MALTREATMENT INVESTIGATION MEMORANDUM
Office of Inspector General, Licensing Division
Public Information

Minnesota Statutes, section 626.557, subdivision 1 states, "The legislature declares that the public policy of this state is to protect adults who, because of physical or mental disability or dependency on institutional services, are particularly vulnerable to maltreatment."

Report Number: 202303183 and 202303878

Date Issued: October 3, 2024

Name and Address of Facility Investigated:

Disposition: Inconclusive

Minnesota Security Hospital dba Forensic Mental Health Program
100 Freeman Dr.
Saint Peter, MN 56082

License Number and Program Type:

801558-RMI (Residential Treatment and Services for Adults with Mental Illness)

Investigator(s):

Jason Pehler
Minnesota Department of Human Services
Office of Inspector General
Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
jason.pehler@state.mn.us
651-431-4830

Suspected Maltreatment Reported:

It was reported a vulnerable adult (VA) was not being provided adequate supervision and services which led to the VA inhaling and or ingesting edible and non-edible items.

Date of Incident(s): Multiple incidents occurring between April 1 and May 9, 2023.

Nature of Alleged Maltreatment Pursuant to Minnesota Statutes, section 626.557, subdivision 9c, paragraph (b), and Minnesota Statutes, section 626.5572, subdivision 15, and subdivision 17, paragraph (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 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 which is not the result of an accident or therapeutic conduct.

Summary of Findings:

Pertinent information was obtained during multiple site visits conducted on April 27, May 31, and June 2, 2023; from documentation at the facility; and through eight interviews conducted with facility staff persons (P1-P6), the VA, and the VA's guardian (G).

During the site visit on April 27, 2023, the VA was not present as s/he was hospitalized so was not interviewed. This investigator attempted to complete an additional site visit during the week of May 22-26, 2023, however the VA was hospitalized so the site visit was not completed since the VA would not be present for an interview. On May 31, 2023, a site visit was completed, and the VA was hospitalized so was not interviewed. P4 and P5 were interviewed but 11 other staff persons (P7-P17) declined to be interviewed as part of the investigation.

The VA returned to the facility on June 1, 2023. A site visit was completed on June 2, 2023, and the VA was interviewed. Additionally, P1-P3 were interviewed, and multiple other staff persons present during the site visit declined to be interviewed.

The VA was admitted to the facility on February 28, 2022. The VA's diagnoses included borderline personality disorder, oppositional defiant disorder, major depressive disorder, generalized anxiety disorder, and post-traumatic stress disorder. The VA had an extensive history of ingesting and inhaling both edible and non-edible items as a self-injurious behavior (SIB). The VA enjoyed writing, playing cards, coloring, doing crafts, and listening to music.

Prior to the VA's admission to the facility, the VA resided at Anoka Metro Regional Treatment Center (AMRTC) due to "unmanageable self-harm" primarily by means of swallowing inedible items, requiring medical intervention on multiple occasions. While at AMRTC, the VA had a 4 to 1 staff person ratio at all times and was still able to acquire items to ingest while staff persons were present at his/her side. It was determined that staffing ratio or proximity to the VA at all times did not impact the VA's ability to obtain and swallow inedible items. It was determined that staff person proximity to the VA added exposure to items s/he could swallow (face masks, name badges, keys, eyeglasses, etc.). Information also showed that the VA's history included a plethora of psychotropic medications and electroconvulsive therapy, none of which were thought to be effective in managing his/her SIBs.

The Department of Human Services (DHS) investigated similar concerns and incidents occurring between February 28 and September 6, 2022, in report 202207168. During that time, the facility did the following to support the VA:

- Support and behavior plans were reviewed at weekly clinical review meetings that included facility staff persons, facility health care professionals (HCPs), supervisors, and other providers and/or treatment team members. The team discussed what was working and what was not working and the plans were updated accordingly.

- There were ongoing changes in the VA's medication management and observation levels, ongoing medical consultations (internal and external), ongoing reviews of the VA's pattern of swallowing, restrictions/limits to items the VA had access to, and ongoing training for staff persons regarding supporting patients who engaged in foreign body ingestion.
- The VA attended groups, individual therapy, Accelerated Rational Therapy (A.R.T), and Dialectical Behavior Therapy (DBT). The VA was given sensory items, read self-affirmations, and supported in

developing coping skills.

The focus of this investigation was incidents that occurred from April 1 to May 9, 2023, and the programing provided by the facility during that time.

The VA's *Person-Centered Master Treatment Plan* dated February 21, 2023, provided the following information:

- The VA had a history of SIBs including banging his/her head, swallowing and aspirating edible and non-edible objects, and cutting him/herself. The VA also had a history of physical aggression toward others including punching, kicking, and spitting which would often occur after staff persons intervened verbally and physically to prevent the VA from engaging in SIBs and during the process of staff persons restraining the VA.

- The VA had some "risk signs" that s/he might engage in behaviors that included being aware of another crisis nearby, looking around/inspecting the unit, becoming argumentative, feeling hopelessness and/or feeling a lack of control, having a difficult conversation/phone call, holidays, phone calls with particular people, and guardianship meetings.

- The VA's *Recovery Goal* was to "reduce my self-harm and use my coping skills more." The plan stated that the VA would benefit from developing skills to manage intense emotions without self-harm or aggression toward others.

- The facility provided the VA with the following support to overcome his/her barriers and achieve his/her goals:

    - The VA was offered medication management meetings monthly to assess the VA's mental state and medication effectiveness.

    - Nursing offered the VA individual meetings at least once a month to assess medical and mental health status and address any concerns or needs.

    - The VA was offered individual therapy weekly to process emotions and develop coping skills to reduce instances of self-harm.

    - The VA was offered meditation group weekly as scheduled to engage in healthy coping strategies.

    - The VA was offered an insight into wellness group weekly to provide education and discussion on topics related to mental health management.

    - The VA was offered occupational therapy sessions weekly to develop and practice skills for self-regulation.

The VA's *Individual Abuse Prevention Plan* (IAPP) dated February 24, 2023, provided the following information:

- The VA engaged in SIBs while at the facility which included swallowing objects like pieces of eyeglasses, paper clips, clothing, towels, playing cards, pieces of a telephone, a toilet paper roll, and a vehicle's vent pieces. The VA required emergent medical care outside the facility due to several of the instances. The following steps would be followed to ensure the VA's safety:

    - Staff persons were to monitor the VA in his/her room using a camera as needed for observation per unit routine.

    - The VA was to receive hygiene items in paper cups, wear a tear proof gown, use edible spoons to eat returning all items from meals/snacks afterwards, and use tear proof blankets and pillows.

    - The VA was not able to have electronic devices, spare cups or containers in his/her room, pens, a toothbrush, condiment packages, milk cartoons, juice containers, straws, and socks.

    - If the VA attempted to negatively modify his/her environment, staff persons were to provide verbal redirection and encouragement to the VA to give staff persons the item and engage in conversation with them or alternate safe behavior.

    - Emergency interventions could be used depending on imminent risk level.

    - An approved variance allowed for the use of mechanical restraints while moving the VA from his/her unit to the ECT treatment room. The variance was to reduce the risk of the VA ingesting items when in "non-sterilized" environments.

    - During every incident of ingestion, the facility's medical providers were to first evaluate if there was a need to transport the VA to a medical facility by ambulance or if they could treat the VA at the facility to limit his/her access to items s/he had historically swallowed while in transport and at the hospital.

The VA's *Foreign Body Ingestion Treatment Plan Addendum* was reviewed and updated 24 times between January 17 and June 20, 2023, and provided the following information:

- Psychopharmacologic (the use of medication in treating mental health conditions) interventions included 14 different medications, some regularly scheduled, and some as needed (PRN), used to attempt to help the VA to regulate and decrease intrusive thoughts and SIB attempts.

