

"JUST PLAIN WRONG"

Excessive Use of Restraints and Law Enforcement Style Devices on Developmentally Disabled Residents At The Minnesota Department of Human Services Minnesota Extended Treatment Program (METO) Cambridge, MN

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State of Minnesota



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Issued under the authority of the Ombudsman for Mental Health and Developmental Disabilities

Roberta Opheim, Ombudsman

STATEMENT BY GOVERNOR LUTHER W. YOUNGDAHL

AT THE BURNING OF RESTRAINTS

ANOKA STATE HOSPITAL, OCTOBER 31, 1949

It is just a little more than 250 years ago since mentally ill and other citizens were burned at the stake at Salem as witches.

A long period of time has elapsed since then. We discarded the stake but retained in our attitudes toward the mentally ill the voodooism, demonology, fears, and superstitions associated with witchcraft.

Tonight – Hallowe'en eve – we employ the stakes and fire for another purpose – to destroy the strait-jackets, shackles, and manacles which were our heritage from the Salem days.

As little as eighteen months ago all but one of our mental hospitals used mechanical restraints. Today most are restraint-free.

The bonfire which I am lighting tonight consists of 359 strait-jackets, 196 cuffs, 91 straps, and 25 canvas mittens.

No patient in the Anoka State Hospital is in restraint. Those restraints were removed from the patients not by administrative coercion, but by the enlightened attitudes of the superintendent, staff, employees, and volunteer workers of the Anoka State Hospital. They were removed as the hospital's answer to witchcraft.

By this action we say more than that we have liberated the patients from barbarous devices and the approach which those devices symbolized.

By this action we say that we have liberated ourselves from witchcraft – that in taking off mechanical restraints from the patients, we are taking off intellectual restraints from ourselves.

By this action we say to the patients that we understand them – that they need have no fears – that those around them are their friends.

By this action we say to the patients that we will not rest until every possible thing is done to help them get well and return to their families.

We have no easy job. The roots of demonology are deep. We have burned one evidence of this tonight. We must be on our guard that it does not creep up in other forms – that what the bonfire symbolizes tonight will carry on in public thinking until every last thing is done to make the state hospital truly a house of hope for these most misunderstood of all human beings.

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Executive Summary

The Minnesota Extended Treatment Options (METO) is a program operated by Minnesota's Department of Human Service's State Operated Services Division. It is licensed as a 48 bed residential program for persons with developmental disabilities. The program was established after the closure of the Cambridge State Hospital and was designed to serve citizens with developmental disabilities who have some of the most challenging behaviors, including those that may have been involved with the criminal justice system or those who have lost their less restrictive community placement.

In April of 2007, the Office of Ombudsman for Mental Health and Developmental Disabilities received a complaint about the use of physical restraints on these disabled citizens that included the use of metal, law enforcement style handcuffs. In addition, concern was raised by family members that if they did not authorize the use of such restraints, they or their loved one would be subjected to retaliation.

Over the course of the next year, the Office of Ombudsman conducted a systematic review of the treatment provided at the program as well as the laws, rules and quality assurance mechanisms that were applicable to the facility. The agency interviewed clients, family members, facility staff and management, county social service case managers, experts in the field of developmental disabilities and interested stakeholders to gather information about the program and its practices.

What the Ombudsman found was a program that was established with a good foundation and lofty goals but had slid into a pattern of practice that used restraints as a routine treatment modality in far too many cases. Generally accepted best practice standards indicate that restraints should only be used in a situation where there is imminent risk to the client or others and only for as long as the risk is present. In addition, the use of restraints is a matter of Civil and Human Rights.

Current best practice standards focus on positive behavioral supports, which includes assessing the purpose of the behaviors and finding positive alternatives for the individual to employ.

In the course of the review, the Ombudsman found that 63% of the residents who were in METO at the time of the Ombudsman's review had been restrained. Most of those who had been restrained had been restrained multiple times. One of the most egregious of the cases revealed a client who had been restrained 299 times in 2006 and 230 times in 2007. One example of reason to place a resident in restraints included "touching the pizza box." When the Ombudsman examined what alternatives had been tried to avoid the use of restraints our agency saw that many times no alternatives were attempted. In some cases the length of time the person was in restraints exceeded the facility's own guidelines.

In addition to practices of the facility, the Ombudsman looked at all of the various agencies who had protective obligations for these clients or responsibility to serve as a checks and balances over the actions of the program. For a variety of reasons, those checks and balances failed to protect the clients served by the program or turned a blind eye to the problem. It was not until the Ombudsman's Office started raising red flags that actions to identify and correct the problems began. The Minnesota Office of Health Facility Complaints (OHFC) issued a report with 99 pages of problems and citations. The DHS Licensing Division followed with a report outlining additional rule violations.

Since the completion of the investigative phase of this review, DHS has contracted with outside experts to assess and assist with the changes needed in the program as well as the system of care for individuals with developmental disabilities. The Office of the Ombudsman is encouraged by this step and will continue to monitor the program to ensure that meaningful changes are made to the benefit of the residents and the staff of the program.



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Preface

The Office of Ombudsman for Mental Health and Developmental Disabilities is authorized to produce reports that raise concerns and provide recommendations about the quality of services provided to some of Minnesota's most vulnerable citizens. The Ombudsman's statutory language states that the Ombudsman may investigate the quality of services provided to citizens and determine the extent to which quality assurance mechanisms within state and county government work to promote the health, safety, and welfare of citizens.

The nature of this review over the course of the past year has led to a number of rumors about this review. Specifically the Ombudsman received feedback that the program and others were of the belief that the goal of the Ombudsman was to see that the METO program is "shut down."

The Office of the Ombudsman wants to make clear that nothing could be further from the truth. METO was developed to meet a specific need for a resource to provide treatment to a small subset of the developmentally disabled receiving services for some of the most challenging maladaptive behaviors that have led to either criminal proceedings or a loss of a less restrictive community placement.

There is a desperate need to have an appropriate place with specially trained staff that is skilled in identifying the purpose of the behavior and what positive alternatives approaches may work for the client. From there staff need to execute treatment plans designed to provide alternative methods that would then result in a reduction in the maladaptive behaviors. METO needs to be a role model and consultant to the provider community on how to provide services to clients to reduce the discharge rate from community placements and allow the clients to be served in the least restrictive alternative. In the minds of many, METO is part of the "State Safety Net" for difficult to serve individuals.

Having said that, it is important that all programs comply with the laws and rules that govern their operation and with the spirit and intent of the law. All citizens of Minnesota regardless of their ability or disability deserve treatment with dignity and respect.

When the State of Minnesota is the provider of services, it rightfully deserves to be held to a higher standard in assuring that the human and civil rights of its citizens are protected. The goal of the Ombudsman in this case is to ask the facility to carefully examine its practices and revamp its programming to be consistent with generally accepted professional practices. In doing so, the program can become the outstanding facility we know it can be. Failure to take corrective action puts these clients at risk.

The Ombudsman also wants to clearly state that she understands that restraints are needed for extenuating circumstances. The Ombudsman believes that restraints are dehumanizing and present serious risks, not only to the person being restrained but also to the staff applying the restraint. The Ombudsman is aware of the research on the use of restraints and has conducted death reviews in Minnesota where the use of a restraint was part of the incident preceding the client's death. Much public outcry occurred and changes made after the Hartford Current, in 1998, published a series of articles outlining the risks with the use of restraints. It is the opinion of the Ombudsman that restraints should only be used as a tool of last resort— only when there is immediate risk of harm and only for the time needed to abate that risk.

If Governor Youngdahl declared we are "enlightened" in 1949, how did we get to this point in 2008?



Legal Authority for the Review

Under Minnesota Statutes 245.91-97, the Office of Ombudsman for Mental Health and Developmental Disabilities is created and charged with promoting the highest attainable standards of treatment, competence, efficiency and justice for persons receiving services or treatment for mental illness, mental retardation and related conditions, chemical dependency and emotional disturbance. Concerns and complaints can come from any source. They should involve the actions of an agency, facility, or program and can be client specific or a system wide concern.

Further, the Ombudsman is directed as to matter appropriate for review as follows:

MN Stat. § 245.94 Subd. 2. Matters appropriate for review. (a) In selecting matters for review by the office, the ombudsman shall give particular attention to unusual deaths or injuries of a client served by an agency, facility, or program, or actions of an agency, facility, or program that:

- (1) may be contrary to law or rule;
- (2) may be unreasonable, unfair, oppressive, or inconsistent with a policy or order of an agency, facility, or program;
- (3) may be mistaken in law or arbitrary in the ascertainment of facts;
- (4) may be unclear or inadequately explained, when reasons should have been revealed;
- (5) may result in abuse or neglect of a person receiving treatment;
- (6) may disregard the rights of a client or other individual served by an agency or facility;
- (7) may impede or promote independence, community integration, and productivity for clients; or
- (8) may impede or improve the monitoring or evaluation of services provided to clients.



Introduction

For over 40 years, it has been the policy of this nation that persons with developmental disabilities have a right to receive treatment in the least restrictive setting. They have the right to achieve the highest attainable integrated life possible. Lawsuits filed in many states around the country in the 1970s and 1980s led to significant change in the quality of life persons with developmental disabilities had a right to expect. Society moved away from institutional warehousing of developmentally disabled citizens toward active treatment and support services based on the individual needs and wishes of the disabled person and their families.

Reason for the Review

In April 2007, the Office of the Ombudsman was contacted regarding concerns for a person civilly committed to the Minnesota Extended Treatment Options (METO) facility in Cambridge, Minnesota. The complaint involved the use of four point restraints including metal, law enforcement style handcuffs and leg hobbles on a vulnerable adult.



Human Rights Context

In addition to being a treatment issue, the Office of Ombudsman views the use of restraints in a treatment program as a matter of civil and human rights as well a matter of dignity and respect. In this country, citizens are guaranteed the

right to liberty. This includes the right to be free of restraints except in very limited circumstances. Civil rights laws assure that your liberty interests cannot be taken away without due process.

Both Federal and State law protect the rights of citizens of Minnesota. In addition to the basic civil and human rights protected by the United States Constitution, Minnesota has statutes that protect the rights of persons receiving care and treatment in facilities governed by Minnesota laws or licensed by agencies the Minnesota such as Departments of Human Services (DHS) and Health (MDH). These laws include the Patient Bill of Rights and the Resident's Rights under Civil Commitment. At the federal level, these rights are enforced by the Department of

Individuals with developmental disabilities in a state institution have a Fourteenth Amendment due process right to reasonably safe conditions of confinement, freedom from unreasonable bodily restraints, reasonable protection from harm, and adequate food, shelter, clothing, and medical care. Youngberg v. Romeo, 457 U.S. 307 (1982).

Justice (DOJ), Civil Rights Division under the Civil Rights of Institutionalized Persons Act (CRIPA) ¹, which specifically covers facilities operated by government including prisons, jails, mental health and developmental disabilities treatment facilities and nursing homes. METO falls within the scope of this Act.

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¹ http://www.usdoj.gov/crt

In reviewing previous findings of the DOJ, the Ombudsman makes note of quotes that express the essence of these rights. Following are two quotes that are often repeated in CRIPA reports:

"Individuals with developmental disabilities in a state institution have a Fourteenth Amendment due process right to reasonably safe conditions of confinement, freedom from unreasonable bodily restraints, reasonable protection from harm, and adequate food, shelter, clothing, and medical care. Youngberg v. Romeo, 457 U.S. 307 (1982). See also Savidge v. Fincannon, 836 F.2d 898, 906 (5th Cir. 1988) (finding that Youngberg recognized that an institutionalized person "has a liberty interest in 'personal security' as well as a right to 'freedom from bodily restraint.'"). Determining whether treatment is adequate focuses on whether institutional conditions substantially depart from generally accepted professional judgment, practices or standards. Youngberg, 457 U.S. at 323. Residents also have the right to be treated in the most integrated setting appropriate to meet their individualized needs. See Olmstead v. L.C., 527 U.S. 581 (1999); Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12132 et seq.; Section 504 of the Rehabilitation Act of 1973, 29 U.S.C."²

"The right to be free from undue bodily restraint is the "core of the liberty protected by the Due Process Clause from arbitrary governmental action." Youngberg, 457 U.S. at

The right to be free from undue bodily restraint is the "core of the liberty protected by the Due Process Clause from arbitrary governmental action." Youngberg, 457 U.S. at 316

316. Consistent with generally accepted professional practice, seclusion and restraints may only be used when a patient is a danger to himself or to others. See Youngberg, 457 U.S. at 324 ("[The State] may not restrain residents except when and to the extent professional judgment deems this necessary to assure such safety to provide needed training."); Goodwill, 737 F.2d at 1243(holding patients of mental institutions have a right to freedom from undue bodily restraint and excess locking of doors

violates patients' freedom from undue restraint); Thomas S. v. Flaherty, 699 F. Supp. 1178, 1189 (W.D.N.C. 1988), aff'd,902 F.2d 250 (4th Cir. 1990) ("It is a substantial

² CRIPA Investigation of the Lubbock State School, December 11, 2006

departure from professional standards to rely routinely on seclusion and restraint rather than systematic behavior techniques such as social reinforcement to control aggressive behavior."); Williams v. Wasserman, 164 F. Supp. 2d 591, 619-20 (D. Md. 2001) (holding that the State may restrain patients via mechanical restraints, chemical restraints, or seclusion only when professional judgment deems such restraints necessary to ensure resident safety or to provide needed treatment). Seclusion and restraint should only be used as a last resort. Thomas S., 699 F. Supp. at 1189. Similar protections are accorded by federal law. See, e.g., Title XIX of the Social Security Act, 42 U.S.C. § 1395hh, and implementing regulations, 42 C.F.R. Parts 482-483 (Medicaid and Medicare Program Provisions); 42 C.F.R. § 482.13(f)(3) ("The use of a restraint or seclusion must be . . . [s]elected only when less restrictive measures have been found to be ineffective to protect the patient or others from harm; [and] . . . [i]n accordance with the order of a physician"); 42 C.F.R.§ 482.13(f)(1) ("The patient has the right to be free from seclusion and restraints, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff.")."³



Details of the Review

During the course of this investigation, the Office of Ombudsman interviewed:

Multiple clients and guardians;

DHS DD policy division staff;

DHS State Operated Services management;

DHS Licensing staff;

A former DHS psychologist;

Department of Health, Office of Health Facilities Complaints (OHFC) staff;

August 6, 2007 Pages 9, 10.

³ CRIPA Investigation of the Connecticut Valley Hospital, Middletown, Connecticut

Members of the Ombudsman's Advisory Committee;

Members of the Governor's Council on Developmental Disabilities;

Staff of the Minnesota Disability Law Center;

An Advocate for ARC;

The program physician,

Program administrators,

Behavioral analysts,

Community providers,

County social service case managers and supervisors.4

In addition to the interviews, Ombudsman staff made multiple visits to the facility to observe activities and conduct chart reviews.



Applicable Statutes, Rules, and Policies

Ombudsman staff reviewed applicable laws, rules, and policies including:

42 U.S.C. § 1997 et seq. Civil Rights of Institutionalized Persons Act

Minnesota Statute 245.825 Aversive and Deprivation Procedures; Licensed Facilities and Services

Minnesota Rules, 9525.2700-9525.2780, Standards that govern the use of aversive and deprivation procedures with persons who have mental retardation or a related condition and who are served by a license holder

⁴ The Ombudsman is careful not to indentify which interviewees provided which specific information. A hallmark of Ombudsman's work is confidentiality in order to assure frank responses from those interviewed.

licensed by the commissioner under Minnesota Statutes, chapter 245A and section 252.28, subdivision 2.

Minnesota Statutes 256.092 Services for Persons with Developmental Disabilities

Minnesota Rules 9525, generally referred to as the "Consolidated Rule for Persons with Developmental Disabilities"

Minnesota Statutes 245B.04, Consumer Rights

Minnesota Statute 144.651 Patient's Bill of Rights

Minnesota Statute 253B.03 Resident's Rights (under Civil Commitment)

National ARC policy statement on Behavior Supports

METO policies on the use of controlled procedures in behavior management



System of Checks and Balances

Statewide care for individuals with Developmental Disabilities has a number of systems involved, each with its specific roles. In the area of the use of restraints, each role is separate and intended to be a checks and balance system to prevent the inappropriate use of this type of programming. Included is a list of roles in this system.

- DHS Long Term Care's DD Policy Division works to develop public policy and resource development to assure that persons with Developmental Disabilities have appropriate residential and treatment options to meet the needs at all levels in the least restrictive setting.
- The County Case Manager is charged with finding appropriate residential
 placement with programming to meet the individual client's needs in the least
 restrictive setting. The County Case Manager is expected to be the primary
 advocate for the client.

- 3. The **Court System** determines whether a person should be civilly committed to the Commissioner for treatment at METO because it is the least restrictive setting to meet the client's needs.
- 4. The **DHS Licensing Division** is responsible for licensing the program to ensure that it is following all of the appropriate laws and rules required under the license (including rules on the use of restraints). Licensing's role is to assure minimum standards which are not the same as generally accepted professional practice.
- 5. The MDH Office of Health Facility Complaints is the designated agency responsible for inspection and enforcement of Federal Center for Medicare and Medicaid Services' (CMS) laws and rules governing ICF/MRs that are certified to receive Federal Financial Participation. MDH is also responsible for licensing Supervised Living Facilities, which includes the noncertified beds at METO.
- 6. The **Program Administrator** is responsible for seeing that the program operates according to the laws and rules that govern the program.
- 7. The **Program Clinical Director** assures that the program offers care and treatment that work and is consistent with generally accepted practice standards.
- 8. The **Program Behavioral Analysts** are charged with assessing the function of the maladaptive behavior and developing the plan of treatment.
- 9. The **Program Medical Staff** which includes the program physician and nursing staff who assure that the client's health needs are met and that the client's health conditions are not compromised by aspects of the treatment plan. They are specifically required to indicate whether or not restraints are contraindicated.
- 10. The **Hospital Review Board**, which consists of three members appointed by the Commissioner of Human Services to review both admissions and discharges of clients, and to hear resident concerns or complaints.
- 11. The **Client's Guardian** if the client has been appointed one by the courts. The Guardian is charged with promoting the client's best interest and with protecting the client's legal and civil rights.
- 12. The **Parents** or **Family**, if not the appointed Guardian, because they have the most knowledge about the client, his/her behaviors, and how the behaviors have been handled in the past.

Any one of these agencies or individuals has the ability and in most cases the obligation to raise concerns when client rights are violated or treatment plans are not adequate to meet the needs of these disabled individuals. The question raised in this review is how specific roles within the system are required to provide the checks and balance and a

level of protection could have turned the other way while these vulnerable individuals were being routinely restrained.



Background

Program Background

METO is a State of Minnesota operated facility that is licensed by the DHS Licensing Division as an Intermediate Care Facility/Mentally Retarded (ICF/MR). METO was partially the result of the closure of the Cambridge State Hospital after the state entered into a Federal Consent Agreement. The

Agreement was the outcome of a lengthy Federal litigation about the conditions of care and treatment of the residents of the Hospital. The current program is licensed to serve up to 48 persons with developmental disabilities. METO was established in 1995 by the Minnesota Legislature.

The Legislature directed DHS to "develop a specialized service model at the Cambridge campus to serve citizens of Minnesota who have a developmental disability and exhibit severe behaviors which present a risk to public safety." METO was formally opened

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in 1999 on the grounds of the Cambridge State Hospital that closed the same year. The purpose of the program was to treat developmentally disabled citizens who may have engaged in actions which may be criminal or present a serious concern for public or client safety. The METO facility is operated under the forensic division of DHS State Operated Services (SOS). The physical plant

⁵www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSele ctionMethod=LatestReleased&dDocName=dhs16_136574

includes eight new residential units in four, one story buildings. Each residential unit has a five-person capacity. Other buildings include remodeled buildings from the former Cambridge State Hospital. These house administration, health services, day/work programs and recreational facilities.

Facilities operating as an ICF/MR need to be licensed in Minnesota by DHS. The facility is governed by MN Stat. § 256B.092 and Minnesota Rules Chapter 9525 (Consolidated Rule).

In order to receive federal funding under the 50% federal match ICF/MR facilities also need to be certified by the Federal Center for Medicare/Medicaid Services (CMS) through the MDH. Several years ago, CMS determined that 36 of the beds did not meet the federal standards for certification. CMS opined the clients placed in those beds did not need an institutional level of care for their basic activities of daily living (bathing, feeding, clothing, toileting). Currently, 10 of the beds remain certified and 36 beds are not certified but the facility license remains as an ICF/MR. For all of the beds, regardless of certification, Minnesota requires that they be licensed by as a Supervised Living Facility (SLF) by MDH in addition to their DHS license.

The 2008 per diem rate for METO is \$861. That cost is for each person residing at the program on any given day. That averages out to approximately \$25,830 per month per client, an annual rate of \$314,000. The majority of these costs are paid with state and county social service funds with 10 of the beds receiving partial federal funding.

