unattended because d about what happens." turned to the facility where alone, both of whom also	0 805			
	C1.  Document review of Vulnerable Adult, in maltreatmentis disemployee is to repoint immediately by phosimmediate supervision.	f an undated policy titled, dicated, "When scovered or suspected, the ort the incident via oral reportine or otherwise to their soraccompanied by a report form". The supervisor				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		COMPLETED		
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0 805	Continued From pa	ge 9	0 805			
	will review and repo entry point within 24	ort to the state-wide common I hours.				
	TIME PERIOD FOR days	R CORRECTION: Seven (7)				
0 840 SS=I	144A.4791, Subd. 4	Acceptance of Clients	0 840			
	provider may accept the home care provider qualifications, compa adequately provide	te of clients. No home care it a person as a client unless has staff, sufficient in betency, and numbers, to the services agreed to in the at are within the provider's				
	by: Based on observation interview, the licens challenging mental three clients (C1, C) sufficient staff in quantimers to adequating interventions agreed	ent is not met as evidenced on, document review and see accepted clients with health diagnoses for three of 2, C3) reviewed without alifications, competency, and tely provide the services or d to in the client service plans a necessary in the client ments.				
	violation that harmed not including serious or a violation that has serious injury, impa- issued at a widesprant are pervasive or rep	ed in a level three violation (a ed a client's health or safety, injury, impairment, or death, as the potential to lead to irment, or death) and was ead scope (when problems present a systemic failure that potential to affect a large clients).				

Minnesota Department of Health

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H33645  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  2240 IDE COURT  MAPLEWOOD, MN 55109	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		COMPLETED		
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  2240 IDE COURT				D MINO		C	,
SALAMS CARE RESIDENTIAL LLC			H33645	B. WING		01/3	0/2020
SALAMS CARE RESIDENTIAL LLC	NAME OF PRO	OVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	SALAMS CA	ARE RESIDENTIAL			5109		
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETE DATE
, , , , , , , , , , , , , , , , , , , ,	0 840 Cd The Cd set of a cd and a cd a cd a cd a cd a cd a cd	Continued From particle of the findings included and received assistance with bath according to a service for C1:  C1 was admitted to 2019, and received disorder, and Type assistance with bath according to a service for C1:  C2 was admitted to acked self-preservation and the following manage physical acked self-preservation and for the following manage physical acked self-preservation and for the following manage physical acked self-preservation and for the following manage included "continued the following potentially display and for the following for diagnoses that in figury, mild mental received complete for diagnoses that in figury, mild mental received complete for the following for diagnoses that in figury, mild mental received complete for the following for	ge 10 e: the facility on August 12, comprehensive home care ses that included order, obsessive-compulsive II diabetes. C1 received daily hing, hygiene, grooming, redication management ice plan dated August 12,  If a form titled, Home Health estomized Living, dated August staff were supposed to reg mental health management in issues as needed behavior gression ggression If a form titled, Individual Plan (IAPP), dated November C1 possessed the inability to langerous situations and ation skills (ignores personal reasures to minimize the risk of instant supervision, cuing, and the facility on April 15, 2019, rehensive home care services included a traumatic brain retardation, organic delusional	0 840	DEFICIENCY)		

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Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		<b>`</b>	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H33645	B. WING		01/3	; 0/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SALAMS	CARE RESIDENTIAL	LLC MAPLEW	COURT OOD, MN 55	5109		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 840	Continued From pa	ae 11	0 840			
	The investigator red C2's service plan, b received.	quested that the facility provide out the service plan was not				
	Abuse Prevention F 2, 2019, indicated C identify potentially of verbally and physical inability to care for a self-preservation sk and refused to take indicated staff were measures to minim which included play	If a form titled, Individual Plan (IAPP), dated December 22 possessed an inability to langerous situations; was ally abusive to others; had an self-help needs; lacked of tills (ignores personal safety); medications. The IAPP supposed to unitize specific ize the risk of abuse to C2, ring his music, taking him to him calm, and constant and reminders.				
	2018, and received services for diagnost depressive disorder personality disorder disorder, and Type medication manage independent with all	the facility on November 5, comprehensive home care ses that included major r, anxiety, borderline r, attention deficit hyperactive II diabetes. C3 received ement services and was I activities of daily living a service plan dated				
	Aide Care Plan-Cus 23, 2019, indicated	n issues behavior ous behavior				