- Consultative review of the VA's program and incidents included discussions with clinical supervisors regarding the VA's clinic care. Recommendations included increasing options for reinforcement when the VA was doing well, discussing the belief and possibility of facility discharge to "build hope" for the VA, researching the use of deep brain stimulation, and developing an information packet for outside providers such as hospital staff persons to inform them how to work with the VA. In addition, it was discussed that a "neutral" person should act as a point person for communication with the VA's family and guardians to ensure communication was consistent and available.

- The VA used a silicone cup, spoon, and plate while eating, and was provided a tear-proof blanket, mattress, and gown for his/her use on unit/bedroom.

- The VA had a *Behavior Clearance Plan* that restricted access to the follwing items; regular clothing/mattress/pillow, shoes, regular meal tray (including plastic silverware, condiment packets and milk/juice containers), safety pens, coin money, washcloths, eye glasses, a comb/brush, a toothbrush, electronic devices with batteries, board games, keeping personal clothing items in his/her room, notebooks, and folders. These items would be returned to the VA based on days of safety with the order being determined by risk/severity of recent ingesting incidents. The VA also had a restriction plan that restricted all paper products including toilet paper.

- The VA could access one tear proof blanket to use after showering but it needed to be returned to staff persons immediately. The VA could check out a radio from staff persons to use in the unit day-room under staff person supervision.

- All garbage was thrown away in the unit station garbage cans to prevent the VA from going into the garbage ingesting items from it. Staff persons would sweep the area and remove any potential items for any off-unit appointments the VA had.

- Sucessful interventions included limiting emotional reactivity to SIBs; engaging in a coping skill in times of stress or boredom as this helped distract the VA when s/he was experiencing difficult emotions; scheduling groups and individual sessions throughout the VA's day which proved helpful for providing healthy distraction from difficult emotions; reading affirmations which the VA stated helped him/her cope with difficult emotions; and check-ins with preferred staff persons. In addition, having the VA use hygiene products placed in paper cups, being mindful of placement/monitoring objects near the unit station door and nurses' station to prevent temptation to take and swallow items, providing hard candy upon request, and utilizing sensory items were also sucessful to reduce the VA's SIB incidents.

- Interventions that were tried and unsuccessful included check-ins twice a day to help identify the VA's mood because s/he was not honest; 4:1 staffing ratio because the VA continued to engage in behaviors despite the increased staffing ratio; nurturing responses to SIBs; transporting the VA to outside medical facilities in a caged van because on several occasions s/he was able to break pieces of vents in the van and ingest the pieces; utilizing handivan to transport the VA because this was found to be unsafe for both staff persons and the VA; aroma therapy because the VA swallowed some items; sterilizing the enviornment because it caused an increase in agression from the VA and was "virutally impossible" to sucessfully limit all items in an environment that was shared with peers; and the use of paper cups, plates, and edible spoons because the VA began to inhale the paper products and some food items.

The VA's *Behavior Plan* dated March 23, 2023, provided the following information:

- The purpose of the behavior plan was to replace behaviors with healthy routines and distractors when the VA was experiencing distressing emotions, which included reporting the desire to swallow items before doing so and utilizing DBT and coping skills in the moment to reduce the incidents of SIBs.

- The VA's identified precursors to behaviors included being hypervigilant, scanning his/her surroundings, and/or being argumentative with others. Staff persons were to meet with the VA at the nursing station window when available, and if staff persons were not available, the VA would be asked to wait and/or staff persons would communicate with the VA through the closed unit station door.

- The VA was very resourceful and had broken items to ingest, hidden those items, and then ingested the items later.

- The VA's *Target Behavior* was "foreign body ingestion" which included swallowing and inhaling items. The behavior resulted in medical attention, after swallowing/inhaling items such as gloves, shoes, spoons/knives, game pieces, safe pens, screws, keys, batteries, garbage bags, clothing items, wash cloths, broken van vent pieces, broken phone pieces, paperclips, glasses, masks, candy wrappers, etc. The VA obtained or attempted to obtain these items from other people, including staff persons and peers, and the surrounding environment.

- The VA received redirection/prompting from staff persons to not ingest objects s/he had, was placed on different observation levels, had nursing assessments, was manually and mechanically restrained, was given the opportunity to talk to preferred staff persons, was given PRN medication, and was seen by non-facility providers.

- The VA had a short list of coping skills, however while dysregulated s/he was unable to utilize these skills and would engage in SIBs to cope with the emotions or thoughts s/he was experiencing. The VA had utilized coping strategies with staff person's assistance for small durations of time, including the longest of 41 days where the VA did not engage in SIBs.

- Some interventions that were attempted but not successful included daily check ins with the VA; talking about discharge from the facility to give the VA hope; staff person ratio and observation level increases; and sterilizing the environment because those would lead to increased aggression and or SIBs. Staff persons would open the half door to the office when the VA was exhibiting precursors to his/her behaviors but when staff persons had done so, the VA attempted to enter the unit station to either aggress toward staff persons or obtain items to ingest. Staff persons would meet with the VA on the unit when s/he was exhibiting precursor behaviors but often the VA would aggress toward staff persons and peers to take items from them to ingest.

While at the facility the VA resided on the Tamarack Unit, and most of the incidents of SIB occurred there. The VA had multiple peers who also resided on the Tamarack Unit, but the VA's peers changed occasionally due to those individuals' treatment/progression from the unit. The unit had multiple rooms, as each individual had their own bedroom. The unit also had a conference room, as well as a shared common area, and an enclosed outdoor courtyard. The unit was accessed by staff persons from multiple locked doors. The unit station was located behind two separate locked doors, which staff persons could use to access the common area on the unit. The staff person unit station included multiple windows which allowed observation to the common area, outdoor courtyard, and the VA's room. Within the unit station a computer was used to observe the VA by camera. The camera provided observation from multiple angles within the unit, including the VA's room. One of the locked doors was designed with a half door that could be unlocked and provide the VA or his/her peers with face to face, non-barrier interaction with staff persons while staff persons were in the unit station. The unit station was

connected to a nursing office, where staff persons could utilize a window to interact with the VA and completed nursing specific tasks. Within the unit there was a meal serving window which the VA and peers would receive their food from staff persons.

As part of the investigation this investigator reviewed video recordings on April 12, 2023, from 5:30 to 7 p.m., and 7:08 to 7:33 p.m., on April 13, 2023, from 6:30 to 8:30 a.m., and on May 7, 2023, from 1:12 to 1:43 p.m., to view staff persons' interactions with the VA. The recordings were of the VA's room, unit common area, hallways, and a garage of the facility. The recordings showed multiple camera angles, and over 200 videos were watched individually. The length of each video was typically between two and five minutes, however there were recordings that were shorter, as well as longer than 15 minutes. Within the recordings there was minimal interaction by staff persons, which included staff persons making comments and/or brief conversations with the VA. There was no observation of staff persons participating in activities with the VA or prolonged verbal interaction with the VA during the video recordings. However, the recordings were of the VA's unit prior to the VA engaging in SIBs, therefore the recording was not a full representation of all the interactions the VA had with staff persons. During multiple recordings the VA would have his/her back toward the camera while in his/her room, or s/he would completely cover him/herself with a blanket while lying in bed. The recordings showed multiple instances of the VA engaging in SIB and the staff persons' responses.

The VA provided the following information:

- The VA said s/he enjoyed interacting with specific staff persons at the facility as they took time to work with the VA when s/he was "struggling." The VA said staff persons would interact with him/her on the unit, and from the staff person and nursing offices.

- The VA said s/he had inhaled multiple types of objects, including food and objects (including toilet paper) s/he got from a peer's room. The VA was unable to recall additional details of incidents of inhaling of objects. The VA estimated s/he had engaged in the SIB more than 20 times.

- The VA was aware staff persons watched him/her via camera, and that staff persons did not feel "comfortable" on the unit with the VA. The VA was also aware of his/her programming plans and the steps s/he needed to take to regain access to items.