Rule 40 Background:

In Minnesota, the term "Rule 40" refers to the rules that govern the use of aversive and deprivation procedures such as seclusion and restraints. Although we all use the old term "Rule 40," it was officially changed many years ago to Rule 9525.2700 – 9525.2810. The rule is established to govern how a program handles clients who have behaviors on

a regular basis that have escalated to a point where an aversive procedure was necessary to protect the client from injury to self or injury of others. The purpose of Rule 40 was not to promote the use of aversive and deprivation procedures, but rather to encourage the use of positive approaches as an alternative and to establish specific standards that must be met when other less restrictive alternatives have been attempted and proven unsuccessful. Rule 40 is a programmatic outline incorporated into the treatment plan with the agreement of the person or their guardian. This can be used as permission to use restraints on a planned but limited basis on clients who have behaviors that are challenging when all less restrictive alternatives have failed. The Rule 40 program is to provide systematic treatment where the treatment team identifies the problematic behaviors, what leads up to them, what function they fulfill for the person, and alternatives to redirect the person in a safe manner (prior to the need to use an aversive procedure). The final purpose of the Rule 40 program is to direct what type of aversive procedure that will be implemented if all other efforts have failed to produce a safe situation. The goal is to provide direct care staff with the tools to work with the client to develop skills needed to reduce or eliminate the need for the aversive procedure and for its safe application when needed. Rule 40 was never meant to be a blanket approval for routine use. The rule directs that the treatment team documents and observes how the plan is working. If the need for aversive programming continues, then a new approach should be developed by the treatment team. Behaviors are often a means of communication when the individual may not be able to adequately express their needs, wants or emotions. Plans should be developed by individuals trained in understanding what need the client is trying to fulfill through the behavior and then find a positive alternative for the client to get their needs met in a safe environment.

Rule 40 plans are to be reviewed to see if they are working and if not, the plan should be amended. The assumption would be that if there is a repeated need to use restraints frequently, then the plan is not working and something else should be tried.

<u>System Issue Background:</u>

The initial concern brought to the Office of the Ombudsman in April of 2007 was concerning the treatment and aversive programming used by the staff at METO. The caller raised concerns about the METO treatment team's lack of regard for the legal guardian's authority to provide or withdraw consent for aversive programs. The caller also expressed what they believed to be threats and

coercion by certain METO staff if they did not sign the aversive program developed by the behavioral staff. Further review of these concerns revealed that staff had been directed to use metal handcuffs and leg hobbles to restrain this person on a frequent and regular basis. Following discussions with all parties of this complaint, METO staff indicated in e-mail messages that they would honor the guardian's decision to revoke their consent for the aversive program, and would no longer use metal handcuffs to restrain persons. Due to the satisfactory resolution of the complaint, the Ombudsman's case was closed at that time.

In September of 2007, the Office of the Ombudsman received new concerns regarding another individual who had been civilly committed to METO. The initial concerns raised were regarding the general treatment of this person and once again, the use of metal handcuffs and leg hobbles to restrain them as part of a behavior program. There were additional concerns raised about the programming being of a very punitive nature instead of instructive and supportive. Based on the information received as a result of these two complaints Ombudsman staff decided to review several other files, chosen at random on September 28, 2007.

Following this initial review of several other records for persons residing at METO, concerns were raised regarding the possible widespread use of restraints, the type of mechanical restraints being used, the reasons persons were placed in restraints and the number and amount of time people were restrained. METO management explained the facility-wide process to Ombudsman staff during a previous visit to METO. It was explained that any person displaying their target behavior for two minutes who could not be redirected, is placed in mechanical restraints. Management stated that the use of mechanical restraints was preferable to manual restraints as it lessened the risk of injury to staff and clients and was the least restrictive way to manage behavior. Management, as well as other staff, stated that this was the only method to get person's behavior under control so they could be discharged to the community. Management and clinical staff echoed the statement that "national studies show the use of mechanical restraints are much safer" than

manual restraints.⁶ The studies being cited only included restraints used by law enforcement to subdue someone in a life-threatening situation. None of the studies advocated the use of mechanical or manual restraint as part of a behavioral program.

Based on this preliminary review, the decision was made to initiate a full-scale investigation into the use of restraints at METO. METO management and the State Operated Services management were notified of the Ombudsman's intent to open an investigation. During the September 28, 2007, visit to METO, Ombudsman staff requested copies of documents from individual files.



Process

Systemic Review Process:

After determining that the use of metal handcuffs was standard practice, the Ombudsman expressed concern about such use in a treatment facility. Generally accepted practice in a health care setting would be to use soft wrist cuffs. Metal handcuffs are associated with law enforcement and criminals. They can be painful and cause injury. The Office of the Ombudsman initially contacted the DHS Licensing Division with concerns regarding the use of restraints at METO, based on the review of five records at the facility. It was the understanding of the Ombudsman that DHS Licensing was responsible for regulatory oversight of Rule 40 programs at the facility. The Ombudsman was

⁶ Ball, H.N. (2005). Death in restraint: Lessons. *Psychiatric Bulletin*, **29**: 321-323.NUNNO, M.A.,

HOLDEN, M.J. & TOLLAR, A. (2006). Learning from Tragedy: A survey of child and adolescent restraint fatalities. *Child Abuse and Neglect*, **30**: 1329-1331. A web link to this study is: http://www.charlydmiller.com/LIB09/2006DecChildAdolescentRestraintFatalities.pdf

O'HALLORAN, R.L.& LEWMAN, L.V. (1993). Restraint asphyxiation in excited delirium. *American Journal of Forensic Medicine and Pathology*, **14**, 289-295.

REAY, D.T., FLIGNER, C.L., STILWEL, A.D., et al (1992). Positional asphyxia during law enforcement transport. *American Journal of Forensic Medicine and Pathology*, **13**, 90-97.

told that DHS Licensing would look into complaints regarding specific persons if those complaints were within their jurisdiction. However, Licensing informed the Ombudsman that they would not expand their review beyond the specific clients named regardless of what they found in those individual records. The Office of the Ombudsman provided the names of individuals and details of concerns for those five persons whose files had

been reviewed in the initial visit to METO.

On October 29 and 30, 2007, forty individual records were reviewed by Ombudsman staff. During this visit to METO, Ombudsman staff met with the METO physician. The physician identified only one individual for whom the use of certain mechanical restraints and a takedown to a prone position would be considered contraindicated. The physician echoed METO staff in stating that mechanical restraints present less risk of injury to persons and staff and it was the least restrictive method to contain severe behavior that might cause harm to themselves or others.

The initial review of all records revealed that at least 65% of the persons at METO at that time had been restrained at least once since their admittance to the facility. Many were being restrained on a regular basis as part of a behavior program or on an "emergency" basis.

The records reviewed were a snapshot of clients in the program on October 29, 2007.⁷ It

Of the 40 records reviewed in

October 2007

65%

of clients had been restrained 73%

of clients restrained, had been restrained multiple times
74%

of clients who were restrained multiple times, had over 10 uses of restraints

Highest numbers of restraints reviewed at that time included some who restrained more than 50 times each

was later learned that additional documentation of restraints were put in an archive file to keep the chart a reasonable size. Once the archives were reviewed, many more restraint uses were identified for some clients.

Upon admission to METO, each individual is given a physical exam. The admission physical exam form includes a statement to determine if the person

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⁷ See Appendix E

has a medical condition that would contraindicate use of restraints. The Ombudsman staff was unable to find an initial exam form in any person's record that did not allow the use of mechanical restraints. In reviewing the medical files there was documentation of individuals with asthma, seizure disorders, history of lung abscesses and other medical issues being cleared for the use of mechanical restraints. One individual had several lung abscesses and continued to be mechanically restrained in a prone position just days after being released from the community hospital for this condition.

This visit to METO also raised concerns regarding the reasons persons were restrained and the methods of restraint. Some persons were being restrained for what was termed aggressive behavior such as touching staff's shoulder, touching a pizza box that was being held by staff, talking about running away, and other behaviors that do not appear to meet any definition of aggressive or dangerous behavior. METO staff and management argued that these behaviors may not appear to be aggressive, but were precursors to dangerous behavior.

Documents in individual records revealed that people were being routinely restrained in a prone, face down position and placed in metal handcuffs and leg hobbles. In at least one case, a client that the metal handcuffs and leg hobbles were then secured together behind the person, further immobilizing the arms and legs, reported it to the Ombudsman staff. Some individuals were restrained with a waist

people were being routinely restrained in a prone, face down position and placed in metal handcuffs and leg hobbles

belt restraint that cuffed their hands to their waist. An individual with an unsteady gait was routinely placed in this type of restraint, putting that person at risk of injury if they should fall, as they would not be able to use their arms or hands to break that fall. Others were being restrained on a restraint board with straps across their limbs and trunk. METO policies stated that a person was not to be restrained for more than 50 minutes. Ombudsman staff found numerous examples of documented incidents where after 50 minutes in a restraint, staff would continue the restraint but document it on a different restraint use form, sometimes with no indication that it was a continuation of the previous restraint.

Documentation revealed that in most cases where restraints were used, the person was calm and cooperative about going into the restraint but began to struggle, cry and yell once they were in the restraints. In some cases, clients appeared to be conditioned to "assume the position" for the application of restraints where they would lie on the floor and put their hands behind their back without resistance. One client who was regularly restrained with metal handcuffs and leg irons stated that once the restraints were on he/she began to experience discomfort which led to crying, yelling and struggling against the restraints. The METO policy stated that a person had to be calm for 15 minutes before they could be released from restraints. During one METO visit Ombudsman staff requested that METO management place the handcuffs on them in a standing position with their hands behind their back. Ombudsman staff did not struggle at all during this time and had the handcuffs on for approximately 5-10 minutes. At that point, it became uncomfortable in the wrists and shoulders. The Ombudsman staff experienced discomfort in their wrists and shoulders for at least an hour after the use of the handcuffs. This raised further concerns for persons that would struggle when in this type of restraint.

During the October 29 and 30, 2007 visit the Ombudsman staff obtained the names of the guardians for the persons whose files were reviewed on those dates. A release of information form was sent to the guardians so the Office would be able to obtain copies of documents from the individual files. The Office received approximately 50% of the signed releases back from guardians. Only one of the thirty-plus county case managers contacted the Ombudsman's Office to obtain more information about the investigation or discuss their concerns. Only one guardian contacted the Ombudsman's Office to express disagreement about the concerns raised concerning the use of mechanical restraints.

The analysis of the individual files, METO policies and procedures, and interviews with staff and management indicate a philosophy that has been established at the facility regarding the use of restraints. Management and professional staff defended this punitive restraint practice as the safest and least restrictive way to control individual's behavior. The Ombudsman has concerns about staff regard for individual rights or risks of this type of programming.

In addition to METO management and staff, three clients, six guardians, two case managers, one social service supervisor and DHS management were

interviewed or were notified of the concerns found in this investigation to that date. The Minnesota Department of Health, Office of Health Facilities Complaints (OHFC) was also notified of the Ombudsman's concerns at METO.



Summary of Licensing Investigations

Summary of the OHFC Investigation and Statement of Deficiencies

The MDH, Office of Health Facility Complaints (OHFC) division conducted an unannounced visit to METO on January 10 and 11, 2008, following information provided to them by the Office of the Ombudsman. The scope of the investigation by OHFC included not only persons residing in the ICF/MR certified beds of the facility, but also those persons who were residing in the non-certified beds, or SLF units. As a result of this investigation OHFC investigators found that fifteen 'Conditions' under the Federal regulations governing ICF/MR facilities were not met by METO. They issued a sixty-five page report to the Department of Human Services detailing the facts of those deficiencies. Federal regulations require that the service provider develop and submit a plan of correction for each deficiency in this portion of the OHFC report.

A separate investigative report by OHFC details the results of their investigation of complaints regarding resident rights in the SLF units at METO. In the twenty-nine page report issued by OHFC, the investigators provided evidence that the facility failed to meet the requirements under MN Statute 144.651, Subdivision 14, to ensure that residents were free from maltreatment, particularly from "unnecessary drugs and physical restraints." METO was given 40 days to correct this violation of State Statute or face monetary fines. The Office of the Ombudsman was informed that the deficiency report issued to METO by Office of Health Facility Complaints was one of the largest reports ever issued to a facility serving persons with developmental disabilities in Minnesota.

Summary of DHS Licensing Investigation and Correction Orders

DHS Licensing issued an Investigation Memorandum and Correction Orders on April 4, 2008 regarding complaints about the use of controlled procedures; in particular, mechanical and manual restraints at METO. DHS Licensing investigated allegations involving clients residing at METO, who are in both federally certified beds and noncertified beds. The DHS Licensing investigation's scope was limited to the four specific concerns or allegations raised by the Office of the Ombudsman on October 15, 2007. At the time of the October 15th meeting with DHS Licensing, the Ombudsman's Office had only reviewed a limited number of client records. More extensive reviews were conducted by Ombudsman staff in the weeks and months to come. The concerns raised by the Ombudsman's Office at this meeting were summarized and categorized into four allegations by DHS Licensing staff. DHS Licensing investigators determined that in three of the four allegations there were violations of MN Rules governing the use of aversive procedures. The fourth allegation was determined to be inconclusive. It should be noted that the fourth allegation concerned the complaints by two guardians of two clients residing in two separate residential units at METO that they were coerced into signing consent for the use of a controlled procedure on their wards. investigators did not interview one of the two guardians.

DHS Licensing issued a Correction Order to the METO facility that contained six citations, which required corrective action. The citations included the following:

- 1. Failure to ensure that all the required standards and conditions for the use of controlled procedures were met.
- 2. Failure to submit data on the use and effectiveness of the controlled procedures to the expanded interdisciplinary team, the internal review committee, and the regional review committee on a quarterly basis.
- 3. Failure to obtain the required assessment information on persons who had a controlled procedure as part of their Individual Program Plan (IPP).
- 4. Failure to ensure necessary conditions were met when an emergency use of a controlled procedure was implemented on a client.
- 5. Failure to implement the program's own policy on the emergency use of controlled procedures.
- 6. Failure to "complete the required reporting and reviewing" of the use of emergency controlled procedures.

At the time of this report, there has been no follow-up information provided by DHS Licensing to indicate that METO has corrected the violations outlined in their Correction Order.



Personal Stories

Many individuals are adversely affected by the METO policies and procedures regarding the use of mechanical restraints. The following are just a few of the persons whose lives have been affected.

Person #1

This person has no family involvement in his/her life and has a private guardian who helps him/her make decisions on life matters. This is an individual who has the diagnosis of moderate mental retardation. schizoaffective disorder, pervasive developmental disorder, as well as numerous other physical issues including a seizure disorder and recurring lung abscesses. This person has challenging behavior, the most severe being injury to He/she was civilly committed to METO after a community program was unable to provide the appropriate programming and support to maintain a safe environment. In discussions with this person's guardian, the Ombudsman was informed that this individual had a difficult and traumatic childhood and has presented a challenge to caregivers. It was explained that in order for the person to feel in control of his/her environment, he/she would display target behaviors to test the caregivers to see if they would initiate the consequences that the behavior program dictated they should do. This was a constant theme in this person's behavior. When this person was admitted to METO a Rule 40 procedure was developed that included no touching of any person without their permission. If this person touched any staff or peer three times in one hour, it is considered physical aggression. He/she would be placed on the restraint board or in a prone, face down position and handcuffed behind his/her back with a leg hobble placed on his/her legs. There was no

documentation of any behavior that could be defined as extremely dangerous or life threatening. Each time he/she was restrained, he/she would cry and yell for the majority of the time. In 2007, this person was restrained approximately 225 times for a total of over 130 hours. In 2006, documents revealed a similar number of restraint uses for the same reasons. Of those 225 plus times in 2007, restraints were only used four times for self-injurious behavior and seven times for hitting or scratching staff or a peer. Nearly 160 of those times he/she was restrained it was for merely touching a staff or an object being held by staff or bumping into someone. Some of the other reasons listed for the use of restraints were: "touching pizza that staff was holding," "threw wash cloth at staff," "spitting at staff," and "touching staff's walkie-talkie." There were several incidents when the person was released from a restraint, that he/she would immediately touch the staff person and be placed back into restraints.

While interviewing this person on his/her residential unit it appeared that he/she was controlling the environment by watching for staff's reaction to any move he/she made. This person was pleasant and personable to Ombudsman staff but constantly asked about getting out of METO and going to a community group home.

Person #2

This person is a young adult in his/her twenties who has a developmental disability and autism. This individual has a supportive family that is active in his/her life. The family members are vocal advocates for their loved one and are always working to get the best services for him/her. Prior to being committed to METO, this person was residing in the community at a state operated group home. According to records, he/she was taken by staff of this community placement to a shopping center. The person became extremely agitated from the external stimulus and began to display behavior that was self injurious that the staff could not control. The staff called the police rather than remove the person from this environment. Police took the individual into custody but quickly determined they had detained someone with severe disabilities that they were not prepared to care for in a community jail.

The group home refused to take the person back and law enforcement officials were forced to find a hospital placement for him/her. The person was subsequently committed to METO from an acute care hospital as there were no

alternative placements available in the community at that time. Staff immediately began to use metal handcuffs and leg hobbles to restrain him/her when he/she displayed behaviors that were deemed to be antecedent to more severe self injurious behaviors. There did not appear to be other methods of programming discussed or considered. Typical behaviors displayed by this person that resulted in restraints include: spitting, becoming agitated (there was not a clear definition of this behavior) and other behaviors that are not unusual for this person to display when their environment is over stimulating or stressful for him/her.

Concerns were also raised about staff training in the treatment of persons with There was also a complaint about certain METO staff members attempting to coerce the guardians of this individual into signing the authorization to use mechanical restraints. The guardians indicated that they were told by one METO staff person if they did not sign the Rule 40 authorization, METO staff would request that the Court review the guardianship (implying the guardians would be removed & replaced) and METO would obtain a court order for the use of restraints. The guardians stated that they felt they had no choice but to sign the authorization for the Rule 40. Following a review of this individual's record and discussions with staff at METO, county case managers and family, the concerns raised were substantiated by the Ombudsman's Office. The guardians rescinded their authorization for a Rule 40 program and the clinical director agreed to stop using metal handcuffs and leg hobbles on this individual. Although the Rule 40 program was discontinued, the restraints were used multiple times on what staff documented as an "emergency basis." The records indicated that those emergency uses were for behavior that was indicative of someone with autism who is stressed out and over stimulated by their environment.

Several months later the individual was discharged from METO to a crisis bed to await a placement being developed by a community licensed facility. The clinical director at METO refused to authorize a voluntary stay when the MR commitment was completed in November 2007. The family was concerned about the stress of two residential moves for their loved one in such a short time. The clinical director provided the following reasons for not authorizing the voluntary stay in a memo to the county case manager: "The majority of [his/her] behavioral episodes have been reactions to disruptive peers... Another barrier to my consent is the fact that the guardians are in open

disagreement with the METO program and its care of their ward. I cannot conceive of a competent guardian who would consent to voluntarily assigning care to a clinician whose personal and professional credibility they attack at every opportunity. I believe my consent to voluntary treatment of [this person] would pose unacceptable risk to me, the the Office program, and the Commissioner."

The family expressed concerns that the clinical director did not express these reasons to them directly and that he appeared to be more concerned about his own reputation than the well-being of the client.

Since his/her discharge from METO the family has noted a difference in their adult child, stating he/she blossomed and has had very few issues with behavior. The family attributed this difference in behavior to the person not being restrained and that the person was provided with choices in their daily life,

"The majority of [his/her] behavioral episodes have been reactions to disruptive peers... Another barrier to my consent is the fact that the guardians are in open disagreement with the METO program and its care of their ward. I cannot conceive of a competent guardian who would consent to voluntarily assigning care to a clinician whose personal and professional credibility they attack at every opportunity. I believe my consent to voluntary treatment of [this person] would pose unacceptable risk to me, the program, and the Office of the Commissioner."

something they indicated was not the case at METO. However, the family indicated that their child was afraid to leave the new facility to attend day programming due to fear of having to return to METO. They also indicated that their child continues to express fear at being returned to METO.

Person #3

This person is also a young adult in his/her twenties who was committed as Mentally Ill and Mentally Retarded to METO from a state operated facility. He/she has the diagnosis of severe Fetal Alcohol Syndrome, mild developmental disabilities, Intermittent Explosive Disorder and other

neurological problems. The records indicate that he/she was committed to METO for aggressive behavior toward staff, suicidal ideation and attempts to run away from the community residential program. Within days of his/her admittance to METO there is documentation of the use of metal handcuffs and leg hobbles in a prone position. Reasons given were yelling at staff; showing anger towards staff when told he/she could not go to church; for "interfering in peer's program"; throwing and tipping over a chair; telling staff he/she wanted to run away; not staying within eye sight of staff after receiving medication and similar incidents. Multiple times the documentation reports that prior to the use of the mechanical restraint the person was calmly watching television or eating a snack. There were two incidents in which he/she was attempting to harm themselves or a peer. There is little noted in the documentation that indicated why this person would suddenly attempt to hit staff. The person's parents report that he/she does not have a history of hitting staff or other physical aggression unless he/she feels provoked by something staff have said or done.8

The parents/guardians attempted to raise concerns regarding the person's treatment related to his/her fetal alcohol syndrome with little success. The parent/guardian was told that staff are to treat the behavior that got the person committed to METO, and the method of treatment was to restrain the person. The guardian stated that efforts to provide information that might be helpful in the treatment of the client were not readily accepted by staff. The guardian stated that when they began to question the use of restraints, the response by METO staff was an attempt to severely limit visitation by the parent. The parent/guardian would only sign a Rule 40 program if it were to be used for a room time-out. A review of the person's record indicated that staff continued to use mechanical restraints on what they documented as "an emergency" situation. The documentation did not indicate life threatening or severe behavior prior to the use of the mechanical restraints in these situations.

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⁸ It is important to note that this does not mean that staff intended to provoke the client but instead it is reflective of how the client may process certain events or actions of others. This could then assist in possible treatment plan options.