Minnesota Department of Health

PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	COMPLETED		
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  2240 IDE COURT  MAPLEWOOD, MN 55109   (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  0 840 Continued From page 12  O 840  STREET ADDRESS, CITY, STATE, ZIP CODE  2240 IDE COURT  MAPLEWOOD, MN 55109  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY)  O 840  O 840			H33645	B. WING		O1/30	0/2020
SALAMS CARE RESIDENTIAL LLC  2240 IDE COURT MAPLEWOOD, MN 55109  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  0 840  Continued From page 12  2240 IDE COURT MAPLEWOOD, MN 55109  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  O 840	NAME OF PROVID	IDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  0 840 Continued From page 12  PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  0 840		SALAMS CARE RESIDENTIAL LLC					
	PRÉFIX (	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETE DATE
During observation on January 30, 2020 between 9:16 a.m. and approximately 12:00 p.m., C1 expressed ongoing concerns and fear regarding C2's behavior and loud outbursts. There had been a prior altercation between C1 and C2, and C1 remained fearful of C2. The investigator also noted during observation that only one staff member was on-duty to monitor and provide constant supervision for C1, C2, and C3. All three clients were noted as behind closed doors for extended periods of time.  Document review of facility policies pertaining to staff training and education did not include any training related to mental health diagnoses, crisis intervention strategies, or undesirable behavior de-escalation techniques.  Document review of unlicensed personnel (ULP)-D's employee file indicated comprehensive training and competencies were completed on October 17, 2019. The content lacked any mental health-related training.  Document review of ULP-F's employee file indicated comprehensive training and competencies were completed on October 17, 2019. The content lacked any mental health-related training.  During an interview on February 3, 2020 at 2:39 p.m., a police officer indicated C1 was brought back to the facility from walking alone outdoors in the cold, ill dressed for the weather, at approximately 9:50 p.m. ULP-D told the officer he went with C1 initially, but then returned to the facility because he was cold; ULP-D told	During: 16 expressions been C1 respectively been C1	ring observation 6 a.m. and appropressed ongoing is behavior and learn a prior altercated during observation was on-dured during observation strategies calation technically and competencies were solutionally and content review of the content alth-related training an interview alth-related training an interview of the solution and competencies were solved and the solution alth-related training an interview of the solution and competencies were solved and solved a	on January 30, 2020 between eximately 12:00 p.m., C1 concerns and fear regarding oud outbursts. There had ation between C1 and C2, and I of C2. The investigator also wation that only one staff ty to monitor and provide in for C1, C2, and C3. All noted as behind closed doors as of time.  If facility policies pertaining to ducation did not include any mental health diagnoses, crisis ies, or undesirable behavior inques.  If unlicensed personnel is file indicated comprehensive tencies were completed on The content lacked any red training.  If ULP-F's employee file ensive training and a completed on October 1, lacked any mental ing.  In on February 3, 2020 at 2:39 or indicated C1 was brought from walking alone outdoors in for the weather, at p.m. ULP-D told the officer tially, but then returned to the	0 840			

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		H33645	B. WING		01/3	; 0/2020
					1 01/3	0/2020
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SALAMS	CARE RESIDENTIAL	LLC MAPLEW	COURT OOD, MN 55	5109		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
0 840	Continued From page 13		0 840			
	a.m., ULP-D said was ervices to C2, C1 outside after C1 and approximately 1.5 be not supposed to be "he can be confuse ULP-D returned to to C2 and C3 who also supervision.  During an interview a.m., registered nurtime of the complaint trained on how to he	on February 3, 2020 at 11:44 while he went to provide left the facility. ULP-D went d walked with him for blocks. ULP-D said C1 was outside unattended because d about what happens." the facility where he had left o required constant  on February 5, 2020 at 9:55 rse (RN)-G said that at the nt, staff had not yet been andle mental health crises. not prepared for the facility's				
	Admission Policy, in accepted for treatm of reasonable criter client's medical, numet adequately by the of residence."	f an undated policy titled, ndicated, "Clients are ent in the home on the basis ia and an expectation that the rsing and social needs can be the Agency in the client's place				
	days	R CORRECTION: Seven (7)				
02015 SS=I	626.557, Subd. 3 Ti	iming of Report	02015			
	reporter who has revulnerable adult is to or who has knowled has sustained a phy	of report (a) A mandated eason to believe that a being or has been maltreated, age that a vulnerable adult ysical injury which is not ed shall immediately report				

Minnesota Department of Health

AND DIAN OF CORRECTION TO IDENTIFICATION NUMBERS		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	H33645	B. WING		01/3	) 8 <b>0/2020</b>
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
SALAMS CARE RESIDENTIAL	LLC MAPLEW	COURT OOD, MN 55	3109		
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
02015 Continued From pa	ige 14	02015			
the information to to individual is a vulne the individual is additional reporter is not required maltreatment of the to admission, unless (1) the individual from another facility to believe the vulnethe previous facility (2) the reporter kethat the individual defined in section 6 clause (4).  (b) A person not provisions of this is as described above (c) Nothing in this known or suspected knows or has reason been made to the control of t	he common entry point. If an erable adult solely because mitted to a facility, a mandated ired to report suspected individual that occurred prior is:  was admitted to the facility by and the reporter has reason erable adult was maltreated in it; or  knows or has reason to believe is a vulnerable adult as \$26.5572, subdivision 21,  required to report under the rection may voluntarily report				
time believes that a agency will determine the reported error w	n investigation by a lead ne or should determine that vas not neglect according to ection 626.5572, subdivision				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
H33645	B. WING	_		C <b>30/2020</b>	
SALAMS CARE RESIDENTIAL LLC	DDRESS, CITY, STOODRESS, CITY, STOODRESS				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
O2015 Continued From page 15  17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c.	02015				
This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to ensure an incident of suspected maltreatment was reported to the State Agency (SA), for three of three clients (C1, C2, C3) reviewed when staff left all three clients who required constant supervision without supervision for an undetermined amount of time.					
This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued 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).					
The findings include:  C1 was admitted to the facility on August 12, 2019, and received comprehensive home care services for diagnoses that included schizoaffective disorder, obsessive-compulsive disorder, and Type II diabetes. C1 received daily assistance with bathing, hygiene, grooming,					