- The VA said having more "check ins" with staff person would be helpful for his/her success, but the VA said s/he would go up to the staff person office door and/or nursing window and interact with people. The VA said s/he did not want to be viewed as "needy," and it was not fair to his/her peers that s/he kept going to the hospital.

- While discussing SIBs and inhaling of objects the VA said s/he was "very resourceful" in obtaining the items, and that s/he had a "problem." The VA said the SIB changed about two months ago, and s/he started inhaling objects to deal with boredom and the VA liked "attention."

- The facility tried to use the positive reinforcement of 1:1 time with the VA's preferred staff persons as a way to ensure his/her safety.

Facility documentation provided the following information regarding incidents of the VA inhaling or ingesting items and the corresponding action taken by the facility:

- From April 1 to May 9, 2023, there were five days in which the VA did not engage in SIB and was not hospitalized due to SIB. The VA's observation level during this time was 1:1 observation with a barrier while the VA was on the unit and in the courtyard. Staff persons could observe the VA via camera when the VA was in his/her room and the sensory room listening to music. The VA "no longer" needed to be observed 1:1 in the shower but staff persons were supposed to stand outside the shower and maintain verbal contact with the VA every two minutes and staff persons were to ensure the VA had nothing with him/her in the shower. Hygiene items were to be poured by staff persons into the VA's hand and the VA was not to have access to cups. The VA also was no longer to have access to washcloths or towels, the VA was to dry with a tear proof gown or blanket.

- April 1, 2023:

  - At 7:39 a.m., the VA refused to participate in an education group.

  - At 8 a.m., the VA was observed eating and breathing without issue.

  - The VA was observed on camera inhaling toilet paper "prior" to 9:30 a.m. Nursing took the VA's vitals and his/her oxygen saturation level, which ranged from 71 to 74%.

  - A medical staff person (P18) was contacted and requested further evaluation and removal of the toilet paper. At 9:45 a.m., the VA was transported by ambulance to a medical facility. During transport the VA made comments that s/he "wants to die."

  - Twelve pieces of toilet paper were removed from the VA's lungs. The VA returned to the facility at 2:55 p.m.

  - A medical order was placed stating the VA could not have toilet paper or paper products. It was noted the VA had a pattern of behavior and staff persons were to follow the treatment plan. Staff persons were to address target behaviors as observed or reported. Safe behaviors and medication adherence would continue to be encouraged.

- April 2, 2023:

  - The VA slept most of the evening after returning to the facility the night prior and did not display any signs of respiratory distress.

  - At 2:40 p.m., nursing staff persons were informed the VA had inhaled toilet paper s/he had received from a peer. The VA's vitals were taken, and the VA's oxygen saturation was at 90%. The VA had audible wheezing and complained of shortness of breath. P18 was contacted, an ICS was initiated, and an ambulance was requested. The VA was transported by ambulance to a medical facility at 4 p.m.

- It was noted the VA had a pattern of behavior and staff persons would continue to support the VA through struggles with SIB behaviors.

- April 3, 2023:

  - The VA engaged in a SIB (non-inhaling) during vehicle transport. The VA forcibly removed a back window of a facility van and threw his/her body onto the highway. The VA sustained injuries and was transported via air ambulance for treatment. See DHS report 202302948 for additional details.

  - A silicone cup was purchased as the VA would not be provided Styrofoam cups. P18 recommended "the most sterile environment available" due to the on-going SIBs. P18 noted that having peers was "a greater risk and may provide [the VA] greater opportunities" to obtain items to ingest or inhale.

- April 4, 2023:

  - At 6:34 a.m., P7 met with the VA and completed the VA's 1:1 treatment planning.

  - The VA's nursing care plan was reviewed. Nursing staff persons and the VA discussed concerns the VA had including wanting a regular mattress, wanting a pillow, and not having a bowel movement for a couple of days.

  - A staff person (P33) reviewed the VA's behavioral data and documentation from March 2023. The VA completed two of the five offered individual coping skills sessions. It was noted that during March the VA engaged in seven incidents of physical aggression towards peers, staff persons, and property.

  - The VA slept a majority of the day and even when staff persons verbally prompted the VA, the VA did not respond and continued sleeping.

  - P2 attempted a monthly psychiatric follow-up with the VA but the VA remained asleep during the scheduled session. Two antipsychotic medications and five psychotropic medications were added to the VA's medication regime for different symptoms. The VA continued to engage in self-harm; however, the behavior had escalated to inhaling items rather than ingesting them. Prior to the escalation the VA was doing well and made it several weeks without unsafe behaviors. The VA had earned back walks in the hallway with staff persons and the VA's mood appeared "hopeful."

- April 5, 2023:

  - The VA received nursing care related to the incident occurring on April 3, 2023.

  - The VA spent most of his/her time in bed lying under blankets, briefly interacting with a peer.

  - An "Urgent Clinical Consultation" occurred regarding the care and treatment of the VA which included eighteen facility staff persons; medical and psychiatric providers, social workers, nursing supervisors, and unit supervisors.

- Following the meeting, recommendations which were put in place included continuing to monitor the VA's phone calls to identify any potentially triggering communications, identifying a "neutral" person to communicate with the VA's family/guardians to ensure communication was consistent and available, increasing options for reinforcement of the VA when s/he was doing, discussing the VA's potential future discharge and "building hope," researching "Deep Brain Stimulation" as a treatment option, researching the use of the medication memantine as a treatment option, developing a "to go" packet for other providers to work with the VA, and identifying supports requested by staff persons working directly with the VA.

- April 6, 2023:

  - The VA was provided nursing services throughout the day related to the incident on April 3, 2023.

  - The VA completed a 1:1 therapy session with a staff person (P28) and processed emotions and developed coping skills. The VA said s/he had previous thoughts about dying and was concerned staff persons would forget about him/her if s/he continued to do well in his/her treatment. While discussing coping skills the VA said if s/he was provided paper products s/he was unsure if s/he would inhale those paper products. P28 noted during the interaction the VA's "affect was incongruent with the serious nature of the conversation," but the VA was "enthusiastic at the prospect of regaining some of her belongings." The VA's goal remained working toward regaining some items by refraining from SIBs.

  - Due to the VA's SIBs a staff person (P29) presented a paper product restriction to a review panel, however the restriction was not approved as written. The restriction was forwarded to the next step of review.

- April 7, 2023:

  - P23 completed a monthly treatment progress note documenting that the past month, the VA attended one of four medication group sessions and one of five processing group sessions. The groups would continue to be offered to the VA on a weekly basis per his/her daily schedule.

  - P29 continued to try and work with the VA within a wellness group, however due to the SIB incidents, the meetings were not completed.

  - The VA was observed urinating on the floor next to his/her bed and using a blanket to wipe up the urine.

  - The VA went to the nursing window and informed nursing that s/he inhaled a peer's facial tissue at 5:20 p.m.

  - Nursing observed the VA was not exhibiting any signs of respiratory distress and checked the VA's vitals. There were no abnormalities noted, but the VA said s/he had discomfort in his/her chest.

- An on-call medical provider was contacted and requested the VA be seen at a medical facility for evaluation/testing.

- The VA was restrained and transported by ambulance to a medical facility around 7 p.m.

- While at the medical facility the VA coughed up the facial tissue but continued his/her attempt to re-inhale it. The VA was transported to a different medical facility for further medical care.

- A bedroom search was completed, and additional paper products were removed that the VA had hidden.

- Staff persons also had observed the VA manipulating screws on an information board posted on the unit. This board was required to display various information and a request was submitted to have all the screws tightened.

- April 8, 2023:

  - The facility was informed the VA would have a bronchoscopy completed mid-morning at the medical facility.

  - At 7:30 p.m., the VA returned from the medical facility and was combative toward the EMTs during transport. The VA attempted to ingest/inhale an EMT's glove.

  - Upon return to the facility the VA denied having any items on his/her body, and agreed to complete a visual check with P34 in a shower area. The VA had "minimal cooperation" and did not show P34 certain areas such as the area under the VA's body folds.