Person #4

This individual is in his/her twenties and was removed from his/her home as a toddler due to parental abuse and neglect. He/she has been given the following diagnoses: mild mental retardation, major depressive disorder, oppositional defiant disorder-nos, antisocial traits, borderline personality disorder, and microcephaly. This individual has several alternative procedures included in his/her Rule 40 program, such as the use of an ice pack to be placed on his/her face, education group and talking with staff. The person's Rule 40 program calls for the person to be placed in a face down, prone position and the use of metal handcuffs and metal leg irons to restrain him/her. This procedure is used even

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the restraints.

if the person is cooperative and calm prior to being placed in the restraints. In the past year, this person has been restrained with the metal handcuffs and leg irons approximately 25 times for a total of 629 minutes, or an average of 25 minutes for each restraint. Multiple incidents where this person was restrained were because of attempted property destruction or threats to staff or attempts to kick or hit staff. While interviewing this person on his/her residential unit, Ombudsman staff saw bruises, both old and new, on this person's wrists and ankles from the use of these restraints. The person stated

that he/she has fewer behavior incidents than he/she did before and that the staff changed his/her program from the use of leg hobbles to leg irons because he/she was able to get out of the leg hobble restraint. It was clear that this person understood what behavior led to the use of restraints. Yet it is unclear if the person was always able to willfully control their own behavior due to their mental health issues and cognitive processing disabilities.

Person #5

This individual is in his/her thirties and was civilly committed to METO in the spring of 2007. Prior to his/her commitment to METO the person resided in a group home in the community managed by DHS State Operated Services. This

person has been given the following diagnoses: schizoaffective mania, severe mental retardation, static hydrocephalus, history of head concussion secondary to trauma at age 4, history of benign heart murmur, psychomotor retardation, and a history of a seizure disorder. He/she has many challenging behaviors including self injurious and pica behaviors.

A discharge summary from the MSOCS crisis home lists this person's diagnosis as "moderate-severe mental retardation, hydrocephalus, seizure disorder, scoliosis, and behavioral dyscontrol." In the 18 weeks while at the crisis home this person displayed 104 incidents of verbal aggression, physical aggression, property destruction, and self-injurious behavior. The staff at the crisis home wrote clear and concise recommendations for behavioral intervention in their discharge summary that was provided to METO staff. It stated in part, "Two person escorts and manual restraints using the basic come along and arm bar to give staff a chance to exit the area were used with some success to maintain the safety of others. [The person] does not calm successfully when restrained and [he/she] retaliates immediately if able to do so. Turning [him/her] away from the exit and releasing [him/her] simultaneously while leaving the area would give [him/her] time to calm." The recommendations go on to say, "Mechanical restraints were not attempted due to safety issues, the number of staff needed to do so safely, and [his/her] need to pace and use tactile stimulation to calm and relax, would not be available if restraints were used."

During the first six weeks at METO, documentation indicates a baseline of 1132 incidents of physical aggression, self-injurious and pica behaviors. Between 9/1/07 to 11/29/07, 1420 incidents of those same behaviors were documented in this person's record at METO. From the date of admittance to METO until August 14, 2007, this person was being restrained both manually and mechanically, including the use of soft handcuffs and leg hobbles in a prone position, and being placed on the restraint board. On August 14, 2007, this method of restraint was discontinued following a spiral fracture of the person's left arm. Since that time staff have used a restraint belt with attached soft handcuffs. The person is allowed to move about the living area while in this type of restraint. In the six months since the person was admitted to METO he/she has been mechanically restrained over 120 times, most of those times for 50 minutes each.



Facility Revisits

On March 20, 2008, Ombudsman staff made an unannounced visit to METO to review several residents' records. This visit and record review was precipitated by the citations and facility response to citations from the Office of Health Facility Complaints (OHFC). The Ombudsman's Office was optimistic that major changes had taken place in the area of programming and patient rights. Four records were reviewed, including progress notes through March 19, 2008. Two records were reviewed of persons residing in the ICF/MR units and two records from persons in the SLF units. Three of the four records are persons whose stories are detailed in the Pertinent Facts and Findings section of this report.

The first record reviewed resides in an SLF unit, where regulatory oversight by OHFC is limited to the Patient Bill of Rights. Ombudsman staff found no changes to this person's Rule 40 program and determined through documentation that this person had been mechanically restrained 23 times from February 10, 2008 to March 17, 2008. Some examples of the reasons this person was restrained, were as follows: touching above the shoulder, touching staff's walkie-talkie, throwing milk at staff, grabbing at staff, threw napkin holder at staff, and threw a "piece of a rag" at staff. There were incidents documented where physical aggression was listed as the reason for the restraint, but the physical aggression was not always defined in clear terms. For example, in one case the staff simply wrote that the client aggressed against another peer by throwing an object at them. The staff did not chart what that object was, which could make a difference in how staff might intervene in the situation.

The second record reviewed was that of a person residing in an ICF/MR unit at METO. The ICF/MR units are closely regulated by the MDH and the program can be sanctioned for violations that are not corrected. This person's Rule 40 program indicated only one minor change since the OHFC citations had been issued to METO. The minor change did not involve the criteria for the use of the mechanical restraints. Note that this person had been restrained over 125 times in the months just prior to the OHFC visit. A review of the progress notes indicated only two dates in February where the person was restrained. There were no restraints documented in the month of March for behavioral issues. The documentation prior to February of 2008 was extensive in

regard to this person's negative behaviors and the need for restraints. There are many notations of negative behavior in the March progress notes in the person's record. However, there is only one written note of how this negative behavior was dealt with by staff. This person's file stated that the staff had received approval from the METO Human Rights committee at the end of February to place a camera in this person's room to observe him/her during a restraint procedure. The reason given for the camera was that the person, while in restraints and in their room, would become agitated and aggressive toward the staff observing the person in restraints.

The third record reviewed was that of a person who resides in an SLF unit. There were no changes to this person's Rule 40 program that allows room time-out only and no changes to the Individual Program Plan. This person had been manually restrained seven times in February and those were documented as "Emergency Restraints." The person, when interviewed, described the restraint procedure as being told to lie down on his/her stomach with four staff holding his/her arms and legs. There was no documentation of any restraints in the month of March. Further review of the record indicated that during the month of March, the person slept most of every day for three weeks, with little or no staff intervention.

The fourth record reviewed was that of a person with a developmental disability and is deaf. This individual resides in an ICF/MR unit. The person has an approved Rule 40 program that requires staff to manually and mechanically restrain the person when target behaviors identified in the program are evident. The program was used on a frequent basis until several weeks before this review. No restraints were documented during the month of March.

It can be concluded that there have been drastic changes in the way programs are initiated in the ICF units, however there remains little change in the programming methods in the SLF units.



Personal Story Updates

These updates are based on information obtained from April 24, 2008 to present.

Person #1

This person remains at METO, residing in the same living unit (SLF). His/her programming has not been altered significantly and he/she continues to be restrained on a frequent and regular basis for behaviors outlined in this report.

Person #2

This person was discharged from METO late 2007 to a crisis bed in the community while he/she awaited a permanent placement. This person's adjustment from METO to the community was somewhat difficult in that he/she was constantly "checking" with

staff and family to make sure he/she didn't have to go back to METO. Staff at his/her permanent placement reported that he/she has a great deal of anxiety about leaving the group home for any new destination, as he/she believes he/she may be taken back to METO. In the beginning of placement, he/she had to constantly be reassured that he/she was not going to be taken back to METO. His/her guardians report that the trained staff in his/her current residence provide him/her with choices for activities each day, which was not the case at METO. This has led to a reduction in the person's anxiety level and the behavior exhibited at METO.

Staff at his/her permanent placement reported that he/she has a great deal of anxiety about leaving the group home for any new destination, as he/she believes he/she may be taken back to METO.

Person #3

This person currently resides at METO (SLF), however is slated to be discharged within weeks to his/her parent's home. Due to the advocacy of his/her guardians and others, this person no longer has a Rule 40 program that includes the use of metal handcuffs and leg hobbles. The guardians have informed the program that they are not to use mechanical restraints. They have told METO staff that they may use manual restraint and room time-out only in emergency situations where there is possible imminent, grave harm to their child. This person continues to communicate that he/she "hates" METO because he/she has been abused there by staff takedowns and the use of mechanical restraints.

Person #4

This person remains at METO in the same residential unit (SLF) as in January of 2008. His/her individual program plan, including his/her Rule 40 program, have not been altered to change the use of metal handcuffs and steel ankle cuffs as part of his/her program.

Person #5

This person remains at METO in the same residential unit (ICF/MR). Following the investigation by the Department of Health (OHFC), METO changed their restraint policy, which does not allow metal handcuffs to be used in the ICF/MR units. This client continues to be restrained with a waist belt that has soft cuffs attached to it. Documentation in the client's record indicates that recently, the internal Human Rights committee at METO has approved the use of a video monitor in this person's room to monitor him/her while he/she is in restraints.



<u>Program Positions Throughout the Review Process</u>

Throughout this investigative process the Ombudsman's Office has discussed with METO management and staff, a METO hospital review board member, DHS State Operated Services management, and DHS Disability Services Division policy staff the grave concerns regarding the use of restraints on persons committed to METO as a programmatic treatment method. There were many statements made by all parties associated with METO in defense of this practice. The staff and management of METO were adamant in their conviction that this method of "behavioral therapy" was the only method that could work on the individuals at their facility.

Comments were made that the Ombudsman and others did not understand the nature of the clients who were placed at METO. The Ombudsman was told that many of the clients would be in jail if they were not in METO. During the many discussions with METO or DHS management regarding the use of restraints on persons at that facility, Ombudsman staff have been told repeatedly that the individuals at METO are "the most difficult and dangerous" persons to serve. Another staff described them as the "worst of the worst." The staff insinuated that most of the persons at METO came there through the criminal courts following the committing of a serious crime.

During the January 8-9, 2008 visit to METO, only five of the forty people committed to the facility had come through the criminal court system. These five individuals were under a Treat to Competency Order (Rule 20.01).⁹ The five individuals all had diagnoses of mild to moderate developmental disabilities with other diagnoses of mental illness, chemical dependency or traumatic brain injury. A thorough review of the five persons' records indicated that only one

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⁹ While there were five under 20.01 (Treat to Competency), there may have been others whose civil commitment was prompted/preceded by a Rule 20. Under Rule 20, if a person is found incompetent and the charge is a misdemeanor, the charges are usually dismissed and civil commitment proceedings are initiated. Those cases would show up as a straight civil commitment. More serious crimes (i.e. Gross Misdemeanor and Felony charges) usually result in a Treat to Competency.

of the individuals had been restrained in any way since their admittance to METO. The person had been manually restrained twice. All five records show individuals who are compliant with treatment and tasks they are directed to do by staff.

The documentation in the individuals' records and statements made about these five people by staff appears to contradict the statements made by METO and DHS management regarding the number of persons being committed to METO through the criminal courts and also that those persons are the most difficult to serve. The program was portrayed as a place where clients who have committed crimes are placed when they are not appropriate for prison, including those who were not competent to stand trial or able to understand the nature of their actions. These were individuals who would be committed there by a criminal court as a result of a Rule 20 assessment.¹⁰ During the course of the review, the Ombudsman discovered that those placed there as a result of a Rule 20 represented only 10 - 15% of the clients served by the program. In fact it is striking to the Ombudsman that those who were there because of criminal court Rule 20 proceedings were less likely to be restrained than those who had been The Ombudsman does acknowledge that the numbers civilly committed. regarding criminal court commitments may not tell the full story because some individuals that have been civilly committed may well have been diverted from criminal court.

The program also expressed a belief that when guardians would not authorize the use of restraints or limited their use in some way, that the program was between a "rock and a hard place." It was further explained that this lack of authorization left the program unable to keep the client and staff safe and made staff unable to treat the client to the point where they could be returned to a less restrictive setting in the community. It was clear that the program believed that use of restraints was the only treatment method for difficult behaviors which is contrary to the generally accepted practice of positive behavioral supports.

Other comments made by staff indicated that it was the belief of the program that it was the fault of the client that they were in the program. Certainly it was the behavior that got the person admitted to the program, but it is not their fault

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¹⁰ MINNESOTA RULES OF CRIMINAL PROCEDURE WITH AMENDMENTS EFFECTIVE JULY 1, 2008: Rule 20

that they have a developmental disability that impairs their executive reasoning function.

One of the points made was that these individuals are not really DD but have mental illness because the clients are high functioning and have the ability to form intent. This implies that it would be acceptable to use these aversive practices in a residential mental health facility. However, if this were a facility for persons with mental illness, they still would not be able to routinely use restraints. There is no provision for the use of restraints comparable to Rule 40 in the mental health system.



Commentary/Analysis

The words and phrasing used by all parties connected to METO were similar or identical, indicating a problem often referred to as "group think," where the message is so ingrained and the leadership philosophy so strong that independent thinking is neither utilized nor tolerated among members of the group. This puts the facility at risk of no one seeing potential problems within the program or the corrective measures that might be needed. The language takes on the characteristics of a "mantra." The following is an attempt to examine some of the standard responses provided to the Ombudsman.

"Worst of the Worst"

Statements referred to the persons served at METO as the "worst of the worst," the "hardest to serve," "the most dangerous," and "the most behaviorally challenged." The use of this wording is demeaning and signifies a lack of respect for the persons at METO as individuals. Residents need to be seen as individuals with their unique abilities and challenges, needs, wants, hopes and desires.

"It's the client's fault they are at METO"

Other statements made by METO and DHS individuals laid blame on the individuals themselves for being sent to METO. It was the individual's failure in the community, the individual's behavior, or the individual's unwillingness to comply with their care givers that resulted in them being committed to METO. First, all the persons at METO have mental disabilities that may not afford them the ability to reason and learn appropriate behavior on their own. By examining the recent history of many of these individuals prior to their commitment, it was sometimes the inability or unwillingness of the caregivers in the community to spend the time, energy and effort to provide appropriate treatment and supports to the person. For example, one individual with severe autism had community caregivers who appeared to panic when they did not know how to calm this individual who had become over-stimulated and began to harm himself/herself in public. For persons with autism, there can be a hyper-sensitivity to stimulation which is a hallmark feature or symptom of this disorder. The residential staff apparently did not have supports necessary to assist this individual and therefore called the local police for help. enforcement took this individual to jail and quickly realized they had a person with severe impairments they were ill equipped to manage the person in their correctional facility. If the residential staff had been provided with the appropriate training and supports from their management, they may have handled the situation differently and the individual may never have spent those long months at METO. Was this the individual's failure? Did the individual form reasoned intent to engage in maladaptive behaviors? Clearly this was not the case. The behavior may have been inappropriate to the situation or environment but the individual did not have the ability on their own initiative to choose to overcome those behaviors. If they were capable of making these changes on their own, there would not be a need for a placement in a specialized facility at a cost of \$861 per day. Cost effective treatment can be done but it takes active, positive redirective programming, something this individual appears not to have received at the time of this incident.

Another example of "blaming the individual" is the situation of a person who resided in a crisis home for at least eighteen weeks (designed to be short-term placement) before being committed to METO. Because a placement was not found or developed in the community, this person ended up in METO. It should be noted that this individual's behavior was managed considerably

better in the crisis home without restraints. In fact, the professional staff from the crisis homemade specific recommendations to METO not to use restraints on the individual because it would not allow him/her to calm him/herself. (Please see Person #5's story in this report.)

These are just two examples appropriate for this report. Once again, it is clearly the responsibility of the professionals within the service delivery system to develop programs and services that are positive in nature and provide the necessary supports for individuals with developmental disabilities.

The Ombudsman's Office recognizes that some individuals receiving services have challenging behavioral issues, and that at times of immediate risk of injury to themselves or others, a person may have to be briefly restrained or removed from their environment to prevent an injury. Using restraints such as metal handcuffs, leg hobbles, leg irons, and restraint boards as a behavior tool to teach an individual not to engage in certain behaviors can be a violation of the individual's rights. It is ineffective in teaching appropriate behavior, and just plain wrong. If individuals are being restrained over 200 times in a year, shouldn't this be indication that the aversive, punitive programming isn't working?

"It is not safe to keep him here" (Retaliation)

Some guardians of persons committed to METO learned that to raise questions about the use of restraints or other punitive methods of behavior management could lead to subtle and not so subtle retaliation from staff. Visiting times with the client and contact with staff became limited and information about their ward became difficult to obtain from METO staff. In one case, an individual's guardian refused to allow the use of mechanical restraints on their ward when he/she engaged in typical behavior associated with his/her autism. The guardian offered referrals to sources that could provide alternative behavioral methods for persons with severe autism, but these offers were ignored by METO staff. When the individual's commitment was coming to end and it appeared that the community placement would not be available for approximately a month after the end of the commitment, the guardian asked that the person remain at METO for that month. The guardian expressed concern about the stress put on the ward if they should have to move twice during such a short period of time. The guardian's request was never directly responded to by

METO staff. In correspondence to the person's county case manager, the clinical director wrote that he would not agree to this temporary, continued stay. He cited that the client had been ready for discharge for many months (the documentation at METO did not support this statement) and he would not allow him to stay beyond the end of the commitment. He went on to say, "I cannot conceive of a competent guardian who would consent to voluntarily assigning a clinician whose personal and professional credibility they attack at every opportunity. I believe my consent to voluntary treatment of [the client] would pose unacceptable risk to me, the program, and the office of the Commissioner."¹¹

The Ombudsman's Office could not find any documentation that the guardians attacked this professional's credibility either personally or professionally. The guardians stated that they believe the decision by the clinical director and his false statements about them attacking his credibility are in retaliation for their refusal to accept mechanical restraints as the appropriate behavior therapy for their ward.

"Rule 40 allows the use of restraints"

The practice conveyed to Ombudsman staff by program staff at varied levels gave the impression that it is acceptable to restrain clients routinely. The Ombudsman disagrees.

Rule 40 (9525.2700-9525.2810) states that its purpose is "not intended to encourage or require the use of aversive or deprivation procedures." It is intended to "encourage the use of positive approaches as an alternative to aversive or deprivation procedures." The rule also requires "documentation that positive approaches have been tried and have been unsuccessful as a condition of implementing an aversive or deprivation procedure."

What did occur was an immediate use of mechanical restraints for "target behavior" that was documented as "emergency use" until a Rule 40 program was written by clinical staff. Under Rule 40 standards for Emergency Use of Controlled Procedures, there are three standards that should be met to use this procedure.

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¹¹ E-mail from the Clinical Director to the County Case Manager.

- A. Immediate intervention is needed to protect the person or others from physical injury or to prevent severe property damage that is an immediate threat to the physical safety of the person or others."
- B. The individual program plan of the person demonstrating the behavior does not include provisions for the use of the controlled procedure."
- C. The procedure used is the least intrusive intervention possible to react effectively to the emergency situation."

Documentation in individual records where an emergency use of controlled procedures was implemented indicated that at least two of these standards (A and C) were not met before it was used on a person. One example of this is a person slamming a door several times. This clearly did not meet the definition of possible severe property damage. Another example is a person talking about running away. There was clearly no immediate danger of injury to this person or others by the threat of running away. In these two examples, it is illustrated how the line of what is considered an "emergency" was blurred to restrain someone for any negative or target behavior even when they did not have approval of the guardian.

In other situations, it becomes clear that the rigidity of the policies and procedures regarding restraint use is beyond the scope of any reasonable person's standard of when a restraint might be needed. One example of this is an incident where a person was excited by the fact they had their annual IPP meeting on a cold autumn day. The meeting was being held in the administration building, about a hundred yards from their residence. person was told to put on a coat before leaving the residence for their meeting. The coat was in the laundry so the person left the residence without a coat. Staff rushed after the person, physically restrained him/her on the sidewalk, and when calm, brought him/her back to the residence. Once in the residence the person was placed in mechanical restraints and not allowed to go to their annual IPP meeting. As documented, this restraint was implemented for not following staff commands to wear a coat. Many people learn best how to dress after they experience the discomfort of being cold. In other words, we learn from our own Unless the person's decision is immediately life threatening, the person should have some rights of self-determination and free choice. Use of a

restraint in that case was not the only method of handling the situation. There were a number of alternative options that could have been considered.

A review of records at METO showed a lack of individualized behavior programs. The difference in the behavior programs appeared to be the named "target behavior" for which the restraints would be used on the person. Ombudsman staff was informed by METO staff and management that staff had been trained to allow only two minutes of any "target behavior" for an individual. If the person did not stop the "target behavior" within this time frame, they were automatically placed in mechanical restraints, per their Rule 40 program. It was rare to find any documentation that staff attempted any less intrusive method to stop a 'target behavior.' In most incidents when staff were asked to document lesser intrusive methods or procedures tried before the restraint was used they wrote, "N/A" or "None." In other cases, they charted "redirected client" but without any detail about the redirection so it could be evaluated for why it was ineffective. It is unclear why the staff of the facility appears to believe that it must be "all or nothing" with regard to the use of restraints.

"This program is a nationally recognized program"

Repeatedly the Ombudsman's Office heard from staff at METO, DHS and others associated with METO that the METO program was considered a nationally recognized program because of their achievements in the reduction of maladaptive behavior in individuals with developmental disabilities.

The Ombudsman's Office has learned through examination of documents that the success of a behavior program is directly linked to a reduction in the use of restraints on a person for target behavior. For example, if a person was restrained 50 times in the first six months of the year and only 30 times in the second six months of the year, the mechanical restraint program was said to be an effective program in reducing maladaptive behaviors. Documents obtained during this investigation indicate this is an incomplete evaluation of program effectiveness. For example, one document clearly indicated that staff was directed to reduce the use of restraints on one person to make it "easier for the person to be placed in the community." There was no indication that there was a reduction in "target behaviors" for this person at the time of this directive to

staff. When use of restraints are suddenly discontinued, the statistical appearance is that the program has dramatically reduced target behaviors.