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AND DIAN OF CODDECTION INTERCATION NUMBER:		l ` ´	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H33645	B. WING		01/3	; 0/2020
NAME OF	PROVIDER OR SUPPLIER		,	STATE, ZIP CODE		
SALAMS	CARE RESIDENTIAL	LLC MAPLEW	COURT OOD, MN 55	5109		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
02015	Continued From page 16		02015			
	dressing, and full medication management according to a service plan dated August 12, 2019.					
	Abuse Prevention F 13, 2019, indicated identify potentially of lacked self-preserve safety). The IAPP is measures staff were minimize the risk of "constant supervision."  C2 was admitted to and received compliant for diagnoses that is injury, mild mental redisorder, organic perdiabetes.  The investigator redistribution for the facility, but one.  Document review of Abuse Prevention F 2, 2019, indicated of identify potentially of verbally and physical inability to care for self-preservation skills.	f a form titled, Individual Plan (IAPP), dated November C1 possessed the inability to langerous situations and ation skills (ignores personal indicated the specific e supposed to utilize to abuse for C1 included on, cuing, and reminders."  The facility on April 15, 2019, rehensive home care services included a traumatic brain retardation, organic delusional ersonality disorder, and Type II quested C2's service plan from was not provided.  If a form titled, Individual Plan (IAPP), dated December C2 possessed the inability to langerous situations; becomes ally abusive to others; has an self-help needs; lacks of kills (ignores personal safety); medications. The IAPP				
	indicated specific method to utilize to minimize which included play Starbucks, keeping supervision, cuing,	neasures staff were supposed the risk of abuse to C2, ring his music, taking him to him calm, and constant and reminders.  the facility on November 5,				
		comprehensive home care				

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STATE FORM 1SSF11 If continuation sheet 17 of 19

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		H33645	B. WING		l	C <b>30/2020</b>	
NAME OF PROVIDER	OR SUPPLIER	STREETA	DDRESS, CITY, S	TATE, ZIP CODE			
SALAMS CARE F	RESIDENTIAI	L LLC	E COURT NOOD, MN 55	100			
(V.4) ID		ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CO	DDECTION	(VE)	
	CH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
02015 Continu	ued From pa	age 17	02015				
depression disorder medical independent (ADLs) Novem The inversion C3's IA During p.m., a back to the collapprox (ULP)-initially he was	sive disorder ality disorder, and Type ation manager according to be stigator received an interview police office the facility for the facilit	er, anxiety, borderline r, attention deficit hyperactive II diabetes. C3 received ement services and was II activities of daily living to a service plan dated  quested the facility provide e was not provided.  Yon February 3, 2020 at 2:39 er indicated C1 was brought from walking alone outdoors in the for the weather at to p.m. Unlicensed personnel ficer he walked with C1 turned to the facility because To let C1 continue on his own					
a.m., Learning services he were approximated not support the care of the care	ILP-D said was to C2, C1 at outside after imately 1.5 keys be confused to be stated he restricted to the material to the mater	quested an incident report atter; no report was provided					
p.m., re	egistered nu	on February 3, 2020 at 4:21 rse (RN)-E said staff did not e incident. Once he became					

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PRINTED: 02/11/2020 FORM APPROVED

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	AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		<b>l</b> ` ′	E CONSTRUCTION	COMPLETED	
		H33645	B. WING		C 01/30/2020	
			<u> </u>		01/00/2020	
NAME OF	PROVIDER OR SUPPLIER		,	STATE, ZIP CODE		
SALAMS	CARE RESIDENTIAL	LLC MAPLEW	OOD, MN 5	5109		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLE	ETE
02015	Continued From pa	ge 18	02015			
02015	aware and question there was "nothing they did not notify the nurse was unaware SA.  During an interview a.m., an RN-G, who facility, stated she was SA be made for the C1.  Document review of Vulnerable Adult, in maltreatmentis distemployee is to reposit mediately by phosimmediately by phosimmediate supervisions completed incident will review and reposit entry point within 24	ned staff about it, they told him clinical or life threatening" so he nurse. As a result, the and, thus, unable to notify the on February 5, 2020 at 9:55 provided consultation to the would expect notification to the incident that occurred with fan undated policy titled, dicated, "When scovered or suspected, the ort the incident via oral report ne or otherwise to their foraccompanied by a report form". The supervisor ort to the state-wide common				

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