  - Around 8:20 p.m., while walking in the unit common area the VA obtained a peers Styrofoam cup and "quickly" moved towards his/her room. Prior to the VA closing his/her door staff persons prompted the VA to give them the Styrofoam cup. The VA broke the Styrofoam cup into pieces and was observed putting it under his/her tear proof gown and potentially into his/her person. The VA provided a portion of the cup to nursing but said s/he inhaled some of the Styrofoam cup.

  - The VA was medically assessed, and his/her oxygen saturation was 95%. The VA was medically stable and remained at the facility.

  - The VA's peer was provided a hardened plastic cup to limit Styrofoam on the unit.

- April 9, 2023:

  - The VA spent most of the morning in bed. The VA ate, took medications, and went back to his/her room.

  - At 2:10 p.m., the VA was observed vomiting in his/her bedroom and staff persons assisted the VA with cleaning the area. Multiple pieces of Styrofoam were observed in the vomit. Thereafter, the VA

attempted to obtain a plastic glove from nursing while medications were being provided, however the VA was not successful in obtaining the glove.

- Around 2:30 p.m., while P34 was engaged with a peer, the VA was observed near a peer's door. P34 verbally redirected the VA away from the peer's door, however the VA entered the peer's room obtaining tissue paper and pieces of a Styrofoam cup. An ICS was activated, and paper product was removed from VA's hand. Thereafter the VA went into his/her room and locked the door. The VA was monitored 1:1 via camera.

- P32 was contacted and discussed potential physical intervention, however it was determined staff persons would give the VA "space to deescalate and offer safe coping skills."

- At 3:15 p.m., the VA was observed via camera to be sitting in his/her bed and attempting to inhale/ingest an item. The VA was redirected from the SIB and encouraged to talk with staff persons at the nursing window. The VA spoke with staff persons who encouraged the VA to spit out the item. The VA provided staff persons with small pieces of a Styrofoam cup that were in his/her hand but attempted to inhale Styrofoam which was in his/her mouth.

- Staff persons shook out the VA's sheets and swept his/her room. The VA did not allow staff persons to complete a visual check of his/her body.

- Nursing checked the VA's vitals and there were no abnormalities noted. P32 was contacted and no emergency measures were deemed necessary at that time.

- The VA continued to attempt to inhale Styrofoam or tissue. The VA refused to follow staff person directives, and staff persons continued to monitor the VA.

- Between 4 and 4:30 p.m., the VA picked at a door handle on the unit, and informed P34 that s/he had inhaled toilet paper. The VA did not show any acute distress, the VA was unable to provide information related to whether the toilet paper was ingested or inhaled. P34 provided encouragement for the VA to not engage in repeated SIB, P34 offered to search the VA's room to support the VA from engaging in SIB. The VA declined and returned to his/her room with the door open. The VA complained of breathing difficulties and nursing checked the VA's vitals. The VA's oxygen saturation was low, and oxygen was administrated to the VA. P32 was contacted and ordered the VA to be seen at a medical facility.

- The VA was transported by ambulance to a medical facility at 5:15 p.m.

- April 10, 2023:

  - The facility communicated with the medical facility regarding the VA's care and a bronchoscopy was completed.

  - While at the medical facility the VA obtained and ingested multiple items so a second bronchoscopy was completed.

- April 11, 2023:

    - The VA returned to the facility at 3:35 p.m. and had obtained a piece of glove from the EMT while being transported. The VA was going to ingest it but staff persons were able to remove the glove from the VA's possession.

    - Upon returning to the facility the VA's 1:1 observation was renewed, the G was contacted, and staff persons assisted the VA in changing into his/her tear proof gown and completed a visual body check to ensure the VA did not have any items on his/her person.

    - At 4:41 p.m., P16 noted the VA entered a peer's room and obtained toilet paper. An ICS was initiated when the VA entered the peer's room and staff persons re-directed the VA's behavior. Staff persons assessed the VA, and the VA did not have any items.

    - At 6:15 p.m., the VA requested a staff person to come onto the unit, and a staff person spoke to the VA at the nursing window. The VA proceeded to inform the staff person that s/he inhaled an item and started showing the staff persons how the VA inhaled items. The VA had a small piece of toilet paper in his/her hand, and staff persons requested the item from the VA, which the VA agreed and gave the toilet paper to the staff person. The VA was asked if s/he had more paper products or other items and the VA declined to answer. The VA said his/her chest hurt, and staff persons encouraged the VA to not engaged in SIB. The VA's oxygen saturation was checked and was at a normal level, an on-call medical provider was contacted and advised to not send the VA to a medical facility. The VA was monitored by staff persons for any change in physical health.

        - It was decided the VA's peers would eat in the conference room when the VA was present to limit paper products on the unit.

        - According to nursing staff persons the VA told EMS staff persons who transported him/her back to the facility on April 11, 2023, that they would be seeing the VA again tonight.

- April 12, 2023:

    - At 12:45 p.m., the VA grabbed a napkin from peer's lunch tray, staff persons went onto the unit and requested the napkin from the VA. The VA was observed to be chewing the napkins and attempted to inhale a ball of the napkin. The VA stuck out his/her tongue and told staff persons, "See I don't have it anymore, now you don't need to take it." The VA went into his/her room and drank water from the sink.

    - Prior to the incident staff persons observed precursors to the VA engaging in SIB because the VA was pacing around the unit and declined his/her lunch. Staff persons "maintained an extra unit presence" and three staff persons were on the unit floor in attempt to prevent the VA from obtaining any of his/her peers' paper products.

    - The VA returned to the common area and approached a peer "rapidly" after the peer received his/her lunch, and the VA obtained the napkin. Staff persons went toward the VA and the VA's peer,

but were unable to prevent the VA from obtaining the napkin. Staff persons physically intervened and attempted to get the napkin, however staff persons were unsuccessful, and a manual restraint was initiated. The VA did not physically struggle during the restraint but spat in staff persons' faces. The VA was placed into a restraint chair for safety and moved to a different unit area for privacy.

- P19 meet with the VA around 1 p.m., after s/he engaged in SIB. The VA was in a restraint chair while interacting with P19. P19 engaged in motivational interviewing with the VA, and discussed the VA's feelings, coping skills, and potential medication changes. P19 documented that the facility continued to "employ all means at our disposal to deter" the VA's SIB, and staff persons have worked "tirelessly" to promote safety, and mental health stability. The VA was familiar with DBT but struggled to apply the techniques.

- P19 noted that the VA expressed feelings of hopelessness, that s/he was going to continue self-harm behavior. The VA was observed with a ball of wet toilet paper in his/her mouth while meeting with P19 but did not attempt to inhale it during the meeting. The VA discussed feeling as though s/he was "bipolar" and that emotions just take over his/her body, without warning, and even when s/he felt good there was a sense of sadness and foreboding. P19 reviewed clinical criteria for borderline personality disorder and how this experience was common of the disorder and can be addressed if motivation to do the work of treatment was present. P19 sought to instill hope, and discussed the science of brain development, long-term prognosis of borderline personality disorder, and the time-limited nature of the VA's civil commitment. The VA talked about and processed stressors from the last few weeks and they discussed coping strategies and ambivalence about self-harm behaviors. P19 noted that s/he attempted to meet with the VA on April 5, 6, and 11, 2023. However, the VA was either receiving medical services, or sleeping. It was deemed "countertherapeutic" to wake the VA for an interaction with P19.

- It was then determined the VA needed a medical evaluation/treatment from an outside medical facility and an ambulance was requested at 2:55 p.m. An ICS was initiated as nursing continued to monitor the VA's condition. The VA's condition "improved," and the ambulance/ICS was cancelled as there was no further need for medical attention at that time.

- At 7 p.m., the VA approached P6, and was observed to be slightly pale in color, and was pointing to his/her neck. The VA handed P6 four or five balled up pieces of toilet paper. The VA was able to walk and talk, and his/her vitals were taken. The VA's oxygen saturation was at 84-86% but dropped to 74-78%. An on-call provider was contacted and ordered the VA been seen at a medical facility. An ICS was initiated, and the VA was transported by ambulance at 7:32 p.m.