Another example of this perception of programmatic success is a person who has been discharged from METO, who had an aversive Rule 40 program that required staff to restrain him/her for behavior that was typical for a person with autism. The guardian rescinded approval of this program. The guardian determined that the program was being used on their ward for behavior that he/she could not necessarily control and that the method of restraint was metal handcuffs and leg hobbles used in a face-down, prone position. When the Rule 40 program was discontinued, the documentation for this person indicates an almost immediate reduction in the "target behavior" for which the person was being mechanically restrained. It is unclear if the target behaviors had been reduced or that staff were not documenting those behaviors because there was no longer a Rule 40 program that required this documentation.

"This is a relatively short-term program"

The original concept was that the METO program would be an interim placement until the behavior could be treated and the client returned to the community. Short term might be nine to 18 months, although it would be based on the client's individual progress. However, a review of the records indicates that many of the clients have been there for years, including individuals who had been there for three, four, seven, and eight years. One resident been there for over 25 years.

METO becomes their home, a place where they feel safe, respected and valued. At least one of these individuals had been restrained between 200 and 300 times per year for the last two years. It is difficult to conceive the client's quality of life. For the taxpayer cost of \$ 314,265.00¹² per year, the client and the public have a right to expect better from the professionals who provide treatment.

Checks and Balances in the System

A question raised earlier in this review is how all of the persons and programs within the system who are required to provide a level of protection to their clients could have

¹² DHS Bulletin #07-77-01

missed that these vulnerable individuals were being routinely restrained. The Ombudsman found generally complacency and a negative view of "what can we do" when we have no other options. Through examination of the various systems of checks and balances, the Ombudsman found a system under stress. It confirmed the philosophy that when everyone is responsible, then no one is accountable. From a policy division standpoint, the Ombudsman saw a system that has evolved over time, a system that is required to serve very complex needs within limited or diminishing resources.

There are not sufficient facilities with the capacity to handle the most difficult to serve individuals. When resources are limited, there can be cutbacks on staff training in community facilities. The state used to set aside funds that could be used to "enhance" the existing funding to find appropriate options for those with higher needs so that they did not need to remain institutionalized. These "enhanced" and "triple enhanced" waiver slots were held by the State and were therefore not dependent on what county a client may be from. This method gave way to pooling of all waiver dollars for a county and allowing the county to manage their funds within their pool of slots.

When county case managers sought placements, they found it challenging to find providers able to treat those with difficult needs. Counties were unwilling to pay for the staffing needed by the facilities to meet these needs. According to some in State Operated Services, the state still runs certain crisis services in name, but the counties are unwilling to pay the real cost of maintaining the professional staff needed to be available for crisis situations. Case managers sometimes carry large caseloads and difficult clients require a lot more of their time and energy. When a case manager is faced with a client in a failed placement, an open bed at METO can be an attractive alternative to developing alternative resources. Despite the expectation that the case manager is to be an aggressive advocate for their client, they generally are not clinical Sometimes they are willing to relinquish experts in this type of treatment. responsibility to METO knowing that someone else is providing for their client. Case managers indicate that their other work demands do not allow for full knowledge of what happens on a day-to-day basis. Case managers told us that they knew about the use of restraints but were not aware that they were law enforcement tools. Once they became aware of this, they expressed concern about the practice.

When parents and guardians raised concerns, case managers were afraid to "rock the boat" because of the limited options for alternative placements. Many of the family members went along with whatever the professionals proposed because they believed the professionals were the experts. Even if family members did not like the practices,

they were afraid to question them because the family members did not have the skills, ability and resources to meet the person's needs at home. As well, the person was "court ordered" to be at METO. For those who attempted to be assertive or even aggressive on behalf of their ward, program staff sometimes described them as "difficult" or "interfering with treatment." They were viewed as part of the problem. The Ombudsman was told about situations where the facility and sometimes the county would imply the need to go into court to question their role as guardian. One family member indicated that he/she would routinely bring up concerns reported to him/her by their ward, even concerns about how other residents on the unit were treated. The client called the family member at one point and said not to do that because his/her treatment would get worse after that. Although unrelated, the client said they had a search of all the rooms on the unit. The client had a piece a paper on which the family member had written the telephone number of an outside advocacy group. The client reported that the contact information was taken from the room and the client was worried about retaliation so was never going to complain again. While DHS licensing may not have been able to substantiate retaliation in reported cases, there was a sense of fear along with a strong sense of unease expressed by some of the family members.

Where was Licensing?

When issues were raised about the treatment methods used, the program staff responded that if the problem was so bad, Licensing would have taken appropriate action.

Until recently, the MDH had a prominent role in overseeing ICF/MRs as well as the DHS Licensing Division. After the Consolidated Rule took effect, an interagency agreement was implemented, delegating the responsibility of investigations to DHS. In 2007, the CMS informed Minnesota that the interagency agreement did not meet Federal expectations. MDH then resumed their investigative role at METO for the beds that were federally certified as well as those licensed under the department's rules for SLFs.

Both MDH and DHS licensing division informed the Ombudsman that they had not been aware of the metal handcuff use and had not received any complaints. DHS made it clear that while they had some concern about the type of devices being used, there was nothing in the rule that limited the type of material that the restraint could be made. DHS went on to indicate that their reviews focused on whether or not the program had appropriate Risk Assessment Plans and Individual Treatment Plans. DHS also reviewed Rule 40 plans for the necessary elements. These included the guardian

signature authorizing the use of restraints. Licensing generally did not second-guess the clinical judgment about when to implement restraints. They emphasized that Minnesota Rules are only the minimum standards, not necessarily optimal standards.

Once Licensing became aware of the concerns, they did respond by conducting investigations within their regulatory scope and issued findings and citations to the facility.

In discussing these issues with parents, Licensing indicated that many clients did not know where to complain or were afraid to complain. Case managers reported to the Ombudsman that actual practices of the facility were not discussed at the team meetings. They reported that at the meetings, the facility generally reported the progress and any changes in the treatment plan. At least one case manager indicated that he/she did not ask any questions of the facility staff or challenge treatment decisions but was disturbed when they learned about the metal handcuffs.

Finally, the HRB indicated that it rarely met with clients but relied on reports from the staff.

Penny Wise/Pound Foolish

In one case, it was reported that the community service provider had been doing a good job with the client and liked having the client in their home. However, because some of the behaviors were challenging they needed to add on another staff member for additional supervision purposes. When the provider requested an increase of the client's waiver allocation to cover the cost, the county denied the request. It was at that point that the facility said that without the extra staff, it would no longer be able to serve the client. The client was placed in the hospital and then in a state operated crisis home. From there the client went to a community setting where he/she had problems. The crisis home said he could not return. The client was then committed to METO at a cost of \$861 per day. However, at METO, the county is only required to pay 10% of that cost and state pays the balance for the majority of the beds. While the clients are at METO, they lose their eligibility for waivered services. There is no guarantee there will be a slot when they are ready to return to the community. Under the county's waiver pool, those funds remain in the pool available for other waiver recipients. However, it is the Ombudsman's understanding that most of those discharged can be reestablished on a waiver when they leave.

The Ombudsman questions the rejection by the county of the additional staff person and the sending of the client to METO, where costs are significantly more.



Ombudsman Conclusions

After a careful review of the information gathered and thoughtful consideration, the Ombudsman concludes that:

- There is an abundance of research and evidence that positive practices can work to alter challenging behaviors.
- Positive interventions are the generally accepted standard of care for persons with developmental disabilities.
- There is a legitimate place in the spectrum of care for a facility envisioned by METO's empowering legislation.
- METO currently has a program-wide practice of routine use of restraints employed as a basic treatment modality. This practice embodies a deeply ingrained philosophy of care.
- Staff members of the facility believe that their clients will not get better if they do not use this form of treatment.
- The practice of using restraints is practiced widely and is anticipated with every admission. This is evidenced by the standard check off on the admission form that there are no contraindications to the use of restraints.
- The facility plans are not sufficiently individualized except for what constitutes "target behaviors" that would precipitate restraint use.
- The facility's documentation surrounding the incidents of restraint use is not adequate to evaluate what alternatives were tried.
- The treatment plans were not routinely reviewed for the effectiveness of the Rule 40 program nor were they amended when the current plans were not producing results.
- Despite all the concerns raised, the program only discontinued restraint use in the two units that are certified and eligible to receive federal funds. The program

stated that the reason for the change was that federal rules were more restrictive and did not allow for it. There is no indication that the change was because of any acceptance that this practice is a problem or that they intend to change their practice in the other six units.

- The facility did agree to look for alternative restraint devices that are safe and more acceptable in a health care setting.
- Inappropriate use of restraints can constitute abuse under Minnesota's Vulnerable Adult Act.
- It is the opinion of the Ombudsman that certain practices have violated the human and civil rights of some clients.
- The system as a whole fell complacent in their roles to protect these vulnerable Minnesotans.
- There are not sufficient facilities in the community that are able to handle clients with intensive support needs and it is not clear who is responsible for their development.
- The clients who are at METO are not the "worst of the worst." There are many
 existing examples of clients with challenging behaviors who are living in the
 community and are successful when given the appropriate supports by welltrained support staff.



Recommendations

- DHS should immediately begin a comprehensive review of the policies, procedures and practices at METO.
- METO should immediately discontinue the use of restraints in any form except when eminent risk of harm is present.
- All staff should receive training in positive behavioral programming, rights of clients, documentation and other training as identified in any program evaluation.
- METO should establish an overarching approach to the use of restraints that
 applies to all clients regardless of what type of licensing covers any given unit.
 Human rights are universal and every client has the right to be treated with
 dignity and respect.
- METO should begin discharge planning for any client who has resided there for more than two years, with adequate safeguards to minimize the stress of transition.
- METO should begin a practice of developing a therapeutic alliance with family members and guardians, even those who may disagree with the program. There should be recognition of the legitimate role and responsibilities of these individuals and understanding that they are critical in the future success of the clients.
- DHS should look for opportunities to divert clients with less challenging behaviors to alternative resources in the community. If none exists, State Operated Community Services should look at developing those services.
- DHS should begin a process of evaluating why there are not adequate resources in the community and why they are not being developed.
- Clarity of who is responsible for developing these resources should be sought. Is it the state or the county? Who is responsible and how can they be held accountable?

- DHS should evaluate whether or not more could be done to support community providers in order to prevent the loss of an existing placement.
- DHS should evaluate the funding methodology to assure that there is a designated reserve to draw upon in that small percentage of cases where the standard methodologies are not appropriate.
- DHS Licensing should consider revising its policy of limiting its investigation to only those specific items identified in a complaint when their investigation reveals a pattern of practice that may reveal that other clients are affected and licensing rules are being violated.
- County case managers should become more active participants in their client's plan of care and should be encouraged to challenge practices to assure that all reasonable methods have been tried before any restraint is to be used.



In Closing

It appears as if the METO program has lost sight of its original vision and mission. Minnesota has fallen back on the failed practices of the past that led to the necessity of a Federal Consent Decree. Without immediate and substantive change, the state is at risk of further federal intervention. METO clients deserve to receive treatment and supports that fully incorporate them into the fabric of our communities as equal and participating members. Those who know and work with these citizens know how much they contribute and how much they enrich our lives. These citizens deserve better and the taxpayers of Minnesota deserve more effective use of their resources.



Addendum

The Ombudsman is aware that during the time this report was being finalized by the Ombudsman, METO and DHS have embarked upon a process to address concerns raised in this report.



- A. Responses from DHS
 - 1) DHS State Operated Services
 - 2) DHS Licensing Division
- B. OHFC Citations
- C. DHS Citations
- D. Informational Web Sites Links
- E. Table of Restraints on Initial Site Visit

Appendix A1 DHS State Operated Services Response



August 8, 2008

Roberta C. Opheim Office of the Ombudsman for Mental Health and Developmental Disabilities 121 7th Place E. Suite 420, Metro Square Building St. Paul, MN 55101-2117

Re: Your Correspondence Dated July 14, 2008, re: Ombudsman's July 2008 (Draft) Report Regarding the Use of Restraints in the Minnesota Extended Treatment Options Program

Dear Ms. Opheim:

This correspondence is in response to the referenced draft report compiled by your office. The report includes the Ombudsman's concerns regarding the use of restraints on disabled individuals at the Minnesota Department of Human Services' (DHS) Minnesota Extended Treatment Options (METO) Program.

The METO program and its dedicated staff constitute a vital and effective asset for individuals with developmental disabilities who present a risk to the public. METO has emerged as a pivotal component of the forensic services network, filling what had been a serious and persistent void in the continuum of care. In an effort to continue to provide and improve upon the quality services we provide, METO undertakes internal quality assessment and improvement efforts, including program reviews completed by outside experts.

One such review was recently completed by four national experts in the field of developmental disabilities who spent three days reviewing the METO program and patient charts. These consultants possess particular expertise regarding patients who exhibit challenging and aggressive behaviors. In addition, the METO program has been the subject of various reviews by the DHS Licensing Division, Minnesota Department of Health's (MDH) Health Compliance Office and Office of Health Facility Complaints ("survey agencies").

The Ombudsman's July draft report is a synopsis of program areas that had been referred to the survey agencies as needing improvement. Consequently, prior to the release of the July 2008 draft report, METO had already begun to satisfactorily address or resolve concerns raised by the Ombudsman. At the completion of an ongoing, comprehensive review and revision of program policies and procedures:

- The consultants will issue a report in early fall with recommendations;
- METO will develop a plan of action in response to the recommendations;

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• The consultants will return in 12-18 months to assess progress on the action plan.

In addition, the actions below have already been taken by METO in response to citations issued by the survey agencies.

Comprehensive Review and Revision of Policies, Procedures and Practices at METO

METO has completed a comprehensive review and revision of its policies, procedures, and practices. The process resulted in substantive changes to facility policies and procedures affecting:

- Safety Planning for Community Activities,
- Emergency Use of Controlled Procedures (Manual & Mechanical Restraint),
- Use of Controlled Procedures in Behavior Management, and
- Staff and Client Conduct.

METO has trained staff and implemented these revised policies and procedures.

Consistent and Limited Use of Restraints

In February 2008, METO established (1) a uniform policy and procedure to be applied to all units, regardless of the type of applicable licensing regimen, regarding the use of restraints, and (2) an aggressive goal and timetable that all staff will be trained by March 1, 2008, and that goal was met. Under the new policy and procedure, METO has discontinued the use of restraints in any form except when imminent risk of harm is present.

Staff Training in Positive Behavioral Programming and Other Relevant Areas

In addition to new employee training and annual refresher training, specific training regarding behavioral management principles was provided to all METO staff in February 2008. This training included a segment regarding the change in policy on the use of restraints and the dangers of restraints. The training also included information on client rights to freedom from unnecessary restraint and other restrictive interventions. To further METO's mission to provide positive behavioral programming, METO is currently looking at various behavioral training curricula; METO is committed to purchasing a positive behavioral management program that will best serve its population.

Admission, Transition Planning, and Discharge

METO's policy and practice is to begin discharge planning upon admission. In practice, discharge planning begins even earlier, with detailed discussions with a prospective client prior to, and when possible weeks before, admission. Additional relevant considerations include:

 METO admission procedures have been strengthened to ensure county case manager involvement earlier and throughout the process. Roberta Opheim Page 3 August 8, 2008

- Assessment and treatment plans are now more focused on issues related to commitment and barriers to discharge, as opposed to long-term training and supports that are best delivered in a communitybased setting.
- The DHS METO Admissions Bulletin has been revised to emphasize that placement at METO is intended to be interim and time-limited, rather than permanent.
- The practice of pre-admission discharge planning was greatly enhanced within the last year by the addition of a member of the DHS Disability Services Policy Division to the METO Admissions Committee. That person's role is to provide a liaison role between METO and the Disability Services Division and support regional staff as they work with counties to help facilitate timely discharge back to the community.

As a result of the preceding focus on maintaining and improving the discharge planning component of the METO program, in the past year alone, four out of nine clients at METO who had a length of stay exceeding two years have now returned to the community.

Involving Family Members, Guardians, Patient Advocates, and Others

METO recognizes the central importance of involving family members in the treatment process, regardless of legal (guardianship) status, in a variety of ways:

- Upon admission the facility fully discloses its policies and procedures related to positive behavioral supports and emergency restrictive interventions. Disclosure includes photographs of mechanical restraints. The family is asked to discuss any concerns regarding restrictive interventions so that appropriate alternatives are identified.
- Family members and others involved in a patients care are provided copies of client bill of rights and METO's policies and procedures relating to client rights, and are invited to tour the campus and interview staff prior to their person's placement.
- Guardians are key members of the Interdisciplinary Team. Treatment with psychotropic medications and/or restrictive interventions can only occur with the consent of the client or guardian.
- Involvement, input, and recommendations from interested third parties, including outside
 consultants, past service providers, patient advocates, and others is also encouraged, afforded serious
 consideration METO staff, and implemented when appropriate.

Identifying and Developing Alternative Community Resources

DHS' State Operated Services (SOS) Division and METO have been working collaboratively with the DHS Disabilities Services Division, the policy division, to clearly identify those clients who meet METO admission criteria and to require community crisis management services to work diligently to

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to find community placements for those clients who do not meet METO admission criteria.

- METO has worked with Minnesota State Operated Community Services to develop alternative community placements. The first such home will be available in the fall of 2008.
- METO Staff collaborated with DHS Disabilities Division to sponsor a community crisis
 conference to focus on the unmet need for community crisis services by county and state
 providers with the goal of avoiding the need for clients to be admitted to METO.
- The METO Admissions Bulletin has been revised to include the following information:
 - Crisis Management Services: In an effort to avoid the need to initiate commitment
 proceedings, clients who are being considered for admission to METO should be referred to
 a community crisis management service to determine the appropriateness and availability of
 alternative care and/or placement.
 - Persons who do not meet METO's admission criteria but who have been committed to the Commissioner will be admitted to a Minnesota State Operated Community Services home, until such time as an appropriate community placement can be secured.

There have also been steps taken to evaluate and increase the capacity of community providers to meet the needs of individuals, in order to avert use of crisis services. As examples:

- The Disability Services Division coordinated with Aging and Adult Services Division this year to conduct an analysis of county capacity in order to identify service gaps, and influence the development of services to meet those gaps. This expanded the previous "Gaps Analysis" done by counties for people who are aging, to include people of any age with disabilities. The analysis of the findings is underway, and will lead to targeted technical assistance efforts by Disability Services Division staff with counties who are responsible for developing community service capacity.
- The Disability Services Division has been evaluating the array of services available through the four disability waiver programs to determine if changes are needed in the definition of any services and/or provider standards to assure people have access to appropriate services.
- The Disability Services Division intends to add crisis services to the CADI and TBI waivers, in addition to the DD waiver. This will allow individuals who do not qualify for ICF/MR level of care to receive needed crisis intervention services as well as short term residential support when necessary through other waiver programs. The provider standards for crisis services are being revised to include competencies with positive behavioral interventions.
- The Aging and Adult Services Division, in collaboration with the Disability Services Division, conducts an annual survey whereby counties, tribes and health plans that provide waiver lead agency administrative responsibilities document administrative assurances in a Quality

Roberta Opheim Page 5 August 8, 2008

Assurance Plan. The survey this year required an inventory of all home and community based providers under contract with the county to gain a more complete picture of the services available to individuals across the state.

Evaluate Funding Methodologies

The Disability Services Division has allocated emergency waiver resources within parameters designed to provide a safety net for people counties are not otherwise be able to serve within their waiver program. These resources have been provided to counties to assist with discharges from METO.

A new state to county budget methodology for DD waiver funding will be implemented January 2009. Training will begin in September for counties. It is expected that the methodology and use of the management tools that were developed to support its implementation will provide more flexibility in the DD waiver program to serve people with developmental disabilities.

There are limits on funding available through the waiver programs. A number of people receiving services through METO are not eligible for ICF/MR level of care, and therefore not eligible for a DD waiver. They may be able to access CADI or TBI waiver programs, based on eligibility for nursing home level of care. Services available through the Mental Health System, health care and other sources are resources that must be appropriately utilized in order to effectively serve people. Staff from the Disability Services Division, Adult Mental Health, Children's Mental Health and other divisions are working to provide better information and support to counties about funding and services that may be available for their clients.

Conclusion

METO is dedicated to upholding the highest standards of service attainable. Among the strategies METO employs to achieve this goal is soliciting and being receptive to input from independent evaluators, including the recommendations of the consultants and survey agencies discussed above. Where areas needing improvement have been properly identified, METO has and will continue to respond, including by implementing appropriate improvements.

Thank you for providing the opportunity to offer input regarding the July 2008 draft report.

Sincerely,

Mike Tessneer, CEO State Operated Services

Appendix A2 DHS Licensing Response Letter



August 8, 2008

Roberta C. Opheim
Office of the Ombudsman for
Mental Health and Developmental Disabilities
121 7th Place E., Suite 420
Metro Square Building
St. Paul, MN 55101-2117

Re: Your Correspondence Dated July 14, 2008, re: Ombudsman's July 2008 (Draft) Report Regarding the Use of Restraints in the Minnesota Extended Treatment Program

Dear Ms. Opheim,

This correspondence is in response to the referenced draft report compiled by your office. The report includes the Ombudsman's concerns regarding the use of restraints on disabled individuals at the Minnesota Department of Human Services' (DHS) Minnesota Extended Treatment Program (METO).

The description of the licensing oversight structure was not quite accurate in the report. The Minnesota Department of Health (MDH) issues a Supervised Licensing Facility (SLF) license to the entire 48 bed METO facility and also issues the Intermediate Care Facility for the Mentally Retarded (ICF/MR) federal certification for 12 of these beds. The SLF licensing standards contain the "Patient's Bill of Rights" that is enforced by MDH. The DHS Licensing Division issues a license under Minnesota Statutes, chapter 245A to the entire 48 bed METO facility, based on the licensing standards located in Minnesota Statutes, chapter 245B. The use of aversive and deprivation programs with clients is monitored by the DHS Licensing Division for compliance with the standards located in Minnesota Rules, parts 9525.2700 through 9535.2810, commonly referred to as "Rule 40." The report references "Minnesota Rules 9525, generally referred to as the 'Consolidated Rule for Persons with Developmental Disabilities." However, other than Rule 40, the only licensing standards in Minnesota Rules, chapter 9525, refer to day training and habilitation, and would not apply to METO.

The report refers to an interagency agreement between DHS and MDH. In an effort to reduce duplicative regulatory oversight, the Minnesota Legislature exempted SLF facilities that are certified by MDH as ICFs/MR from extensive sections of the otherwise applicable licensing standards under Minnesota Statutes, chapter 245B, enforced by DHS. DHS remains responsible for monitoring for compliance with those remaining licensing standards. (See Minnesota Statutes, section 245B.03, subdivision 2.) As it relates to investigation of maltreatment complaints under the Vulnerable Adult Act, the Minnesota Legislature assigned the investigative responsibility to the DHS Licensing Division under Minnesota Statutes, section 626.5572, subdivision 13. The Centers for Medicare and Medicaid (the

Roberta C. Opheim August 8, 2008 Page Two

federal agency that oversees MDH certification of programs as ICF/MR) previously approved this arrangement for approximately 12 years, however, a recent change in their approval caused the need for an interagency agreement in late 2007 between MDH and DHS. Through this interagency joint powers agreement, MDH now has the duty to investigate alleged maltreatment in ICF/MR facilities.

While the Licensing Division conducted the investigation and issued the correction orders referenced in the report, the division also completed two additional investigations of the METO program involving issues related to the use of restraints also completed during the relevant time period. These investigations resulted in separate correction orders issued on September 10, 2007, and March 11, 2008.

The report recommends that the Licensing Division "consider revising its policy of limiting its investigation to only those specific items identified in a complaint." The Licensing Division does NOT have a policy of restricting its review of program compliance to only those specific issues identified in a complaint. In fact, the opening paragraph of the September 10, 2008, correction order letter states that the original complaint related to the use of mechanical restraints, and while no violations were determined related to that area, "during the course of the investigation, additional information revealed that the license holder was not in compliance" in other areas that resulted in citations and orders for correction that were not immediately related to the original complaint. This is common practice of the Licensing Division in its completion of approximately 1,600 investigations across various services per year.

To the extent that some inaccurate perceptions were established by the Ombudsman, the Licensing Division is committed to more clearly communicating the focus of its regulatory oversight.

Sincerely,

Jerry Kerber, Director Licensing Division

Appendix B Office of Health Facility Complaints Findings



Minnesota Department of Human Services

State Operated Forensic Services

Minnesota Extended Treatment Options
1425 State Street
Cambridge, MN 55008-9003

February 26, 2008

Kris Lohrke, RN, Supervisor Office of Health Facility Complaints Division of Compliance Monitoring 85 E. 7th Place, Suite #220 P.O. Box 64970 St. Paul, MN 55164-0970

Dear Ms. Lohrke:

Enclosed please find the revised Plan of Correction (POC) for the survey conducted at the Minnesota Extended Treatment Options (METO) program January 17, 2008. As requested, the POC has been entered onto your form. Some revisions were made after our telephone conversation with you on Monday, February 25. A copy of the document will also be sent to you by certified mail.

Please contact me at (763) 689-7160 if you need any additional information.

Sincerely,

Douglas Bratvold METO Director

/jb

Enclosure

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ABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		TITLE ' '?		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

MEto Direct 2/11/08

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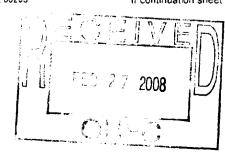
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W 128				128	The facility's specially of stituted committee will be changes in policy regarding emergency and programmation restraint, to ensure their and approval process meets revised policy's increased of severity of behavior for use of restraint is indical specifically, no use of restraints.	e oriented ag both use of review the sthe standard or which	
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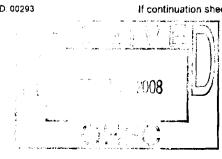
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after being calm for four minutes. The supervisory

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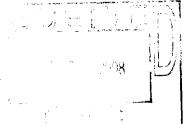
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minutes with Posey wrist restraints and leg

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section of the form indicated the client told staff,

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION 24G502 NAME OF PROVIDER OR SUPPLIER MEXTENDED TREATMENT (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFEX TAG REQUIATORY OR LSC IDENTIFYING INFORMATION) W 128 Continued From page 6 "Sorry, he deserved the implementation." "On June 20, 2007 at 6.20 p.m. client #3 refused to stay away from a peer that was sitting on the floor. Client #3" kicked at peer's feet." The client would not stop kicking at the peer, and it was "swearing, refusing directionsinvading peer's staffs space (with) wheelchair." The client then "stapped" a staffs forearm with an open hand. He was then restrained with leg nobbles and wrist cuffs for 22 minutes. "On August 5, 2007 at 3.55 p.m., client #3" was stopped in wheelchair in front of office, and would not redirect to move." The "other alternatives tried and/or considered" included, cueing the client "several times to move" and "secort by pushing wheelchair." Client #3 was restrained in hand cuffs and leg hobbles for 23 minutes, after he "struck staff with fist." The documentation did indicate that it was likely for the client's physical aggression to reoccur. At 6.00 p.m., "[client #3] was asked 3 times to move cut of view of TV in dayroom. The 4th time he refused, he was being escorted to room [client #3] hit staff." The ceiter was manually restrained for two minutes then estimated with was manually restrained for two minutes then estimated with wind the properties of the client's physical aggression to reoccur. At 6.00 p.m., "[client #3] was asked 3 times to move cut of view of TV in dayroom. The 4th time he refused, he was being escorted to room [client #3] hit staff." The client was manually restrained for two minutes then restrained with wrist cuffs and leg hobbles for 23 minutes.	CLINIL	VO LOLL MEDICYLE	a MEDICAID SERVICES				CIVIL INC	<u> </u>
NAME OF PROVIDER OR SUPPLIER MN EXTENDED TREATMENT (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECOLLATORY OR LSC IDENTIFYING INFORMATION) W 128 Continued From page 6 "Sorry, he deserved the implementation." "On June 20, 2007 at 6 20 p.m. client #3 refused to stay away from a peer that was sitting on the floor. Client #3 'kicked at peer's feet." The client would not stop koking at the peer, and it was "possible" that he "may have grazed peers feet." Client #3 was sked to stop and lie down on the floor. Client #3 was steed to stop and lie down on the floor. Client #3 was then manually restrained for two mirruites. "On June 23, 2007 at 5:43 p.m., client #3 was "swearing, refusing directionsinvading peer/slatifs space (with) wherelchair." The client then "slapped" a staff's forearm with an open hand He was then restrained with leg hobbles and wrist cuffs for 22 minutes. "On August 5, 2007 at 3:55 p.m., client #3 was stopped in wheelchair in front of office, and would not redirect to move." The "other alternatives tried and/or considered." included, cueing the client "several times to move" and "escort by pushing wheelchair." Client #3 was restrained in hand cuffs and leg hobbles for 23 minutes, after he "struck staff with fist." The documentation did not indicate when the client struck staff. However, the documentation did indicate that it was likely for the clients physical aggression to recocur. At 6.00 p.m., "glient #3) was seked 3 times to move out of view of TV in dayroom. The 4th time he refused, he was being escorted to risom [client #3] hit staff." The client was manually restrained for two minutes then restrained to two minutes then restrained to this morn. As he was being escorted to riso more continued to manually restrained for two minutes then restrained to the wind the minutes then restrained to the minutes then restrained for two minutes then res						E CONSTRUCTION		ETED.
MN EXTENDED TREATMENT ON IDEACH STATE STREET ADDRESS, CITY, STATE, ZIP CODE 1425 STATE STREET CAMBRIDGE, MN 55008 ON IDEACH STATE STREET CAMBRIDGE, MN 55008 IDEACH CERCICATORY OR LSC IDENTIFYING INFORMATION) W 128 Continued From page 6 "Sorry, he deserved the implementation." "On June 20, 2007 at 6:20 p.m. client #3 refused to stay away from a peer that was sitting on the floor. Client #3 "kicked at peer's feet." The client would not stopk kicking at the peer, and it was "possible" that he "may have grazed peers feet." Client #3 was asked to stop and lie down on the floor. Client #3 was tenne manually restrained for two minutes "On June 23, 2007 at 5:43 p.m., client #3 was "swearing, refusing directions invading peers/staffs space (with) wheelchair." The client then "slapped" a staff's forearm with an open hand. He was then restrained with leg hoobles and wrist cutffs for 22 minutes. "On August 5, 2007 at 3:55 p.m., client #3" was stopped in wheelchair in front of office, and would not redirect to move." The "other alternatives tied and/or considered:" included, cueing the client "several times to move" and "escort by pushing wheelchair." Client #3 was restrained in hand cuffs and leg hobbles for 23 minutes, after he "struck staff with fist." The documentation did not indicate when the client struck staff. However, the documentation did indicate that it was likely for the client #3) was saked 3 times to move out of view of TV in dayroom. The 4th time he refused, he was being escorted to insoom. As he was being escorted to froom. Like the was being escorted to froom. As he was being escorted to froom. Sa he was being escorted to froom. As he was being escorted to froom [client #3] hit staff." The client was manually restrained for two minutes then restrained with this vist cutfis and leg home.			24G502	B. WII	1G		l l	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY) W 128 Continued From page 6 "Sorry, he deserved the implementation." "On June 20, 2007 at 5 20 p.m. client #3 refused to stay away from a peer that he "may have grazed peers feet." Client #3 was asked to stop and lie down on the floor. Client #3 was then manually restrained for two minutes. "On June 23, 2007 at 5 43 p.m., client #3 was "swearing, refusing directions. Invading peers/staffs space (with) wheelchair." The client then "slapped" a staff's forearm with an open hand he was then restrained with leg hobbles and wrist cuffs for 22 minutes. "On August 5, 2007 at 3 55 p.m., client #3 "was stopped in wheelchair in front of office, and would not redirect to move." The "other alternatives tried and/or considered." included, cueing the client "several times to move" and "escort by pushing wheelchair." Client #3 was restrained in hand cuffs and leg hobbles for 23 minutes, after he "struck staff with fist." The documentation did not indicate when the client struck staff. However, the documentation did indicate that it was likely for the client's physical aggression to recocur. At 6:00 p.m., "[client #3] was asked 3 times to move out of view of TV in dayroom. The 4th time he refused, he was being escorted to iron [client #3] hit staff." The client was manually restrained for two minutes then restrained with with stuffs and leg	NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	-	STREE	T ADDRESS, CITY, STATE, ZIP CODE		
(X4) ID PREFIX RAD DEFICIENCY MUST BE PRECEDED BY FULL RECULATION COLST IDENTIFYING INFORMATION) W 128 Continued From page 6 "Sorry, he deserved the implementation." 'On June 20, 2007 at 6:20 p.m. client #3 refused to stay away from a peer that was sitting on the floor. Client #3 "kicked at peer's feet." The client would not stop kicking at the peer, and it was "possible" that he "may have grazed peers feet." Client #3 was asked to stop and lie down on the floor. Client #3 was then manually restrained for two minutes. 'On June 23, 2007 at 5:43 p.m., client #3 was "swearing, refusing directionsinvading peers/staffs space [with] wheelchair." The client then "slapped" a staff's forearm with an open hand. He was then restrained with leg hobbles and wrist cuffs for 22 minutes. 'On August 5, 2007 at 3:55 p.m., client #3 "was stopped in wheelchair in front of office, and would not redirect to move." The "other alternatives tried and/or considered." included, cueing the client "several times to move" and "escort by pushing wheelchair." Client #3 was restrained in hand cuffs and leg hobbles for 23 minutes, after he "struck staff whose, saffer he "struck staff whose, after he "struck staff whose, the documentation did not indicate when the client struck staff." The documentation did not redirect to move." The "other alternatives tried and/or considered." Included, cueing the client "several times to move" and "escort by pushing wheelchair." Client #3 was restrained in hand cuffs and leg hobbles for 23 minutes, after he "struck staff whose, safer he "struck staff whose, safer he "struck staff whose, safer he struck staff whose, safer he struck staff whose, safer he struck safer was also presented to its room. As he was being escorted to his room.	MN EXT	ENDED TREATMENT			i			
"Sorry, he deserved the implementation." 'On June 20, 2007 at 6.20 p.m. client #3 refused to stay away from a peer that was sitting on the floor. Client #3 "kicked at peer's feet." The client would not stop kicking at the peer, and it was "possible" that he "may have grazed peers feet." Client #3 was asked to stop and lie down on the floor. Client #3 was then manually restrained for two minutes. 'On June 23, 2007 at 5:43 p.m., client #3 was "swearing, refusing directions invading peers/staffs space (with) wheelchair." The client then "slapped" a staffs forearm with an open hand. He was then restrained with leg hobbles and wrist cuffs for 22 minutes. 'On August 5, 2007 at 3:55 p.m., client #3 "was stopped in wheelchair in front of office, and would not redirect to move." The "other alternatives tried and/or considered." included, cueing the client "several times to move" and "escort by pushing wheelchair." Client #3 was restrained in hand cuffs and leg hobbles for 23 minutes, after he "struck staff with fist." The documentation did not indicate when the client struck staff. However, the documentation did indicate that it was likely for the client's physical aggression to reoccur. At 6:00 p.m., "[client #3] was asked 3 times to move out of view of TV in dayroom. The 4th time he refused, he was being escorted to his room As he was being escorted to room [client #3] hit staff." The client was manually restrained for two minutes then restrained with wrist cuffs and leg.	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	DULD BE	COMPLETION
*On September 6, 2007 at 5:48 p.m., client #3 was in the day room. He was asked to elevate his feet and he refused. Then he hit a peer in the	W 128	"Sorry, he deserved to June 20, 2007 to stay away from a floor. Client #3 "kick would not stop kick "possible" that he "Client #3 was aske floor. Client #3 was two minutes. *On June 23, 2007 "swearing, refusing peers/staffs space then "slapped" a st hand. He was then and wrist cuffs for 2 *On August 5, 200 stopped in wheelch not redirect to move and/or considered." "several times to move wheelchair." Client cuffs and leg hobbl "struck staff with fis indicate when the condumentation did the client's physica 6:00 p.m., "[client #0 out of view of TV in refused, he was be he was being esconstaff." The client was minutes then restrate hobbles for 43 minutes then governments."	at 6:20 p.m. client #3 refused a peer that was sitting on the ked at peer's feet." The client ing at the peer, and it was may have grazed peers feet." It to stop and lie down on the other manually restrained for at 5:43 p.m., client #3 was directionsinvading [with] wheelchair." The client aff's forearm with an open restrained with leg hobbles are minutes. The "other alternatives tried included, cueing the client ove" and "escort by pushing #3 was restrained in hand es for 23 minutes, after he of included that it was likely for aggression to reoccur. At aggression to reoccur.	W	128			

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and manually restrained the client for one minute.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		ULTIPLE LDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		24G502		ig		01/	C 17/2008
	ROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP CODE S STATE STREET		
MINIEATE	ENDED TREATMENT			CAN	MBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 128	previously kicked hereleased from their to use personal bot skills and to talk to "On September 26 was watching the teasked the client if he programs. Client #3 and turned the tele then attempted to the "Fick You" and ask him alone. The statun-plug the televisithe dresser to pull the dresser against manually restrained leg hobbles and his was "agitated" for 1 restraints after 28 mindicates that the butilized for, is "likely response was the incoming personal in review of the facility Emergency Use of revealed the follow "On May 24, 2007 manually and mechaninutes. Prior to be skills as was "agitated" for 1 review of the facility Emergency Use of revealed the follow "On May 24, 2007 manually and mechaninutes. Prior to be	staff that the other client had im. After the client was manual restraints he was told undaries, anger management staff if he feels unsafe. 2007 at 8:22 p.m., client #3 elevision and a staff person he wanted to do one of his 3 turned away from the staff vision up. The staff person urn the television off and client aff person's hand and stated ted the staff person to leave ff person then attempted to on and put his/her hand behind the plug and client #3 slammed the wall. The client was differ two minutes then put in a wrists were cuffed. The client 18 minutes and released from minutes. The documentation ehavior the restraints were y to reoccur." The client's neident was "staffs fault" mental retardation, asthma, tory of poking others and tems at others' heads. A y's "Documentation for Controlled Procedure"	W ·	28			
	for over an hour." T	he client was cued to go to shower or bath. The staff					

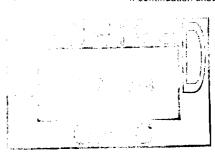
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"attempted to talk w/ [client #4] about what was bothering her."

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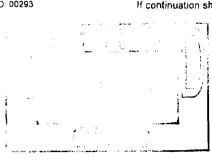
CENTE	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES				OMB NO	<u>. 0938-0391</u>	
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	MULTIPLE ILDING	E CONSTRUCTION	(X3) DATE S COMPL		
	24G502 NAME OF PROVIDER OR SUPPLIER		B. Wil	۷G		C 01/17/2008		
	ROVIDER OR SUPPLIER			1425	T ADDRESS, CITY, STATE, ZIP CODE 5 STATE STREET MBRIDGE, MN 55008			
(X4) IO PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION]	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE	
W 128	her room "hitting the the room and "tried kitchen." An arm be to take the client to manually then med of 50 minutes (the are not documente indicates "Other All considered" include down and relax or light of the client #6 has seven history of behaviors. November 2006. History of behaviors. November 2006. History of behaviors. November 2006. History of behaviors. "Documentation for Procedure" and "Diuse or Emergency Medication" reveale "Upon arrival to the admission, May 7, to bite and kick starestraint was imple to struggle and attendient was in restrate to the mechanical milligrams of Haldo 50 milligrams of Be 10.25 a.m. At 11:30 Documentation ind "scared" and he did client #6 was in the A staff person cued washcloth. The staff per of the client's mout person three times	at 6:26 p.m., the client was in e door." Then she came out of to shove staff to get into the ar takedown was implemented the floor. The client was hanically restrained for a total specific mechanical restraints d). The documentation ternative tried and/or ed. the staff told the client to sit to take a bath or shower. The mental retardation and a real deterioration since the was admitted to the facility in the facility's the Emergency Use of Controlled ocumentation of Psychotropic	W	128				

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CENTER	13 FUR MEDICARE	& MEDICAID SERVICES				OIMB MC	<u>). 0938-0391</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		NULTIPLE	E CONSTRUCTION	(X3) DATE S	
		24G502	B WI	NG		01/	17/2008
	ROVIDER OR SUPPLIER			142	ET ADDRESS, CITY, STATE, ZIP CODE 5 STATE STREET MBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 128	Continued From pa	ge 9	W	128			
	client was in restrain p.m., client #6 atter Documentation ind during escort." The staff. A double arm both emergency may were implemented aggression. The climinutes. *At 5:26 a.m., on M staff open handedly after being re-direct asked to wash his lawas used and the crestraints for 28 mi "came out of his robathroom attempt staff Staff tried to stop." Client #6 was handcuffs for 50 m yelled and was ban *At 12:55 p.m. on M person one time. Thold by 4 staff and hobbtes. He was re *At 3:15 a.m. on M trying to swing at staffst. The staff person to restrain the client that at 3:20 a.m. the client was agitated was re-applied. At struggling, trying to abrasions to his wriand the client was present the client was agitated was re-applied. At struggling, trying to abrasions to his wriand the client was present and the client was present as the client was agitated was re-applied. At struggling, trying to abrasions to his wriand the client was present as the client was present as the client was agitated was re-applied. At struggling, trying to abrasions to his wriand the client was present as the client was agitated was re-applied. At struggling, trying to abrasions to his wriand the client was present as the client was present	ing to hit staff and did kick a verbal prompt [client #6] to s put in leg hobbles and inutes. During restraint he ging his head on the floor. May 9, 2007, client #6 hit a staff he client was put in a manual then in metal cuffs and leg strained for 50 minutes. ay 10, 2007, client #6 was aff person's face with a closed in used an arm bar take down to Documentation indicated to hobble was removed. The and kicking, and the hobble 3:35 a.m. client #6 was get cuffs off causing sts. The cuffs were removed but in a manual hold. The did until 4:00 a.m. when he was					