- April 13, 2023:

  - The medical facility completed a bronchoscopy, and the VA was transferred back to the facility on April 13, 2023, at 5:45 a.m.

  - After the VA returned, s/he said s/he obtained Band-aids while at the medical facility. The VA said while being transported back to the facility the VA inhaled the Band-aids at 5:30 a.m. Staff persons attempted to re-direct the VA; however, were not unsuccessful. Nursing consulted with a medical

provider and the VA was not immediately sent back to the medical facility as his/her oxygen saturation levels were stable. The VA was not in distress, had unlabored breathing, and walked and talked without difficulty.

- Just before 8 a.m., the VA stumbled out of his/her room and was in apparent respiratory distress. The VA said s/he inhaled pieces of a washcloth s/he had found on the floor. The VA was assisted to the floor, and nursing assessed the VA's vitals. The VA's oxygen saturation was low at 40% and nursing provided the VA with oxygen. The VA's oxygen saturation increased to 92% over the course of a few minutes.

- An ICS was initiated, and the VA was transported to a medical facility at 8:15 p.m. The facility was unsure where or when the VA obtained the washcloth, and were unable to locate any other pieces of the washcloth.

- The VA was going to be moved to the Willow East unit upon return.

- April 17, 2023:

  - The VA's plan was updated and stated that the VA's incoming mail was to be checked for potential items that could be inhaled or ingested.

- April 19, 2023:

  - A treatment plan meeting regarding the VA was completed with 12 supervisors and providers present. The VA was not present as s/he was hospitalized.

  - At the meeting, the "past review period" was discussed and the VA's continued struggles were discussed "in-depth." The VA's objectives/goals remained the same, as well as individualized therapy, occupational therapy, and A.R.T. The VA's *Foreign Body Ingestion Addendum* was also reviewed for successful and unsuccessful interventions.

- April 20, 2023:

  - The VA was at the medical facility until April 20, 2023, and engaged in SIB on the following dates while there:

    - On April 14, 2023, the VA inhaled pieces of an IV tube despite have 4:1 supervision. A bronchoscopy was completed.

    - On April 16, 2023, the VA inhaled a piece of an absorbent pad and a bronchoscopy was completed.

  - The VA returned to the facility and s/he was placed on the Willow unit where no other residents resided at the time. Staff persons assisted the VA in changing into his/her tear proof gown. The VA's 1:1 observation was renewed, and the VA then rested in his/her room.

- Trom 2 to 5 p.m., staff persons documented the VA as sleeping and that the VA took his/her medications. The VA requested physical assistance from staff person to use the bathroom, and staff persons verbally prompted the VA to complete the task independently and the VA did. The VA spent most of the time the rest of that day on his/her mattress but went to the door twice prior to returning to the bed.

- April 21, 2023:

  - Around 7:30 a.m., the VA was sleeping, and P6 prompted the VA for morning medications. The VA walked to the nursing window and was observed to be "slightly pale" in color and his/her breathing was "rapid and labored." The VA said s/he did something "stupid" and inhaled a "small piece of plastic." The VA had stored a piece of plastic tubing from the medical facility in his/her belly button and inhaled the tubing. The VA vitals were taken, and the VA's oxygen saturation was between 70-78% so nursing provided the VA oxygen. The VA oxygen saturation increased to 92-96%.

  - A medical provider was contacted, ICS was initiated, and the VA was transported to a medical facility; however, the plastic was not found. P6 and other staff persons assisted the VA with hygiene prior to ambulance transport. The VA also disclosed auditory hallucinations since returning to the facility on April 20, 2023. The G was contacted regarding the incident.

  - The medical faciality did not find the plastic piece, however the VA was intubated due his respiratory concerns, and was diagnosed with bilaterally pulmonary embolisms. The VA remained at the medical facility until April 29, 2023.

- April 26, 2023:

  - P7 was unable to complete the VA's weekly 1:1 session discussing his/her treatment plan as s/he was at the medical facility.

  - An inter-agency discussion involving multiple supervisory level employees and the G took place.

  - The VA's IAPP dated April 27, 2023, was updated to say that on April 21, 2023, the VA engaged in SIB and a medical facility found the VA had bilaterally pulmonary embolisms and s/he was intubated. The medical facility successfully dissolved the blood clots, and the VA was started on a blood thinner, Xarelto. Due to the significant history of SIB, staff persons should intervene if the VA started to engage in attempts of SIB as the blood thinners put the VA at a high risk for causing serious/permanent damage to him/herself.

- On April 27, 2023, during the site visit, this investigator viewed live video footage of the unit the VA resided on. However, the VA was at the medical facility so staff persons interactions with the VA were not able to be observed.

- April 28, 2023, P28 noted the VA did not complete DBT groups during April 2023, due to being "absent" from the unit. Upon the VA's return P28 planned to meet with the VA twice a week for therapy.

- April 29, 2023:
    - The VA returned to the facility at 11:05 a.m. and was placed on the Tamarack unit as the Willow Unit was under construction, nursing was more available on Tamarack, and staff persons were able to intervene quicker to the VA's behaviors.
    - The VA's supervision resumed at 1:1 observation, and a medical provider placed an order for an easy chew diet and thickened liquids.
    - Nursing observed the VA throughout the day as there were multiple concerns with the VA including, but not limited to his/her breathing, weakness, falling/lowering him/herself to the floor, and feeling dizzy.
- April 30, 2023:
    - A nursing care plan was started as the VA had a risk of respiratory infection and ineffective airway clearance.
    - The VA ate breakfast, took medications, and spoke with staff persons.
    - At 9:17 p.m., the VA informed staff persons that s/he inhaled pieces of a washcloth and was observed with his/her hands around his/her throat, indicating s/he was choking. Staff persons preformed the Heimlich multiple times until the item was dislodged and the VA was able to breathe.
    - The VA provided staff persons with two of his/her peers' washcloths which s/he obtained after the peers had showered. The VA said s/he inhaled pieces of one of the washcloths and his/her oxygen saturation was at 88-93%. A medical provider was contacted, and the VA remained at the facility.
    - Staff persons provided education to the VA on continued dangers of inhaling items. The VA's room was searched by staff persons and an edible spoon, part of a washcloth, and bread crust was removed from the VA's room.
- May 1, 2023:
    - At 4 a.m., the VA informed staff persons s/he had inhaled a piece of washcloth on April 30, 2023, at 9:45 p.m., after s/he stored it in his/her body. Nursing assessed the VA and the VA's oxygen saturations were between 70-80%.
    - An on-call medical provider was contacted and the VA was transported to a medical facility. The VA returned from the medical facility at 4:30 p.m., no additional changes were made at this time.
    - During the evening the VA entered a peer's room, and staff persons spoke with the VA, and s/he denied obtaining any items. Staff persons were unable to determine if the VA had obtained any items, but the VA was displaying signs and symptoms of precursors of SIB by scanning the environment, entering a peer's room, and was described as having an "intense stare" and "mouth

slack." Staff persons educated the VA on the dangers of inhaling items.

- The VA declined to participate in a nursing education group.

- May 2, 2023:

  - At 3:30 a.m., the VA informed nursing s/he inhaled toilet paper. The VA's vitals were monitored, and the VA's oxygen saturation dropped to 71%. Nursing administrated oxygen. An on-call medical provider was informed of the incident. The VA was transported to a medical facility at 4 a.m.

  - While at the medical facility, the VA attempted to inhale food, which was the first observed incident of attempted inhaling of food.

  - The VA returned from the medical facility at 6:35 p.m., ate supper, took his/her medications, and went into his/her room.