*At 11:12 a.m., client #6 was "repeatedly touching

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CENT	ENS FOR MEDICARE	A MEDICAID SERVICES					ONID NO	<u>7. 0936-039 I</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1'	IULTIPLE ILDING	E CONSTRUCTION	_	(X3) DATE SURVEY COMPLETED	
		24G502	B. WII	B. WING			01/	C 17/2008
	F PROVIDER OR SUPPLIER (TENDED TREATMENT			142!	ET ADDRESS, CITY, STATE, ZIP 5 STATE STREET MBRIDGE, MN 55008	CODE		
(X4) IE PREFII TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ION SHO HE APPR	ULD BE	(X5) COMPLETION DATE
W 12	restraint for 15 min was "pacing, grabb and peers room". restraint for 9 minuty given 10 milligrams client #6 "hit staff was put in handcuffs an *At 11.17 p.m. and client #6 was hitting manually restrained 12:30 p.m., client #6 was put in a Pofor 45 minutes. At milligrams of Atival *Documentation or client #6 was restra 2:40 p.m., client #6 Seroquel. Client #6 implementations to (no specific behavi (eating inedible obj follow-up by a nurs was re-implemente Seroquel was miniculient #6 was given milligrams of Bena behavior" indicated agitation/aggressio minutes." *Client #6 was put June 5, 2007 at 10 grabbing, pinching, (fingers in mouth, to aggress when received Ativan 2 minuty grabbing in mouth, to aggress when received Ativan 2 minuty grabbing in mouth, to aggress when received Ativan 2 minuty grabbing grabbi	staff direction, and e client was put in a manual utes. At 2:02 p.m., client #6 sing at staff, walking in office He was put in a manual tes. At 2:15 p.m., client #6 was of Zyprexa IM. At 5:45 p.m., with handslaps." A double arm implemented and client #6 was id hobbles for 30 minutes. 11:28 p.m., on May 21, 2007, g staff and the client was deach time for 2 minutes. At 16 tried to pinch and grab staff, is sey restraint with leg hobbles 1:20 p.m., client #6 was given 2 in IM. In June 2, 2007, indicated that ained at least seven times. At 1 was given 100 milligrams of	W	128				

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CENTE	<u> 15 FOR MEDICARE</u>	& MEDICAID SERVICES				OMBING	<u>). 0938-0391</u>
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		MULTIPL ILDING	E CONSTRUCTION	(X3) DATE S COMPL	
		24G502	8 WI	NG		01/17/2008	
NAME OF F	ROVIDER OR SUPPLIER	<u> </u>		STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
MN EXT	ENDED TREATMENT				S STATE STREET MBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 128	Continued From pa	age 11	W	128			
	client #6 was "giver	n the Ativan (2 milligrams at					
		itely after release of restraint					
		The precipitating behavior					
		ression toward staff, refusal to cues." (No specific behaviors					
	were identified on t						
		garding client #6 for June 18,					
		"Rule 40 implemented 5x this					
		ession/agitation-each one					
		time held." At 5:05 p.m. client					
		igrams of Ativan and 50 dryl IM. A follow-up note					
		indicates that one Rule 40					
		shortly after medication given."					
		dicates that on January 8,					
		client #6 "woke up from nap,					
		ted aggression before getting					
		S was asked to calm down and nimself. He was escorted back					
	to his room Client:						
		staff multiple times." A					
		nt was implemented. The					
		icates client #6, "did not meet					
		empted release at 50 minutes,					
		ss." At 1:58 p.m , on January ation indicated that client #6					
		ld, reimplemented Rule 40					
		le was released at 2:48 p.m.					
		nanically restrained for a total					
	of one hour and for	ty minutes.					
	· ·	mental retardation. A review of					
		mentation for Emergency Use					
		edure" revealed the following: 2007 at 7:00 p.m., client #7					
		nce supper, ignoring staff					
		ked her to go to "home 3" so					
		ther clients. The client "refused					
		f stood beside her chair then					

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CLIVIL	AS FOR MEDICANE	A MILDIOAID SERVICES				OIND IAC	<u>7. 0330-039 i</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPL	E CONSTRUCTION	(X3) DATE S COMPL	ETED
		24G502	B WI	NG		01/	C 17/2008
	PROVIDER OR SUPPLIER			142	ET ADDRESS, CITY, STATE. ZIP CODE 15 STATE STREET		
				CA	MBRIDGE, MN 55008		_
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	X	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	DULO BE	(X5) COMPLETION DATE
W 128	Continued From pa	ge 12	W	128			
	"negotiate" with the quiet time in her rot bar takedown was a was restrained mar client's mood after as "feeling depress QMRP (Qualified M Professional), indice will be implemented *A review of the fact Implementation Of Deprivation Proced *On December 21, was "arguing w/ starecovery[programin restart she started the wall very hard." then mechanical recuffs, for 28 minutes "kicking the wall." If for 18 minutes before supervisory comme implementation of the accordance with client "On December 24, entered client #7's The client "screame [at and] kicked [at] "stop" and then she and leg hobbles for minutes client #7 client provisory comme the restraints was a series of the supervisory comme the restraints was a series of the supervisory comme the restraints was a series of the supervisory comme the restraints was a series of the supervisory comme the restraints was a series of the supervisory comme the restraints was a series of the supervisory comme the restraints was a series of the supervisory comme the restraints was a series of the supervisory comme the restraints was a series of the supervisory comme the restraints was a series of the supervisory comme the restraints was a series of the supervisory comments of th	ated that a "Rule 40 program d, likely to reoccur." cility's "Documentation For Approved Aversive And/Or ures, " revealed the following: 2007 at 9:10 p.m., client #7 aff about her g], when told she had to screaming at staff [and] kicked. The client was put in manual straints, leg hobbles and wrist as due to property destruction, he client "screamed and cried" are she was calm. The ents indicated that the the restraints was in ent #7's program. 2007 at 8:28 a.m., staff room to wake her for work, and 'leave me alone' and swung staff." The client was cued to exa restrained in wrist cuffs and struggled. The ents indicated that the use of appropriate.					
	autism, a brain ster A review of the faci	erate mental retardation, in tumor, and seizure disorder. lity's "Documentation For Approved Aversive And/Or					

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RS FOR MEDICARE	: & MEDICAID SERVICES	<u> </u>			OWR NO	<u>. 0938-0391</u>
OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SO COMPLE	
	24G502	-			1	C 7/2008
ROVIDER OR SUPPLIER	<u></u>		STREE	T ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	112000
NDED TREATMENT			1425	STATE STREET		
				MBRIDGE, MIT 33000		
(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREF	ΊX	(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE
Continued From pa	ige 13	W	128			
*On September 9, 2 "ran to bathroom as shower, then ran to his door." Staff cue throw objects or slap property destruction of his bedroom and bedroom and slaminandcuffed and his of 10 minutes. The indicated that the u was appropriate be behaviors is slamm *On September 27, "ran through the horefused to let staff I he ritually pounded cued the client to "snot to run also cued the client to slapped at staff's hip pitcher. He ran into door." The client walled, and tried to "On September 30, "ran up to the wall, head on the floor as slammed the door." "stop [and] not pour client's Rule 40 was hand cuffed and his restrained for 15 m he struggled, spit, the staff for five min	2007 at 7:20 p.m., client #8, and threw his socks in the his bedroom and slammed did the client to "walk and not arm doors because that is in." As a result the client ran out it into another "unoccupied" med that door. The client was legs were hobbled for a total supervisory comments se of the Rule 40 restraints scause one of the target hing doors. 2007 at 4:56 p.m., client #8 buse with pitcher of water. He have pitcher, and once he did, on walls with both fist." Staff stop and put pitcher down and led not to hit walls." Client #8 hands when they asked for the bathroom and slammed as restrained in hand cuffs and minutes. For the first 29 struggled, scratched, kicked, get up." 2007 at 7:50 p.m., client #8 pounded on it, banged his not ran to his room and 'Staff re-directed the client, and or slam the door." The simplemented and he was a legs were hobbled. He was inutes and during his restraint ried to bite, kick, and scratch nutes.					
the shower for appr	roximately 20 minutes and was					
	ROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa Deprivation Proced *On September 9. "ran to bathroom and shower, then ran to his door." Staff cue throw objects or sla property destruction of his bedroom and bedroom and slam handcuffed and his of 10 minutes. The indicated that the u was appropriate be behaviors is slamm *On September 27. "ran through the ho refused to let staff in he ritually pounded cued the client to "s not to run also cue "slapped at staff's in pitcher. He ran into door." The client wa leg hobbles for 39 in minutes the client to yelled, and tried to "On September 30, "ran up to the wall, head on the floor a slammed the door." "stop [and] not pour client's Rule 40 was hand cuffed and his restrained for 15 m he struggled, spit, t the staff for five min "On October 5, 200	F CORRECTION IDENTIFICATION NUMBER: 24G502 ROVIDER OR SUPPLIER	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 Deprivation Procedures," revealed the following: "On September 9, 2007 at 7.20 p.m., client #8, "ran to bathroom and threw his socks in the shower, then ran to his bedroom and slammed his door." Staff cued the client to "walk and not throw objects or slam doors because that is properly destruction." As a result the client ran out of his bedroom and slammed that door. The client was handcuffed and his legs were hobbled for a total of 10 minutes. The supervisory comments indicated that the use of the Rule 40 restraints was appropriate because one of the target behaviors is slamming doors. "On September 27, 2007 at 4:56 p.m., client #8 "ran through the house with pitcher of water. He refused to let staff have pitcher, and once he did, he ritually pounded on walls with both fist." Staff cued the client to "stop and put pitcher down and not to run also cued not to hit walls." Client #8 "slapped at staff's hands when they asked for the pitcher. He ran into bathroom and slammed door." The client was restrained in hand cuffs and leg hobbles for 39 minutes. For the first 29 minutes the client "struggled, scratched, kicked, yelled, and tried to get up." *On September 30, 2007 at 7:50 p.m., client #8 "ran up to the wall, pounded on it, banged his head on the floor and ran to his room and slammed the door." Staff re-directed the client. "struggled, scratched, kicked, yelled, and tried to get up." *On September 30, 2007 at 7:50 p.m., client #8 "ran up to the wall, pounded on it, banged his head on the floor and ran to his room and slammed the door." Staff re-directed the client. "stop [and] not pound or slam the door." The client's Rule 40 was implemented and he was hand cuffed and his legs were hobbled. He was restrained for 15 minutes and during his restraint he struggled, spit, tried to bite, kick, and scratch the staff for five minutes. *On October 5,	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFINITION OF DEFICIENCIES) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY ORLSC IDENTIFYING INFORMATION) Continued From page 13 Deprivation Procedures," revealed the following: "On September 9, 2007 at 7.20 p.m., client #8, "ran to bathroom and threw his socks in the shower, then ran to his bedroom and slammed his door." Staff cued the client to "walk and not throw objects or slam doors because that is properly destruction." As a result the client ran out of his bedroom and into another "unoccupied" bedroom and slammed that door. The client was handcuffed and his legs were hobbled for a total of 10 minutes. The supervisory comments indicated that the use of the Rule 40 restraints was appropriate because one of the target behaviors is slamming doors. On September 27, 2007 at 4:56 p.m., client #8 "ran through the house with pitcher of water. He refused to let staff have pitcher, and once he did, he ritually pounded on walls with both fist." Staff cued the client to "stop and put pitcher down and not to run also cued not to hit walls." Client #8 "slapped at staff shands when they asked for the pitcher. He ran into bathroom and slammed door." The client was restrained in hand cuffs and leg hobbles for 39 minutes. For the first 29 minutes the client "struggled, scratched, kicked, yelled, and tried to get up." *On September 30, 2007 at 7:50 p.m., client #8 "ran up to the wall, pounded on it, banged his head on the floor and ran to his room and slammed the door." Staff re-directed the client. "stop [and] not pound or slam the door." The client's Rule 40 was implemented and he was hand cuffed and his legs were hobbled. He was restrained for 15 minutes and during his restraint he struggled, spit, tried to bite, kick, and scratch the staff for five minutes. *On October 5, 2007 at 9 46 a.m., client #8 was in	TO DEFICIENCIES F CORRECTION (X1) PROVIDER SUPPLIER PROVIDER OR SUPPLIER ROCKIDER OR SUPPLIER SUMMARY STATEMENT OF DERICIENCIES (EACH DEFICIENCY) SUMMARY STATEMENT OF DERICIENCIES (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DERICIENCIES (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION) CONTINUED FROM page 13 Deprivation Procedures, " revealed the following: "On September 9, 2007 at 7, 20 p.m., client #8, "ran to bathroom and threw his socks in the shower, then ran to his bedroom and slammed his door." Staff cued the client to "walk and not throw objects or slam doors because that is properly destruction." As a result the client ran out of his bedroom and into another "unoccupied" bedroom and slammed that door. The client was handcuffed and his legs were hobbled for a total of 10 minutes. The supervisory comments indicated that the use of the Rule 40 restraints was appropriate because one of the larget behaviors is slamming doors. "On September 27, 2007 at 4:56 p.m., client #8 "ran tryongh the house with pitcher of water He refused to let staff have pitcher, and once he did, he ritually pounded on walls with both fist." Staff cued the client to "stop and put pitcher down and not to run. also cued not to hit walls." Client #8 "siapped at staff's hands when they asked for the pitcher. He ran into bathroom and slammed door." The client was restrained in hand cuffs and leg hobbles for 39 minutes. For the first 29 minutes the client "struggled, scratched, kicked, yelled, and tried upound or slam the door." The client's Rule 40 was implemented and he was hand cuffed and his legs were hobbled. He was restrained for 15 minutes and during his restraint he struggled, spit, tried to bite, kick. and scratch the staff for five minutes."	OF DEFICIENCIES F CORRECTION X1) PROVIDERSUPPHIERCATION NUMBER X2) MULTIPLE CONSTRUCTION X3) DATE S COMPLIED X3 DATE S COMPLIED X4 DEVICE X4 DEVICE

refusing to get out. He slammed the door on staff

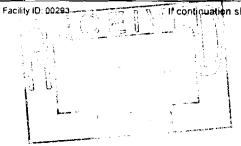
PRINTED: 02/01/2008 FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		MULTIPLE	CONSTRUCTION	(X3) DATE S COMPL	
		24G502	8 WII			01/	C 17/2008
NAME OF P	ROVIDER OR SUPPLIER			1	T ADDRESS, CITY, STATE ZIP CODE		
MN EXT	NDED TREATMENT			ſ	STATE STREET MBRIDGE, MN 55008		İ
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	·IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 128	Continued From pa	ge 14	w	128			
	and was then put in	leg hobbles and hand cuffs					
		property destruction. The					
		ents indicated that the use of					
	the restraints was a						
	-	007 at 2.57 p.m., client #8 is mental health review and					
		air when he "suddenly jumped					
		the bedroom and bathroom.					
		on the door and the walls of					
		nd linen closet, and slammed					
		and he"dropped" the phone					
		the phone room. The client,					
		when staff asked him to lay					
		was then hand cuffed and leg ed. He was restrained for 10					
		visory comments indicated					
		restraints was appropriate.					
		07 at 8:24 a.m., client #8 was					
		uffs and leg hobbles for 10					
		ty destruction and physical					
		ocumentation indicates that					
		rbal prompt not to slam the					
		ntation does not indicate the last required the implementation					
		ver, the documentation does					
		ent laid on the floor per staff					
		restraint implementation. The					
		ents indicate that the use of the					
	restraint was appro	priate.					
		mental retardation, autism, and					
	a brain lesion. A rev						
		r Implementation Of Approved					
		eprivation Procedures,"					
	revealed the followi	ng: i07 at 2:25 p.m. client #9					
		when he was returning to his					
		it kicked a car and bit himself					i
		ot identified). He was prompted					Ì

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Event ID: DRV111

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CLITTL	TO LOLL MEDIOWICE	A MEDICAID SERVICES	-, -			OMP IN	<u>J. 0930-0391</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPLE LDING	CONSTRUCTION	(X3) DATE COMP	LETED
		24G502	B WII	1G		01/	C /17/2008
	PROVIDER OR SUPPLIER			1425	T ADDRESS. CITY, STATE, ZIP CODE S STATE STREET		
				CAN	MBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 128	restrained first man total of 46 minutes. indicate if he was rehome 3. The super the use of the restrement to the use of the use o	ry He hit staff and was hually then mechanically for a The documentation does not estrained outside or back at visory comments indicate that aint was appropriate. 2007 at 6:43 a.m. client #9 wer and "pounding" on the own head. Staff utilized to (the specific negotiations not was restrained with leg hobbles 10 minutes. The supervisory that the use of the restraints. 2007 at 7:05 a.m., after client of cereal, he was cued to take client slammed the table with this hit himself in the head three rained with leg hobbles and ninutes. The supervisory did that the use of the restraints. The supervisory did that the use of the restraints are also included: "asked him hy are you hitting yourself, Staff cued client #9 to lie down. If and was manually restrained, oles and wrist cuffs for a total was "agitated" for seven minutes of being calm he was estraints. The evaluation of the tation indicated that the use did that "with great likelihood."	W	128			
 	to the incident was, addition, client #9 c	occur." The client's response "I'm sorry - don't bite," In only had red marks on his arms ed biting. At 11:35 a.m. client					

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Facility ID: 00293

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CENIE	RS FUR MEDICARE	A MEDICAID SERVICES				OMB M	<i>).</i>	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IULTIPLI ILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		24G502	B. Wil	NG		01/	C 17/2008	
NAME OF F	PROVIDER OR SUPPLIER			1	ET ADDRESS, CITY, STATE, ZIP CODE			
MN EXT	ENDED TREATMENT				5 STATE STREET MBRIDGE, MN 55008			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
W 128	watching television became self injurio Staff "attempted to "aggressed toward calm down and to a "waited for extra staclient was manually cuffs and leg hobble. The client was note relax, but, "he was and the client "atter up." The leg hobble reapplied at 12:25 minutes. The docuplan was to, "encoulisten to music, take "On August 24, 200 removed the foot so Client #9 started to forearm. Staff intenclient to lie down armouth and listening does not indicate if directives. A double and then the reside leg hobbles for 50 indicates that the community was made restraints and he "kep.m. his restraints winutes. At 7:20 p. Ativan IM. *On September 28 received Ativan becauggressive." At 2.3 his cheeks and put	aing inappropriately while At some point, the client us (specifics not documented). negotiate" and the client is staff." The client was cued to keep his boundaries. The staff aff before takedown." The y restrained and placed in wrist es for a total of 50 minutes. ed to be crying and trying to being held" in a prone position mpted to grab staff [and] get es and wrist cuffs were p.m. for an additional ten mentation indicates that the urage client to rest in room.	W	128				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 '	IULTIPLE	CONSTRUCTION	(X3) DATE COMPL	
		24G502	B WII			01/	C 17/2008
	PROVIDER OR SUPPLIER	-		1425	T ADDRESS, CITY, STATE, ZIP CODE S STATE STREET MBRIDGE, MN 55008		171200
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	was "escorted to room by staff but [the client] kept grabbing at staff." The client was restrained for 12 minutes, manually then mechanically with handcuffs and leg hobbles because he was physically aggressive and hit staff. Client #10 has moderate mental retardation and infantile autism, he has a history of biting people, making himself throw-up, and becoming increasingly agitated when others attempt to interact with him. Client #10 was discharged from the facility on November 7, 2007. A review of the facility's "Documentation For Implementation Of Approved Aversive And/Or Deprivation Procedures," revealed the following: *On February 28, 2007 at 8:03 p.m., client #10 was restrained for ten minutes in handcuffs and hobbles because he bit his hand. *On March 6, 2007 at 7:59 p.m., client #10, "was given a snack. He began spitting on kitchen table. Staff cued the client to stop spitting and to go to his room and calm down. While in his room he			128			
	on staff and was re handcuffs and hob *On March 9, 2007 restrained for six mandcuffs because client #10 was exhand he spit water. [and] resume work minutes in handcuff spitting/emesis direction the spit in a cued to lay down a restrained for six march 13, 200	at 10:09 a.m., client #10 was ninutes in leg hobbles and he "bit self." At 12:38 p.m., libiting "excessive laughing" He was "encouraged to calm x 3." He was restrained for 14 ffs and leg hobbles for ected at staff." At 6:25 p.m., staff person's face. He was nd he complied and was					

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Event ID: ORV111

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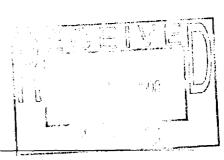
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		MULTIPLE CONSTRUCTION		(X3) DATE S	
			A. BU	ILDING	_	1	С
		24G502	B. WI	NG		01/	17/2008
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 1425 STATE STREET CAMBRIDGE, MN 55008	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	EX (EACH CORRECTIVE ACT	ION SHOP HE APPR	ULD BE	(X5) COMPLETION DATE
W 128	Continued From pa	ige 18	W	128	_		
	minutes because hand made it bleed. that other intervent applicable). *On March 17, 200 restrained in hand minutes for biting hindicates that there interventions. *On March 18, 200 restrained for six mouffs because he being directed to caindicates that the chis own, and was made to make the chis own, and was made to make the chis own, and was made to make the complete of the comp	e bit the back of his left hand. The documentation indicates ions were "NA" (not. 7 at 4:41 p.m. client #10 was cuffs and hobbles for six is hand. The documentation was "no time" for any other. 7 at 1:58 p.m., client #10 was inutes in leg hobbles and hand it the back of his left hand after alm down. The documentation lient laid down on the floor on estrained. 7 at 5:02 p.m. client #10 was mulating." Staff told the client to the client bit his left hand e was told to lay down on the led. He was "calm" but minutes in handcuffs and leg. 7 at 12:00 p.m., client #10 was had an emesis and spit it at restrained for fourteen minutes g hobbles. 7 at 7:14 p.m., client #10 was obbles and handcuffs for six is hand after staff told him not. 7 at 9:14 p.m., client #10 bit a down in his hand and he was simutes in leg hobbles and entation indicated that there eventions available prior to the					

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB N	O. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	MUL T IPLE	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		24G502	B. WI	vG		01	C / 17/2008
	ROVIDER OR SUPPLIER			1425	T ADDRESS CITY, STATE, ZIP COD S STATE STREET	E	
				CAN	MBRIDGE, MN 55008		_
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
W 128	Continued From pa	ge 19	W	128			
	handcuffs and leg it *On April 3, 2007 a making "loud vocali was told to "quiet, to slapped his leg three restrained for six mouffs. *On April 4, 2007 a his day program and front of face making instructed to continuands to calm." The shirt. He was mech handcuffs and leg it *On April 5, 2007 a "self stimulating in a sounded like AHAH"quiet down," and "sore" on the back of down on the floor a so. The client was a mechanically restrated handcuffs for six mouth then put hand hand Staff told [clifloor He bit himsel client was manually with leg hobbles and supervisory commether restraints was a *On April 6, 2007 a stream to the restraints was a *On April 6, 20	t 9:28 p.m., client #10 was ization for 10 - 15 minutes." He ake breaths, [and] go to it the back of his hand and be times. The client was inutes in leg hobbles and hand it 10:18 a m., client #10 was at d he was "wiggling hands in g noises." The client was ue his work, "or to sit on his e client bit his hand through his anically restrained with hobbles for six minutes. It 7:45 p.m., client #10 was room, making loud noises, IAH" The client was cued to relax." The client bit an "old off his left hand. The client laid fiter being cued by staff to domanually restrained then sined with leg hobbles and inutes. It 11:35 a.m., client #10, "was and starting finger flaling by his id in shirt and bit his ent #10] to stop and lie on the fithrough his sweatshirt." The other mechanically restrained d handcuffs for 7 minutes. The ents indicated that the use of					
	and spitting all over	his room." Staff cued him to eep breaths." The client spit in					

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the staff's face. The client was manually then

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Facility ID: 00293

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CENTER	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES				OMB NO	<u>0. 0938-0391</u>
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		MULTIPL	E CONSTRUCTION	(X3) DATE COMP	
		24G502	B. WI	NG		01/	C 17/2008
	PROVIDER OR SUPPLIER			142	ET ADDRESS, CITY, STATE, ZIP CODE 5 STATE STREET		
				CA	MBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 128	Continued From pa	•	W	128			
	cuffs for 25 minute indicated that the uprogram and appropriate of the thand. Staff told the hand through a bla hand. At some point (specific area of the The client was rest handcuffs per his F supervisory commente restraints was a "On April 11, 2007 jumping around his vomit [and] spit. He hysterically." Staff the encouraging deep bedroom. "The clies spit it at staff." The minutes in leg hobs supervisory commendations and the supervisory commendations are supervisory commendations.	it 3:48 p.m., client #10 bit his client to "stop." He bit his nket that was covering his nt, the client hit himself twice body was not documented). rained in leg hobbles and Rule 40 for 18 minutes. The ents indicated that the use of					
	on January 10, 200 all the clients at the and exhibit either paggression, and minjurious behavior, how quickly the factinappropriate behavior to two years aguse of mechanical behavior. In Novemmechanical restrait was discontinued in	inistrative staff was interviewed 18 at 9:30 a.m. and stated that a facility are legally committed roperty destruction or physical ay have some degree of self. The average stay is based on illity is able to stabilize a client's vior. Approximately one and a go, the facility implemented the restraints for inappropriate aber 2007, the use of the for emergency situations in the ICF/MR. However, the restraints continues to be					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IULTIPLE	CONSTRUCTION	(X3) DATE COMP	SURVEY
		24G502	B. WI			01	C / 17/2008
NAME OF F	PROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		71772000
MN EXT	ENDED TREATMENT			1425	STATE STREET MBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
W 128	specially constitute restrictive behavior programs. In emergmanual restraints of utilized for the Rule wrist cuffs, metal has (usually used toget restraint board. The two minutes of marclient(s) continues mechanical restraint Employee (E)/admit on January 31, 200 the clients admitted restrained to reduct dangerous or likely	ats with Rule 40 (the facility's decommittees' pre-approved management practice) gency situations, the staff use only. Examples of the restraints at 40 programs include: soft andcuffs and leg hobbles ther), and in some cases a Rule 40 programs start with hual restraining and if the to struggle, they are put in hits. Inistrative staff was interviewed at 9:30 a.m. and stated that did at the facility should only be the target behaviors that are to lead to dangerous behavior.	W	128			
	restrained, related mentioned by the ir stated that from the reviewed, the risk a activity versus the rwhack." The facility as a whore the restriction of the restri	examples of client #3 being to television viewing, were neestigator, employee (E) e sounds of the examples analysis (risk of continuing the risks of restraining) is "all out of tole does not have a "no-touch"					
W 239	reviewed and open people who live in a policy is intended to people who are ag another's aggressic with interpersonal b observe the practic touched another cli dangerous situation	d be "household agreements," for negotiation, made by the a household. The "no-touch" be a therapeutic support for gressor's, the recipient of on, or there are other problems boundaries. If a client failed to be of "no-touch" and simply ient, that would not constitute a n.	w	239	7- 2008		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION	(X3) DATE COMP	\$URVEY LETED
			A BU	ILDIN	<u> </u>]	С
		24G502	B. WII	NG		01/	17/2008
	ROVIDER OR SUPPLIER			14	EET ADDRESS. CITY, STATE, ZIP CODE 425 STATE STREET AMBRIDGE, MN 55008	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 239	Continued From pa	age 22	W:	239	IPPs for all clients pl	laced	2/26/08
					in the facility's ICF/N	1R	
		ng program designed to			program will be revised	d to	
		ectives in the individual			ensure that each client	z's	
		t specify provision for the			program plan includes a	a a	
	, , ,	ssion of behavior and the ppropriate behavior, if			specific plan to increa		
		havior that is adaptive or			client's use of adaptiv		
	appropriate.				appropriate alternative		
					behaviors targeted for		
					reduction.		
		is not met as evidenced by:			reduction.		
		ntation review and interviews, edevelop functional			222	c -	
	-	viors related to the target			All staff responsible		
		e of nine clients (#6, #8, #9) in			implementation of prog		
	the sample. Findin				for clients placed in		
	,				facility's ICF/MR prog		
		re mental retardation and has a			will be trained to prop	perly	
	-	al deterioration since			implement each client's	3	
		fe was admitted to the facility in			program.		
		cific behaviors include biting, ig, head-butting, hair pulling,			Persons Responsible:		
		#6's Rule 40 (the facility's			Scott TenNapel, Ph.D.,	L.P.,	
		ed committees' pre-approved			METO Clinical Director	; Beth	
	restrictive behavior	r management practice)			Klute and Julie Patten	,	
		s that if client #6 exhibits signs			BA3s and QMRPs		
		ing out or touching staff, not			~		
		al redirectives, pacing, ing, or screaming), the staff will			and the second s		
		cue to stop the behavior. If the					
		mediately" stop, staff will escort			والمناب مسافل والأراث	11	
		droom or a private place. If			ì		
		to engage in the behavior,			20003	2	
		restrain his arms until they can not name) soft cuffs to his					
		ttached to a RIPP (brand				! د	
		secured around his waist. A			:	# # # # # # # # # # # # # # # # # # # #	
		indicates the restraints will be					
		ne client has zero incidents of					2/26/08

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Event ID: DRV111

Facility ID: 00293

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	\	MULTIPLE ILDING	E CONSTRUCTION	(X3) DATE SI COMPLE	
		24G502	B. WI	NG			C 7/2008
NAME OF P	ROVIDER OR SUPPLIER	······		STREE	T ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
MN EXT	ENDED TREATMENT				STATE STREET MBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 239	Continued From pa	ge 23	W	239			
	inedible objects) ov Other than providin there is no mention prevent the client's indication of the de antecedent behavion when the client mig day he arrived to pre- exhibit behaviors are restrained for exhibit focus on the plan with ho in elicit or strengthen.	n, self injury, and PICA (eating for three consecutive months. It is a cue to stop the behavior, of interventions to modify or behaviors. There is no evelopment of a list of fors to assist staff in knowing the exhibit behaviors. From the resent, client #6 continues to had he continues to be diting these behaviors. The reas to stop the "maladaptive indication of how staff would appropriate behaviors. The record was reviewed and as moderate mental					•
	retardation, autism, client has a history self-injurious behave "Client #8's target attempted behavior to other(s), includin hitting, scratching, others, throwing ite manipulating an obsignificant damage	and a brain stem tumor. The of physical aggression, viors, and property destruction, behaviors include: "actual or that may cause pain or harm g: lunging at others, biting, kicking, slapping, pushing ms at people, and spitting;" ject in a manner that causes to that object based upon its function, and/or poses risk to					
	others if thrown or slamming doors an of intent, that may o slapping, hitting, so body parts on hard. The client's signs o checking doors, ign vocalizations." Clienthat the client's alter break" with verbal of	dunction, and/or poses risk to used as a weapon; including diacts against self, regardless cause significant injury (i.e. ratching, biting self, pounding surfaces or head banging.)." If agitation include: "running, foring staff directions, and loud in t#8's behavior plan indicates rnative to agitation is to "take a cueing 80% of the time for two s. In addition, the client has a			130g		

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CENTE	KO FUK MEDICAKE	A MEDICAID SERVICES				ON GIND	<u> </u>	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		24G502	B. WING			01/17/2008		
NAME OF F	PROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE			
MN EXT	ENDED TREATMENT				STATE STREET			
				CAR	MBRIDGE, MN 55008			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
W 239	Continued From pa	age 24	W	239				
	Rule 40 plan revise	ed on August 22, 2007, with a						
		r. The objective is to decrease						
		on of physical aggression,						
		n, and self-injurious behaviors						
	to zero for three consecutive months. If the client							
	exhibits any of the above target behaviors staff							
	are to cue the client to stop the behavior and lie							
		f the client does not lie down						
	on the floor, the sta	iff are to manually restrain the						
	client in a prone position (on his stomach) and							
	apply handcuffs to his wrists and hobbles around							
	his legs. If the client lies down on the floor							
	independently the h	nandcuffs and leg hobbles will						
	still be applied. One	ce the client is "safe" he will be					į	
	turned onto his side	e. He needs to be calm for five						
	minutes and then the	he leg hobbles will be						
		ther five minutes of calm the						
		emoved. The focus on the plan						
	was to stop the "ma	aladaptive behavior" with no						
	indication of how st	aff would elicit or strengthen						
	appropriate behavio	ors.						
	Client #9's medical	record was reviewed and his						
		mild mental retardation and						
		nistory physical aggression,						
		iors, and property destruction					i	
		ated or angry, exhibiting						
		ous behaviors, ignoring staff						
		d vocalizations." His target						
		physical aggression-"Actual or			and the second s			
	attempts to hurt and	d/or cause pain or harm to				$(-1,1,\dots,\nu)$. 1	
		hitting, biting, scratching,			janda e dan endarre	:		
		ushing others, throwing items						
		ing at others;" self-injurious			· · · · · · · · · · · · · · · · · · ·	400	. / }	
		gainst self that are intended to			· -			
		apping, hitting, scratching,				:		
		g body parts on hard surfaces						
		Client #9's program plan			and the second s		5	
	indicates that when	he exhibits symptoms of						

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CENTER	19 LOK MEDICAKE	a MEDICAID SERVICES				ONI DIVIO	<u>, 0936-039 i</u>	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	AULTIP ILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		24G502	B. WII	NG	· .		C 17/2008	
NAME OF F	IDOVIDED OD BUDDUED	<u> </u>		Γ			1772000	
	ROVIDER OR SUPPLIER ENDED TREATMENT			14	EET ADDRESS, CITY, STATE, ZIP CODE 125 STATE STREET		į	
			_	C	AMBRIDGE, MN 55008		ĺ	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
W 239	Continued From pa		W:	239				
		native to the agitation will be to						
		ddition, the client has a Rule						
		dated on September 13, 2007						
		ne year. The objective was to						
		daptive behaviors" to zero for months. The plan included						
		"stop" and if the client stopped						
		in would be directed to go to a						
		aff would offer calming						
		ecific calming techniques were						
		e client did not stop the						
		would be cued to "stop" and lie						
		If the client did not comply he						
		restrained in a prone position ally restrained with handcuffs						
		nd turned to his side when he						
		e was calm for five minutes his						
		be released and after another						
		ng calm his handcuffs would be						
		nt followed directions when						
		on the floor the procedure						
		mechanically restraining him						
		and hobbles. The focus on the						
		e "maladaptive behavior" with						
	strengthen appropr	v staff would elicit or						
	strengthen appropr	iate ochaviors.						
	Employee (C)/hum-	an services support specialist						
		ewed on January 10, 2008 at						
		ited that she is able to visibly			•			
		s unable to control himself as					÷ .	
		ve behaviors, and she thinks			·			
		out because he wants to be s a hands free (clients must						
		s a nands free (clients must e arms length of each other			*** **	٠.		
		et come within one arms length				i	1 1	
		ss the clients need physical			\$ 100 miles 100		, , , , , , , , , , , , , , , , , , ,	
	help.				e e e e e e e e e e e e e e e e e e e	v ·•		

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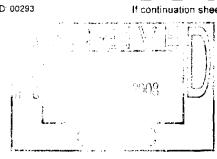
VEITE	O I OIT WILL DIONITE	G WEDION OF OF TANOED				CIVID NO.	. 0330- 0331
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	IULTIPI LDING	LE CONSTRUCTION	(X3) DATE SI COMPLE	TED
		24G502	B. WII	NG		C 01/17/2008	
	ROVIDER OR SUPPLIER			14:	EET ADDRESS, CITY, STATE, ZIP CODE 25 STATE STREET AMBRIDGE, MN 55008		772000
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 239	Continued From pa	ge 26	W	239			
W 257	on January 11, 200 when a client exhib that could lead to ir aggression or self i client is destructive trained to utilize the personal boundarie then escort, and the Rule 40 restraint pl 483.440(f)(1)(iii) PF CHANGE The individual progleast by the qualified professional and rebut not limited to sifailing to progress to	vior analyst I was interviewed 8 at 8:10 p m. and stated that its an inappropriate behavior signal such as physical injurious behaviors, or if a to property, the staff are following techniques: as, negotiation and cueing, an restrain. If the client has a san that is initiated as written. ROGRAM MONITORING & aram plan must be reviewed at different mental retardation vised as necessary, including, tuations in which the client is lowerd identified objectives forts have been made.	w	257	The facility will imple a quality management process to ensure that the QMR changes to client IPPs that adequate treatment velocity is maintained all clients. Specification monthly data reflecting progress in treatment in	rocess P makes such t for ally, g	2/26/08
	Based on interview qualified mental ret failed to review and plans as necessary progress toward idereasonable efforth nine clients (#2, #6 Findings include: Client #6 exhibited kicking, etc. on admestrained with han behavior. According Documentation for Aversive And/Or De January 8, 2008, cl	s not met as evidenced by: and record review, the ardation professional (QMRP) revise individual program where the client was failing to entified objectives after ad been made for three of and #9) in the sample. behaviors of biting, hitting, mission, May 7, 2007. He was dcuffs and leg hobbles for that g to a form titled, Implementation of Approved eprivation Procedures, dated ient #6 exhibited similar g, scratching, and headbutting,			be reviewed by the factorial Director, or of with the object of efficient Persons Responsible: Some TenNapel, Ph.D. L.P., In Clinical Director	designee, ecting o the to straint.	

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Event ID: DRV111

Facility ID: 00293

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OWR NO	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		24G502	B. WI	NG			C 1 7/2008
NAME OF P	ROVIDER OR SUPPLIER			1	T ADDRESS, CITY, STATE, ZIP CODE		
MN EXT	ENDED TREATMENT				S STATE STREET MBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
W 257	hold. The informed medications dated December 4, 2008, milligrams of Seroc of Ativan twice a dato ten per day. Pag that client #6's targ aggression went froincidents to 1,325 i September 1, 2007 Physical and chem day of admission a though some of clie changed since he was a street of the seroc of the se	ned with cuffs and a Rule 40 consent for psychotropic December 5, 2007 to indicates client #6 is on 700 quel daily, and two milligrams ay with additional milligrams up the two of the consent indicates et behavior of physical om his "baseline" of 334 incidents in the period of thru November 27, 2007, ical restraints were used the not continue to be used even ent #6's behaviors have not was admitted.	W	257			
	(C)/human services and employee (D)/lonsite on January client #6's restraints the Rule 40 continuwritten. Client #2 has mode autism and deafnes facility in August 20 clearing objects off throwing, ripping, o cutting herself; hitti	evioral analyst, employee is support specialist (HSSS), HSSS, were interviewed while 10-11, 2007, and stated that is are not effective, however uses to be implemented as erate mental retardation, iss. She was admitted to the 1000. Her behaviors include it tables, counters or desk; ir slamming objects; biting or ing the wall with her fist; or					
	trying to injure othe kicking, slapping, p	ers by hitting, biting, scratching, bushing, etc. A psychological ebruary 14, 2006, indicated					

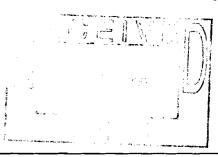
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self-injurious behavior at a high frequency," which fluctuates from month to month and ranges from six to eighty-five episodes. The majority of the episodes were considered "minor" in severity. The summary indicated that the client is overall

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CENTE	13 FOR MEDICARE	- A MEDICAID SERVICES	_		·	CIVID IN	<u>J. 0930-039 I</u>
	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	' '	MULTIPL ILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		24G502	B. WI	NG		C 01/17/2008	
	ROVIDER OR SUPPLIER			142	ET ADDRESS, CITY, STATE, ZIP CODE 5 STATE STREET MBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SECROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
W 257	always be a high riagainst others and herself. A comparicontrolled procedu January 27, 2007 a January 25, 2008 if use of the restraint later document ind necessary to contribute consecutive holdings." Client #2 restraints (see Tag Client #9 has mild a brain lesion. Her June 2007. Client aggression, proper According to his coassessment summ #9 does not under condition and how psychotropic medic October 2, 2007, the behaviors from Jul 2007 included 49 in controlled and how psychotropic medic October 2, 2007, the haviors from Jul 2007 included 49 in controlled and how psychotropic medic October 2, 2007, the haviors from Jul 2007 included 49 in controlled and how psychotropic medic October 2, 2007, the haviors from Jul 2007 included 49 in controlled and how psychotropic medic October 2, 2007, the haviors from Jul 2007 included 49 in controlled and how psychotropic medic October 2, 2007, the haviors from Jul 2007 included 49 in controlled and have the highest page 10 to 10 t	paseline. "There will most likely sk" that client #2 will aggress cause considerable harm to son of informed consents for res dated October 28, 2006 to and October 24, 2007 to ndicates the reasons for the is were basically the same. The licates that restraints are of behavior. The controlled erminated when the client has months of "zero physical 2 continues to be put in	W	257			

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procedures, dated December 10, 2007 to March 9, 2008 indicates that from September 16, 2007 to December 5, 2007, there was an increase to 72 incidents of physical aggression. Client #9 is currently on psychotropic medications and is mechanically restrained with handcuffs and leg hobbles in accordance with his Rule 40 program.

The QMRP has not changed the client's programming to see if something other than restraints would reduce his behaviors.