  - P33 reviewed the VA's previous month, April 2023. The VA was offered four individual therapy sessions, however due to the VA's SIBs and hospitalizations the VA was not available, or it was not appropriate for the session to occur. The VA engaged in 21 attempts of SIB, and 16 incidents of inhaling objects during the month of April 2023. The VA had 14 bronchoscopy procedures and was hospitalized on three separate occasions.

- May 3, 2023:

  - At 2 p.m., P6 documented the VA was awake for breakfast and lunch without any concerns. The VA spent the majority of the time in his/her room, but spent some time on the unit and in the courtyard.

  - At 2:45 p.m., P33 completed an "individual coping skills session" with the VA. The VA engaged in a verbal discussion regarding coping skills, but P33 noted the VA was scanning the environment during and after the session.

  - At 3:34 p.m., P2 noted s/he spoke with the VA at the medication window and the VA felt bored, and hopeless. P2 attempted to encourage the VA and ensure the VA would get more activity into his/her day, and work toward simplifying the VA's medications.

  - At 5:40 p.m., the VA entered a peer's room and obtained toilet paper. Staff persons approached the VA and VA placed the toilet paper in his/her mouth. Staff persons lowered the VA to the floor and started negotiating with the VA to give the toilet paper to staff persons. The VA did not verbally respond and staff persons attempted to retrieve the toilet paper from the VA's mouth. The attempt was unsuccessful, and despite the manual restraint the VA was able to inhale/ingest the toilet paper. The VA was placed in a manual restraint chair, and nursing assessed the VA.

  - At 9:05 p.m., P6 documented the VA's oxygen saturation was monitored throughout the restraint, and the VA was provided food once s/he was removed from the restraint chair. Thereafter, the VA

was in his/her room, with a blanket covering his/her entire body. P6 used the intercom system to ask the VA if s/he was attempting to inhale something, however the VA did not respond. P6 and other staff persons entered the unit and then the VA's room, and a balled-up piece of bread was observed in the VA's hand. The bread was removed, however the VA refused to remove the blanket, so P6 removed food and crumbs that were visible. The VA breathing was "even and unlabored". The VA remained in his/her room, covered by the blanket.

- P32 was consulted, however the VA remained at the facility, and the VA was to be monitored closely for any respiratory compromise.

- P23 documented there were four "positive relationship" groups, and four "medication" groups from April 3 to 24, 2023. The VA did not attend any of the groups as s/he was receiving outside medical services.

- P30 documented the VA was scheduled for a weekly "conflict resolution" group, however the VA was not medically or psychiatrically stable so could not attend.

- P31 and P32 discussed options to limit the VA's diet and risks due to attempts of inhaling food items. Multiple options were discussed including removing high risk food and the VA's food being minced/moist or pureed. However, due to multiple circumstances such as the difficulty with identifying high-risk foods, the VA's ability to inhale most items, and the VA having access to peers' food, it was decided all options would "likely have limited success."

- A change was made to the VA's diet, which include an "easy to chew diet" order and no peanut butter sandwiches as a unit alternative to meals.

- P32 noted the removal of peanut butter products would assist, but not prevent further attempts in which the VA attempted to inhale food.

- P2 completed a progress note detailing the VA's past month's incidents, provider orders, plans, treatment, and medications which provided the following information:

    - The VA's current observation level included providing supervision of the VA while showering. Staff person would ensure no items were in the shower, provided verbal contact every two minutes, the VA was not provided any cups for shower products, staff person poured the products into the VA's hand, and the VA did not have access to washcloths or towels. The VA would dry off using a tear proof gown or blanket.

    - There was an order that was related to the removal of toilet paper/paper products due to the VA's SIBs. Staff persons attempted to brainstorm alternatives, including biodegradable toilet paper, however it was found that biodegradable toilet paper did not disintegrate faster than regular toilet paper. A sanitary bottle was also considered; however, the bottle would likely be unsafe due to the VA's ability to manipulate objects, and thereafter inhale objects. A small sized cloth which was tear proof was being considered, however at the time of the note the VA had the option to shower after

urinating and/or having a bowl movement.

- P2 documented that treatment with medications had not been effective in reducing the VA's SIBs. Based on the information, the VA had been prescribed 27 psychotropic medications and on-going collaboration with P19 was occurring to address the VA's behaviors. In addition, ECT was completed twice, but there were no known beneficial effects.

- P2 noted that due to several hospitalizations the VA had limited time at the facility and had not made much improvement in reduction of SIBs. Staff persons continued to develop ways to help the VA improve and promote safety. The VA's plans were being reviewed as s/he continued to obtain washcloths and toilet paper and attempted to inhale the items.

- The VA did not have signs of mania or psychosis, and denied wanting to die, however the VA's "risk for accidental fatality remains very high."

- May 4, 2023:

  - The VA woke up, ate breakfast, and took medications. Then, the VA took a peer's washcloth and attempted to inhale pieces of the washcloth.

  - An ICS was initiated after the VA obtained a washcloth from a peer. Staff persons negotiated with the VA to prevent him/her from inhaling the washcloth, and the VA gave the washcloth back to staff persons. After the VA gave staff persons the washcloth the VA began scanning the unit and asked a peer for toilet paper for him/her to inhale.

  - Staff persons found a hardened bagel or English muffin in the VA's room and the item was removed.

  - During the late morning, the VA entered a peer's room, locked the door, and inhaled the toilet paper. Staff persons unlocked the peer's door and continually prompted the VA to spit out the toilet paper, but s/he continued to engage in the behavior and inhaled the toilet paper.

  - An on-call medical provider was contacted and nursing continued to assess the VA. There were no signs of distress and nursing continued to monitor oxygen saturation levels. The VA continued to try and inhale toilet paper and was later transported to a medical facility at 11:20 a.m.

  - The VA returned to the facility at 4:58 p.m. The VA continued to be monitored.

- May 5, 2023:

  - The VA spent time in the common area, listening to music, and laying outside in the courtyard. The VA completed a 1:1 meeting with a P28 and processed emotions and worked on developing coping skills.

- The VA spoke with P29 about frustrations related to a phone plan and feeling like the team was "punishing" the VA for his/her behavior. P29 encouraged the VA to work with the team on using coping skills. P29 ensured the VA the team was trying to keep the VA safe, and not punish him/her.

- P29 noted the VA struggled to progress toward his/her goals and was consistently in and out of the facility due to SIBs. During the month of April 2023, the VA only completed one meeting with P29.

- The VA's diet order changed to restrict bread products per recommendation from a pulmonologist.

- The VA was offered 600 minutes of Music Group during the past quarter. The VA attended 50% during that time.

- May 6, 2023:

  - The VA spent time watching television, socialized with a peer, took a shower, and made a phone call.

  - P7 completed a 1:1 weekly treatment plan review with the VA. The VA did not formulate a plan to quit SIBs.

  - The VA was observed storing an edible spoon on his/her body. The VA had been eating the edible spoons that were provided, and stated, "I'm hungry," after staff persons asked the VA about it. The VA requested mints in an effort to "satiate" his/her urges of SIB.

  - The VA received an entire apple from a peer. Staff persons informed the VA of the concerns of aspiration and repeated intubations; however, the VA was not receptive. The VA ate the apple in front of the staff person and provided the staff person with the core upon completion.

  - Nursing provided the VA with education on medical conditions and medications. The VA refused to take his/her blood thinner.

- May 7, 2023:

  - The VA spent the morning listening to music and talking with a peer in the courtyard.

  - At approximately 1:30 pm, the VA told P20, "You're going to be mad at me," and said s/he inhaled "lots of stuff" over the last couple days. The VA said the items included peanuts, parts of an edible spoons, an apple, bread, and cereal. The VA said s/he stored some of the items in a body orifice. The VA was not in respiratory distress and oxygen saturation was 95-96%. P20 contact a medical provider at the facility, and an ambulance was contacted for the VA to be transported to a medical facility. The VA was transported to a medical facility at 3:03 p.m.

  - It was noted the VA was "laughing and smiling" with emergency personnel at times. At approximately 5 p.m., P20 was informed the VA was undergoing a bronchoscopy to remove a foreign object from his/her right lung. The VA was expected to return to the facility during the evening on May 7, 2023.

- The medical facility noted the VA had been admitted 36 times within the last 12 months. It was noted the VA's behavior was a pattern and staff persons would continue to support and encourage safe behaviors.

- May 8, 2023:

  - At 9:52 a.m., it was noted occupational therapy (OT) had not been able to start interactive metronome due to the VA "being in and out" of hospitals for several weeks. OT was placed on hold until the VA was able to maintain safety for two weeks.

  - The VA returned to the facility at 7:56 p.m. The VA was monitored by nursing and the VA's oxygen saturation was assessed within normal ranges, and no other physical abnormalities were noted.

- May 9, 2023:

  - At 3 p.m., the VA informed staff persons s/he inhaled "more things." Prior to the incident it was documented the VA slept the majority of the morning, and had food. Staff persons encouraged the VA to cough and complete deep breathing to ensure his/her oxygen levels stayed up. The VA watched television and socialized with peers on the unit.

  - The VA informed nursing s/he inhaled two small metal pieces of an EKG lead s/he obtained while at the medical facility. The VA gave staff persons a foam sticker and a third metal piece. The VA was not in physical/medical distress, walked around the unit, vital signs were normal, and no observed abnormal breathing.

  - The VA was transported to a medical facility at 3:24 p.m. During transportation the coughed up the EKG lead and attempted to inhale it, however swallowed the piece of the EKG.

  - A computerized tomography (CT) scan was completed, which showed the items were in the VA's stomach, and no procedure was necessary. The VA returned to the facility at 6:53 p.m.

  - The VA attempted to vomit in his/her room and P5 encouraged the VA to discontinue the behavior. P5 attempted to educate the VA on the harmfulness of the behavior. P5 believed the VA was attempting to vomit to gain access to the EKG lead. The VA did not respond to P5, but stopped attempting to vomit. P5 spoke to the VA, and the VA response was, "I don't have anything to do." P5 encouraged the VA to work on positive activities to progress with his/her plan and treatment. The VA said s/he did not need a "lecture" from P5.

  - P5 contacted an on-call psychiatric provider and developed a plan if the VA continued his/her attempts to vomit.

  - The VA was provided information related to the plan which was developed and provided options if the VA was feeling "bored." The VA communicated that s/he planned to eat supper, take mediations, and go to bed. The VA refused his/her blood thinner medication, and there were no

additional concerns during P5's shift.

On June 2, 2023, during the site visit, the VA was present on the unit, so this investigator planned to view live video footage to observe the VA and staff persons' interactions. However, prior to the planned observation the VA engaged in SIB after obtaining toilet paper from another client's bedroom or bathroom. This investigator observed the following:

- At approximately 1:15 p.m., this investigator observed the VA from the staff person office. The VA was initially in the common area of the unit, in the courtyard, and in his/her bedroom. During the observation multiple staff persons including, but not limited to P1, P2, P7, and P18 continuously attempted to engage with the VA. The incident lasted approximately two hours and the VA was transported to a medical facility after the VA inhaled toilet paper.

- Staff persons attempted to negotiate with the VA as it appeared the VA had the toilet paper on his/her body, while in the courtyard due to how s/he was walking. Staff persons maintained visual and verbal interaction with the VA. The VA moved from the outdoor area to his/her bedroom and laid down in his/her bed.

- Once the VA was in his/her room, this investigator could no longer directly see the VA but was able to continue to observe the incident via camera.

- While staff persons continued negotiating with the VA s/he moved a blanket over his/her head. The VA moved the toilet paper from his/her body to his/her mouth.

- After approximately one hour staff persons exchanged places so different staff persons could interact with the VA. The staff persons who exchanged out of the incident moved into the office to discuss the process, attempted to problem solved, and discussed options related to the VA's safety and medical needs. The discussion involved scenarios and concerns with the VA taking a blood thinner, the use of a two-person restraint, as well as the use of bite gloves, and when emergency personnel would need to be contacted.

- During the incident the concern was escalated to include a medical provider.

- Staff persons appeared to remain calm and communicated with the VA in a neutral or positive temperament. Staff persons continually attempted to work with the VA during the behavior/incident.

The VA's *Client Profile – Order Details* showed P2 and P19 created multiple orders of 1:1 observation of the VA between April 4, and May 9, 2023.

- During the investigation for report 202207168 an order was created on March 2, 2022, which stated, "1:1 observation at all times. May use camera when in room. When on unit, may have one barrier but view must be unobstructed at all times. When showering, staff [persons] must stay outside shower and interact verbally every one minute. Prior to showering, staff [persons] must search shower room and remove all items in shower. Patient may be given shampoo/body soap in paper cup. . . Patient will utilize edible spoons to eat. [The VA] will turn in all items from meals/snacks afterwards. [The VA] may be given

a washcloth for dental hygiene but should turn this back in when completed." Given the VA's level of "dysregulation and agitation when restrained, and [his/her] history of trauma, staff [persons] should weigh the risks of going hands on to the behaviors we may be attempting to cease. It is recommended that hands-on intervention may be limited to absolutely only when necessary."

- From April 1, until April 18, 2023, the order stated, "1:1 observation with barrier while on unit and in courtyard. May utilize camera while in room. May also use camera while in the sensory room listening to music as areas has been evaluated by staff [persons] for any safety concerns. [The VA] no longer needs to be observed 1:1 in the shower but staff [persons] will stand outside the shower and maintain verbal contact every two minutes. Staff [persons] will assure that [the VA] has nothing present in the shower. Hygiene items will be poured in [the VA's] hand via staff [person] as [the VA] will not be given access to cups any longer. [The VA] no longer will have access to washcloths or towels. [The VA] will dry with a tear proof gown or blanket. Please do not share details of this observation level with [the VA]."

- From April 20, until May 9, 2023, the order was consistent to that of above order from April 1 until April 18, 2023.

- From May 9, until May 16, 2023, the order remained consistent with the orders above, but also included, "[The VA] does not need to have Columbia screen done daily as this order is for self-injurious behavior not suicidal ideation."

The following was consistent information provided by staff persons interviewed (P1-P7). P1-P7 also provided consistent information related to the above incidents and information found in the multiple documents as stated above:

- The VA's behavior escalated from physical aggression to SIB, which at first was ingesting items, but more recently the VA started inhaling objects. Thus, the VA's behavior intensified and increased the likelihood of the VA being harmed as a result of SIB.

- The facility had taken multiple steps (as described above) attempting to ensure the VA's safety however the VA continued to engage and intensify his/her SIBs. The facility had also switched the VA to a silicone bowl and cup, removed items such as trash cans from the unit, but staff persons believed it was just a matter of time before the VA figured out how to obtain other items for SIB.

- The facility had changed the VA's access to personal items, types of utensils, clothing, blankets, and the VA did not have direct access to paper products. However, other peers did have access to paper products, which the VA was then able to access.

- The VA's SIB were both planful and spontaneous, and the VA was able to obtain items that were in the unit's common area, from peers' rooms, and from medical facilities and transportation. The VA engaged in SIB while at the facility, but also while being transported by emergency personnel (under multiple point restraints), and while at the hospital.

- Medical providers placed an order restricting the VA's access to paper products including toilet paper. The VA was provided the ability to take a shower after going to the bathroom. Toilet paper did remain on

the unit as the VA's peers were not restricted in their paper products. The facility tested different toilet paper options that may have dissolved quicker, however that was unsuccessful. Additionally, there was discussion on tear proof products the VA could use after going to the bathroom, however that product was not used.

- There were staff person that did not like the removal of the toilet paper but followed the order. The restriction did not make sense as the VA would engage in SIB by utilizing any objects including food, or other items that s/he could find. Even the tear resistant items the VA was provided could still be torn, and therefore presented a danger.

- Staff persons cleaned any noticeable bodily fluids on the unit immediately that may have come from the VA and/or any other person.

- The VA ingested/inhaled a wide variety of items. Staff person would scan the common area for loose debris, plastic wrappers, pebbles, and other items during wellness checks that were completed every 15 minutes.

- The VA's supervision requirement was being met by staff persons and had been adjusted multiple times in an attempt to meet the VA's needs. Staff persons did not "traditionally" sit on the unit. Staff persons spent time on the unit with the VA, but there were no concerns from staff persons about other staff persons regarding a lack of engagement or interaction the staff persons had with the VA. The VA received face to face interaction with staff persons of multiple positions (direct care, nursing, social work, medical doctors, etc.) on a daily basis. Staff persons did not believe the VA engaged in SIB due to a lack of stimulation, however the facility had not been unable to identify why the VA engaged in the SIB and when s/he was going to do so.

- The VA was provided interaction and support by staff persons in the unit common area, 1:1 sessions, treatment/groups, and conversation at the staff person and nursing door/windows. Staff persons estimated they spent between two to ten times more time serving the VA than any other vulnerable adult in the facility. Staff persons completed mandatory 15 minute wellness checks on the unit and all staff person had an awareness of the VA's SIB behavior. The 1:1 camera observation included staff persons watching the VA on camera for hours at a time.

- There were situations in which staff persons had prevented the VA from engaging in SIB, however there were also times the VA acted quickly to grab items off staff persons or peers, and/or at other times the VA would hide items in areas the staff person could not see such as on the VA's body. Although staff persons were physically present and/or engaged with the VA that did not prevent the VA from engaging in SIB.

- P2 said s/he attempted to spend as much time as possible on the units s/he supervised. P2 estimated that would be approximately two to three hours each day, but that time was spread across multiple units s/he supervised. P2 estimated about 30 minutes a day P2 interacted with the VA.

- The VA's programming and treatment was reviewed on at least a weekly basis, and any changes were reviewed by staff persons. The VA's behavior had escalated from physical aggression, to ingesting of items, to inhaling items.

- The VA's treatment plan progression and stabilization had been difficult to maintain due to the constant SIB and multiple hospitalizations. Moreover, while at the facility the VA spent a large amount of time sleeping, or returning to crisis and engaging in SIB. Staff persons tried to provide support and treatment, however there was just a minimal amount of time to interact with the VA. The VA's programming included progression in which s/he would gain access to items; however, this also placed the VA in potential danger, but staff persons tried to encourage the VA to progress.

- The facility had implemented multiple plans and interventions that were not successful at reducing the VA's behavior. Some of the plans included, but were not limited to reinforcements, increased observation levels, medications, and therapeutic sessions. Staff persons did not observe the progression and it was challenging because the VA did not respond to the treatment that were best practices for a person like the VA.

- The VA had multiple plans addressing the concern of SIB and specific steps within his/her programming to support the VA in his/her progression. The VA was offered groups, and 1:1 time with staff persons within the unit, but there were difficulties with limited activities the VA could do with staff persons because the VA was not able to access paper products, plastic pieces etc. During the time the VA was at the facility s/he spent a lot of his/her time lying in bed, and staff persons were limited on items in which they could engage with the VA as no playing cards or other games were on the unit due to the VA's SIB.

- The VA's on-going behavior was observed by staff persons and staff persons continued to try and provide the VA with care and services. Staff persons communicated their concerns and suggestions regarding the VA, however there were a lot of people involved in the treatment and services of the VA.

- It was unknown why the VA engaged in SIB. The VA stated s/he was trying kill him/herself, but also had stated it was for attention.

- Staff persons did not believe any abuse or neglect of the VA was occurring. Staff person believed they were doing what they could to ensure the VA was provided the least restrictive and most beneficial treatment possible. However, it was noted the VA's physical health had decreased due to on-going SIB.

- Staff persons had a general concern of being the person whom the VA obtained an item from resulting in serious harm or even death to the VA. Staff persons were nervous that the VA would obtain an item off their body, but they were not unwilling to engage with the VA. All staff persons were aware of the VA's behaviors so while interacting with the VA, ensuring there was separation from the VA and staff person while they were on the unit. Staff persons said it was important to be mindful of what was on staff persons while on the unit including gloves, glasses, employee badges etc.

- Staff persons continued to try and work with the VA, however staff persons believed the VA's SIB were the most complex they had observed. The facility continued to dedicate "hundreds of hours" to develop the VA's care and services through meetings with multiple levels of supervisors/leadership.

- An ICS was activated during most incidents, which interrupted the service and care for the VA's peers on

the unit, but also for all persons at the facility.

- Staff persons said the facility was reactive to the incidents, but also attempted to be proactive as well. An example was observed when a staff persons tested natural items (cotton wood debris) from the courtyard and how that would dissolve under water. However, there was also a balance of speculating on the VA's SIB which removed the VA's rights/freedoms and the ability to engage in treatment without an incident occurring. Staff persons did not want the VA to have punitive and restrictive care, but also uncertain on the VA's current quality of life due to the SIB.

- Staff persons said a peer would provide the VA with access to items for the VA to engage in SIB.

- Staff persons were involved in constant meetings regarding the VA's care, treatment, and problem solving of the SIBs, however the VA continued to place him/herself in unsafe situations. Staff persons did not believe techniques such as physically prying the VA's mouth open to retrieve the items were suitable care and services for the VA. Staff persons tried to balance the VA's safety with the treatment and programming that was being provided.

- The facility had consultations with outside medical providers such as Mayo Clinic, and the VA was recommended "palliative care."

The facility trained all staff persons on client specific information, the facility's policy and procedures, and the Reporting of Maltreatment of Vulnerable Adults.

Conclusion:

A previous investigation (202207168) showed the VA's "self-harm continued despite the facility taking multiple steps to ensure the VA's safety, while also trying to provide the VA services which were least restrictive and person-centered."

Between April 1 and May 9, 2023, the VA continued to engage in on-going SIB, including inhaling of multiple items such as toilet paper, facial tissue, band-aids, and food. The VA had an order for 1:1 observation, with multiple interactions and services that were provided by different staff persons. The VA required multiple hospitalizations, and medical procedures due to the SIB, and subsequent physical health issues related to the SIB. The VA described him/herself as resourceful, and the VA engaged in both spontaneous and planned SIB.

Regarding the incidents within this investigation staff persons and medical professionals responded to the incident(s) quickly and effectively. The information that was reviewed; documentation, video recordings, and interviews, provided consistent information related to the response within the incidents. The VA was provided immediate care and services from medical professionals and staff persons when a medical emergency occurred.

The VA had an established 1:1 observation plan, as well as multiple staff persons that provided other interactions. The persons interacting with the VA including, but not limited to direct care staff, therapist, social workers, nursing, medical provider, and psychiatrics. The VA was provided the supervision as stated; however, the facility was had not been successful in preventing the VA from engaging in SIB. Staff persons said the VA's care and services were difficult to provide, but the treatment the facility provided continued to be person centered.

The facility had attempted multiple changes to the VA's plans and environment, however without creating a completely sterile environment the VA would continue to have access to items. It should also be noted that was virtually impossible to successfully limit all items at the facility within the VA's environment, and even if that was accomplished the plan would not be sustainable over time.

Based on the above information, there was not a preponderance of the evidence whether there was a failure to provide the VA with reasonable and necessary care and services.

It was not determined whether neglect occurred (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 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 which is not the result of an accident or therapeutic conduct.)

Action Taken by Facility:

The facility completed internal reviews regarding each incident. The facility determined that the policies and procedures were not adequate related to the incidents on April 12 and 13, 2023. The facility took action to protect the health and safety of the VA, and discussed potential tools that could be considered for assistance with assuring safe transportation, and planned to consult with a few external parties regarding the VA.

Action Taken by Department of Human Services, Office of Inspector General:

On October 3, 2024, the facility was issued a Correction Order for not meeting requirements of the VA's IAPP as determined during licensing investigations 202300449, 202302880, and 202304805.