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RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0938-0391		
OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	24G502	B. WING			01/17	; /2008	
ROVIDER OR SUPPLIER			1425	STATE STREET			
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE	
In summary, from to clients exhibited cerestrained for exhibited continue to be restrouched individual, i.e. client clients wanting to to the QMRP has not identified antecede order to help the stexhibit behaviors. The client's program other than restraint room) would be effective exhibited to the client's program of	he time of admission, these rtain behaviors, were siting those behaviors and they rained for exhibiting those IRP has not identified what a considered acceptable for an at #9 engaging in laughter or buch a staff person, etc. Also provided the staff with ints to the client's behavior in aff identify when the clients will the QMRP has not changed iming to see if an intervention is (i.e., use of the time out ective.			The facility will rev	i se		
CHANGE The facility must deconstituted commit of members of faci guardians, clients (persons who have contemporary practient behavior, and controlling interest This STANDARD is Based on document the facility failed to regular participation the Behavior Mana and at the Human a Findings include: The committee me	esignate and use a specially tee or committees consisting lity staff, parents, legal as appropriate), qualified either experience or training in tices to change inappropriate dipersons with no ownership or in the facility. In sometimes as evidenced by: Intation review and interview, have the required members in at the scheduled meetings of gernent Review Committee and Legal Rights Committee.	**		its policy regarding functioning of its sp constituted committee Specifically, a single specially constituted committee (i.e., the Management Review Comwill review the IPP, psychotropic medicati of restraints, and proto restrict client riall clients placed in facility's ICF/MR productionally, policy mandate that a quorum present in order for	the pecially as. Behavior mittee) use of cons, use oposals aghts for a the agram. will a be a meet-		
	ROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa In summary, from t clients exhibited ce restrained for exhib continue to be restr behaviors. The QM behaviors would be individual, i.e. clien clients wanting to te the QMRP has not identified antecede order to help the st exhibit behaviors. The client's program other than restraint room) would be effected 483.440(f)(3) PROC CHANGE The facility must de constituted commit of members of faci guardians, clients (persons who have contemporary prac client behavior, and controlling interest This STANDARD is Based on documer the facility failed to regular participation the Behavior Mana and at the Human a Findings include: The committee me	ROMDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 29 In summary, from the time of admission, these clients exhibited certain behaviors, were restrained for exhibiting those behaviors and they continue to be restrained for exhibiting those behaviors would be considered acceptable for an individual, i.e. client #9 engaging in laughter or clients wanting to touch a staff person, etc. Also the QMRP has not provided the staff with identified antecedents to the client's behavior in order to help the staff identify when the clients will exhibit behaviors. The QMRP has not changed the client's programming to see if an intervention other than restraints (i.e., use of the time out room) would be effective. 483.440(f)(3) PROGRAM MONITORING & CHANGE The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility. This STANDARD is not met as evidenced by: Based on documentation review and interview, the facility failed to have the required members regular participation at the scheduled meetings of the Behavior Management Review Committee and at the Human and Legal Rights Committee.	ROVIDER OR SUPPLIER ENDED TREATMENT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 29 In summary, from the time of admission, these clients exhibited certain behaviors, were restrained for exhibiting those behaviors and they continue to be restrained for exhibiting those behaviors would be considered acceptable for an individual, i.e. client #9 engaging in laughter or clients wanting to touch a staff person, etc. Also the QMRP has not provided the staff with identified antecedents to the client's behavior in order to help the staff identify when the clients will exhibit behaviors. 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Findings include: The committee members do not regularly	ROVIDER OR SUPPLIER ENDED TREATMENT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 29 In summary, from the time of admission, these clients exhibited certain behaviors, were restrained for exhibiting those behaviors and they continue to be restrained for exhibiting those behaviors would be considered acceptable for an individual, i.e. client #9 engaging in laughter or clients wanting to touch a staff person, etc. Also the QMRP has not provided the staff with identified antecedents to the client's behavior in order to help the staff identify when the clients will exhibit behaviors. The QMRP has not changed the client's programming to see if an intervention other than restraints (i.e., use of the time out room) would be effective. 483.440(f)(3) PROGRAM MONITORING & W 261 The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility. This STANDARD is not met as evidenced by: Based on documentation review and interview, the facility failed to have the required members regular participation at the scheduled meetings of the Behavior Management Review Committee and at the Human and Legal Rights Committee. Findings include:	A BUILDING 24G502 STREET ADDRESS CITY, STATE ZIP CODE 1425 STATE STREET CAMBRIDGE, MN 55008 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 29 In summary, from the time of admission, these clients exhibited certain behaviors, were restrained for exhibiting those behaviors and they continue to be restrained for exhibiting those behaviors would be considered acceptable for an individual, i.e. client #9 engaging in laughter or clients wanting to touch a staff person, etc. Also the CMRP has not provided the staff with identified antecedents to the client's behavior in order to help the staff identify when the clients will exhibit behaviors. The QMRP has not changed the client's programming to see if an intervention other than restraints (i.e., use of the time out room) would be effective. 483.440(f)(3) PROGRAM MONITORING & CHANGE The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary ractices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility. This STANDARD is not met as evidenced by: Based on documentation review and interview, the facility failed to have the required members regular participation at the scheduled meetings of the Behavior Management Review Committee The committee members do not regularly The committee members do not regularly	A BULLIONG 24G502 ROMDER OR SUPPLIER ENDED TREATMENT SUMMANY STATEMENT OF DEFICIENCES (EACH DEPRICEMENT MUST BE PRECEDED AN PULL REGULATIONY OF LAST DEFINITION OF THE CHARMANY STATEMENT OF DEFICIENCES (EACH DEPRICEMENT MUST BE PRECEDED AN PULL REGULATIONY OF LAST DEPRICEMENT MUST BE PRECEDED AN PULL REGULATIONY OF LAST DEPRICEMENT MUST BE PRECEDED AN PULL REGULATIONY OF LAST DEPRICEMENT MUST BE PRECEDED AN PULL REGULATIONY OF LAST DEPRICEMENT MUST BE PRECEDED AN PULL REGULATIONY OF LAST DEPRICEMENT MUST BE PRECEDED AN PULL REGULATIONY OF LAST DEPRICEMENT MUST BE PRECEDED AN PULL REGULATIONY OF LAST DEPRICEMENT MUST BE PRECEDED AN PULL REGULATIONY OF LAST DEPRICEMENT MUST BE PRECEDED AN PULL REGULATIONY OF LAST DEPRICEMENT MUST BE PRECEDED AN PULL REGULATIONY OF LAST DEPRICEMENT MUST BE PRECEDED AN PULL REGULATION OF LAST DEPRICEMENT MUST BE PRECEDED AN PULL REGULATION OF LAST DEPRICEMENT MUST BE PRECEDED AN PULL REGULATION OF LAST DEPRICEMENT MUST BE PRECEDED AN PULL REGULATION OF LAST DEPRICEMENT MUST BE PRECEDED AN PULL REGULATION OF LAST DEPRICEMENT MUST BE PRECEDED AN PULL REGULATION OF LAST DEPRICEMENT MUST BE PRECEDED AN PULL REGULATION OF LAST DEPRICEMENT MUST BE PRECEDED AN PULL REGULATION OF LAST DEPRICEMENT MUST BE PRECEDED AN PULL REGULATION OF LAST DEPRICEMENT MUST BE PRECEDED AN PULL REGULATION OF LAST DEPRICEMENT MUST BE PRECEDED AN PULL REGULATION OF LAST DEPRICEMENT MUST BE PRECEDED AND PRETE AND PROVIDED AND PROVIDED AND PROVIDED AND PRETE AND PROVIDED AND PRE	

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		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	1 .	ULTIPL LDING	LE CONSTRUCTION	(X3) DATE S	
							•	С
24		24G502	B. WII			01/	17/2008	
		ROVIDER OR SUPPLIER ENDED TREATMENT			142	ET ADDRESS, CITY, STATE, ZIP CODE 25 STATE STREET IMBRIDGE, MN 55008		
PR	4) ID EFIX AG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIED TO THE APPR	ULD BE	(X5) COMPLETION DATE
W	261	Continued From pa	age 30	W	261	and a mechanism to ens	ure	
			vioral Management Review			that any member not pr	esent	
			e members, one of which is a			was given opportunity	to	
			er. The minutes from the last the committee met monthly to			consider the informati	on	
			rogram Plans related to			reviewed prior to the		
			neeting minutes reviewed			Committee's approval.		
	between February 2007 to November 2007, the March 2007 meeting was the only meeting that all of the members attended.				Persons Responsible: D Bratvold, METO Directo	_		
		members not in attended the telephone or were	imentation to indicate that the endance participated via contacted about the ed at the meetings prior to					
		minutes were revie and January 2008. monthly. However,	n and Legal Rights Committee wed between September 2007 This committee also met the only meeting which all of ded was the November 2007					
		members not in attitutelephone or were	ementation to indicate that the endance participated via contacted about the ed at the meetings prior to					
		on January 10, 200 the Human and Leg Behavioral Manage monthly and review facility's specially or pre-approved restripractice).	inistrative staff was interviewed 18 at 9:30 a.m. and stated both gal Rights Committee and the ement Review Committee meet of the client's Rule 40 plans (the onstituted committees' ctive behavior management					
W	266	483.450 CLIENT B PRACTICES	EHAVIOR & FACILITY	W:	<u>2</u> 66			

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OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	1/Y2\ M	LU TIOL	E DOMETRUGEION	L	
	IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	24G502	B. WI	IG		1	C 7/2008
ROVIDER OR SUPPLIER			142	25 STATE STREET		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE
The facility must enbehavior and facility met. This CONDITION Based on interview the facility failed to restrictive intervent behaviors, failed to causing harm, faile facility's specially or pre-approved restripractice) plans in a treatment plans, fail interventions when behavior, failed to trappropriate behaviors are strictive intervencemergency restrainencourage appropri	is ure that specific client and practices requirements are as a specific client and practices requirements are as and documentation review, provide clients with the least ions related to inappropriate implement restraints without a to utilize Rule 40 (the constituted committees' ctive behavior management accordance with active led to change restraint they have failed to change ailor the client interventions for vior to the client, failed to use ventions instead of using ts, and failed to teach and late behavior to replace the	W	266	program delivery practices to promote client growth, development and independence; ensure that less restrictive interventions are attempted prior to use of restraints; ensure that behavior manage- ment procedures are employed with sufficient safeguards and supervision to protect client rights; ensure restraint is never used as a substitute for active treatment; ensure systematic intervention to manage behaviors are incorporated into a client's IPP; ensure that use of restraint is part of an		
See documentation W288, W289, W29 483.450(a)(1)(i) CC These policies and growth, developme client. This STANDARD is	at tags: W268, W278, W285, 5, W296, and W304. NDUCT TOWARD CLIENT procedures must promote the nt and independence of the	w:	268	(Continued on attached The facility will char policy regarding clier conduct to better prov the ability of clients grow and develop with to physical/interperso boundaries and touch.	sheet) nge its nt note s to regard onal	2/26/08
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa The facility must en behavior and facility met. This CONDITION i Based on interview the facility failed to restrictive interventi behaviors, failed to causing harm, failed facility's specially co pre-approved restric practice) plans in an treatment plans, fai interventions when behavior, failed to to inappropriate behaviors restrictive interventions when behavior failed to to inappropriate behaviors Condition of Particip See documentation W288, W289, W29 483.450(a)(1)(i) CO These policies and growth, development client.	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR USC IDENTIFYING INFORMATION) Continued From page 31 The facility must ensure that specific client behavior and facility practices requirements are met. This CONDITION is not met as evidenced by: Based on interviews and documentation review, the facility failed to provide clients with the least restrictive interventions related to inappropriate behaviors, failed to implement restraints without causing harm, failed to utilize Rule 40 (the facility's specially constituted committees' pre-approved restrictive behavior management practice) plans in accordance with active treatment plans, failed to change restraint interventions when they have failed to change behavior, failed to tailor the client interventions for inappropriate behavior to the client, failed to use less restrictive interventions instead of using emergency restraints, and failed to teach and encourage appropriate behavior to replace the maladaptive behavior. These failures render this Condition of Participation unmet. See documentation at tags: W268, W278, W285, W288, W289, W295, W296, and W304. 483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the	ROVIDER OR SUPPLIER ENDED TREATMENT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 31 The facility must ensure that specific client behavior and facility practices requirements are met. This CONDITION is not met as evidenced by. Based on interviews and documentation review, the facility failed to provide clients with the least restrictive interventions related to inappropriate behaviors, failed to implement restraints without causing harm, failed to utilize Rule 40 (the facility's specially constituted committees' pre-approved restrictive behavior management practice) plans in accordance with active treatment plans, failed to change restraint interventions when they have failed to change behavior, failed to tailor the client interventions for inappropriate behavior to the client, failed to use less restrictive interventions instead of using emergency restraints, and failed to teach and encourage appropriate behavior to replace the maladaptive behavior. These failures render this Condition of Participation unmet. See documentation at tags: W268, W278, W285, W288, W289, W295, W296, and W304. 483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client.	STREENDED TREATMENT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 31 W 266 The facility must ensure that specific client behavior and facility practices requirements are met. This CONDITION is not met as evidenced by. Based on interviews and documentation review, the facility failed to provide clients with the least restrictive interventions related to inappropriate behaviors, failed to utilize Rule 40 (the facility's specially constituted committees' pre-approved restrictive behavior management practice) plans in accordance with active treatment plans, failed to change restraint interventions when they have failed to change behavior, failed to tailor the client, failed to use less restrictive interventions instead of using emergency restraints, and failed to teach and encourage appropriate behavior to replace the maladaptive behavior. These failures render this Condition of Participation unmet. See documentation at tags: W268, W278, W285, W288, W289, W295, W296, and W304. 483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. This STANDARD is not met as evidenced by Based on interview and documentation review, the facility has failed to treat eight of nine clients	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 31 The facility must ensure that specific client behavior and facility practices requirements are met. This CONDITION is not met as evidenced by. Based on interviews and documentation review, the facility size to imperent restraints without causing harm, failed to implement restraints without causing harm, failed to change restraint interventions ristead of using emergency restraints, and failed to change behavior, failed to take the delent interventions when they have failed to hange behavior, failed to take the client, failed to use less restrictive interventions instead of using emergency restraints, and failed to teach and encourage appropriate behavior to replace the maladaptive behavior. Those failures render this Condition of Participation unmet. See documentation at tags: W268, W278, W288, W289, W299, W296, and W304. 483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. This STANDARD is not met as evidenced by Based on interview and documentation review, the facility has failed to trate eight of nine clients. Serior ADDRESS CITY STATE STREET CAMBRIDGE, MN 55008 PREPRIX TAG PREPRIX TAG PREPRIX TAG PREPRIX TAG PREPRIX TAG PROVIDER: OA MRIDGE, MN 55008 PREPRIX TAG PREPRIX TAG PROVIDER: PROVIDER: CAMBRIDGE, MN 55008 PREPRIX TAG PREPRIX TAG PROVIDER: OA MRIDGE, MN 55008 The facility will modify program delivery pract: to promote client grow and sevelopment and independence of the client fine program delivery pract: to promote client grow and development and independence of the client fine program delivery pract: to promote client grow with sufficient safegur and supervision to profice client rights; ensure: is never used as a subject of the program leading to	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 31 The facility must ensure that specific client behavior and facility practices requirements are met This CONDITION is not met as evidenced by Based on interviews and documentation review, the facility failed to provide clients with the least restrictive interventions related to inappropriate behavior; failed to utilize Rule 40 (the maidagative behavior to the client, failed to use less restrictive interventions instead of using emergency restraints, and faired to teach and encourage appropriate behavior to replace the maidagative behavior. These failures render this Condition of Participation unmet. See documentation at tags: W268, W278, W285, W289, and W304. 483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. This STANDARD is not met as evidenced by Based on interview and documentation review, the facility has felied to treat eight of ninne clients. SUMMARY STATEMENT CAMBRIDGE, MN 55088 STREET ADDRESS CITY, STATE, ZIPCODE 1425 STATE STREET CAMBRIDGE, MN 55088 PREPIX CAMBRIDGE, MN 5608 PREPIX CAM

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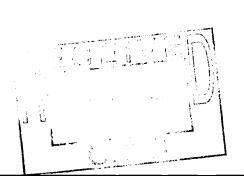
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0938-0391
	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTR A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED
		24G502				C 01/17/2008
	ROVIDER OR SUPPLIER			l	ET ADDRESS CITY, STATE, ZIP CODE 25 STATE STREET	
IAIIA EXT				CA	MBRIDGE, MN 55008	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLÉTION
W 268	Continued From pa	age 32		268	uniform facility police	cy that
	manner related to the use of restraints and the				prohibits clients from	=
	•	promote the growth and			ing staff or one anoth	ner, and
		ents related to touch. Findings			that specific boundar:	ies re-
	include:				garding touch will be	specified
	Client #2 has mode	erate mental retardation,			as group agreements,	sensitive
		ess. A review of the client's			to the specific charac	cteristics
		at she was unnecessarily 15, 2007, May 4, 2007, May 5,			of the clients in the	group,
		17, June 25, 2007, July 10,			and open to negotiation	
	2007, July 25, 200	7, July 29, 2007, and August			staff will be trained	to policy
		ist cuffs behind her back and			change.	
ļ	leg hobbles.					_
	Client #3 has mild	mental retardation,			Persons Responsible:	
	osteoarthritis, limite	ed range of motion in his left			Bratvold, METO Directo	
l 		ee pain, and prefers to use a			TenNapel, Ph.D., L.P.	METO
		ew of the client's record as unnecessarily restrained on			Clinical Director	
		lay 10, 2007, June 20, 2007,			IPPs for all clients	placed in 2/26/08
	June 23, 2007, Au	gust 5, 2007, September 6,			the facility's ICF/MR	
	2007, and Septem	ber 26, 2007.			will be revised to en	
	Client #4 has mild	mental retardation, asthma,			for any client having	
		tory of poking others and			management program ta	
		items at others heads. A review			the reduction of inap	_
l		aled that she had been trained on May 24, 2007, and			touch, and/or where a	=
	May 30, 2007.	trained on May 24, 2007, and			restraint has been tr	=
	•				inappropriate touch,	the IPP
		re mental retardation and a			includes provisions for	
		al deterioration since review of his medical record			the growth and develop	pment of
}		as unnecessarily restrained in			appropriate touch.	
		sychotropic medications on				
		10, 2007, May 21, 2007, June			Persons Responsible:	
	2, 2007, June 5, 2007, June 12, 2007, and June 18, 2007. He was unnecessarily restrained with				TenNapel, Ph.D. L.P.,	
		nts on May 8, 2007, May 9			Clinical Director; Be	th Klute,

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Julie Patten, BA3s and QMRPs

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATÉ SURVEY COMPLETED
		24G502	B. WING			C 01/17/2008
	PROVIDER OR SUPPLIER ENDED TREATMENT		1 ,-	1.	REET ADDRESS, CITY, STATE, ZIP COD 425 STATE STREET CAMBRIDGE, MN 55008	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
W 268	her record revealed restrained on Dece 2007, and December 2007, and December 2007, and December 2007, and December 2007, September 2007, September 2007, September 2007, Client #9 has mild a brain lesion. A rerevealed that he was August 5, 2007, August 5,	8, 2008. mental retardation. A review of d that she was unnecessarily ember 12, 2007, December 21,	W	268	The facility has cont with a registered Occ Therapist, with compe delivering sensory in therapies to individu developmental disabil Service delivery will effective 02-04-08 an on clients placed in facility's ICF/MR pro and will include: ass clients to determine to which problem behabe reflective of sens assisting the treatme develop appropriate h programming, and staf	upational tency in tegration als with ities. begin d be focused the gram, essing the degree viors may ory issues, nt team to abilitation f training
	and December 11, Client #10 has mod infantile autism, he making himself vor agitated when othe Client #10 was disc November 7, 2007 revealed that he was February 28, 2007, 2007, March 13, 20 18, 2007, March 15, March 27, 2007, April 6, 20 2007. Interviews with em January 10 and 11				to increase skill in sensory needs of clie Persons Responsible: METO Director; Shirle METO Nursing Supervis Effective 01-08, the increased requirement QMRP oversight of eme use of restraint to i enhanced evaluation of that may have contribuse of restraint, eff of less restrictive a attempted, specific r	Doug Bratvold, y Davis, R.N. or facility 2/26/08 s for rgency nclude f factors uted to the ectiveness lternatives

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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	
		240502	B. WING			С	
	 	24G502				01/1	7/2008
	ROVIDER OR SUPPLIER ENDED TREATMENT		_	142	ET ADDRESS, CITY STATE, ZIP CODE 25 STATE STREET AMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 268	staff are not allower providing care, and touch staff. Employ stated this is because going to hurt their interview that the net ICF/MR facility because however, the facility treatment center. Employee (E)/admit on January 31, 200 the clients admitted restrained to reduce dangerous or likely. When two specific restrained, related to mentioned by the instated that from the reviewed, the risk and touch staff.	allowed to touch other clients, d to touch clients unless clients are not allowed to ee (B) when interviewed se staff do not know if a client m. Employee (C) stated in an o touch policy is difficult in an ause of the clients they serve, is not their home it is a not their home it is a nistrative staff was interviewed at 9:30 a.m. and stated that at the facility should only be a target behaviors that are to lead to dangerous behavior. Examples of client #3 being to television viewing, were executed to the examples of the examples unalysis (risk of continuing the	W	268	for changes to the clied IPP to reduce need for restraint, and communic collaboration with members the Expanded Interdiscit Team, including the leg representative and count manager. QMRP documentate recorded on a newly develorm and will be tracked part of ongoing file audients. Persons Responsible: ScottenNapel, Ph.D., L.P., Clinical Director The facility implemented staff training initiation increase staff skill in	further ration/ pers of plinary ral ety case ation is reloped red as reloped red as record metro.	
W 278	activity versus the risks of restraining) is "all out of whack." The facility as a whole does not have a "no-touch" policy. There should be "household agreements," reviewed and open for negotiation, made by the people who live in a household. The "no-touch" policy is intended to be a therapeutic support for people who are aggressor's, the recipient of another's aggression, or there are other problems with interpersonal boundaries. If a client failed to observe the practice of "no-touch" and simply touched another client, that would not constitute a dangerous situation. 8 483.450(b)(1)(iii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR		w:	278	(alternatives to restrateffective December 14, All staff currently asset to the ICF/MR program we receive this training. training has also been to the new employee ori (Continued on attached)	int) 2007. signed vill This added entation	1

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G502 B. WING			C 01/17/2008	
	ROVIDER OR SUPPLIER		14	EET ADDRESS, CITY, STATE, ZIP CODE 26 STATE STREET AMBRIDGE, MN 55008	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
W 278	inappropriate client the use of more re- client's record doci incorporating the u	byern the management of t behavior must insure, prior to strictive techniques, that the uments that programs se of less intrusive or more s have been tried systematically	W 278	The facility has modified documentation format and strative review process f use of restraint, to assuless intrusive techniques tried and found to be ine or reasons why less intruinterventions could not be	admini- or any re that were ffective sive
	This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to clearly document in the medical record that less intrusive and more positive techniques had been tried systematically, prior to the implementation of more restrictive techniques, to manage inappropriate client behavior for eight of nine clients (#2, #3, #4, #6, #7, #8, #9 and #10) whose medical records were reviewed. Findings include:			The facility has establis debriefing process to mon and provide coaching regastaff implementation of r IPPs for all clients place facility's ICF/MR program revised to ensure that eaclient's program includes specific system of positi	itor rding estraint. ed in the will be ch a
	Implementation Of Deprivation Proced Emergency Use of Documentation for Initiation of Psychothat facility staff co or mechanical rest less intrusive and I Documentation of procedures provide	ility's "Documentation For Approved Aversive And/Or dures, Documentation for Controlled Procedures, [and] Emergency Use or Emergency stropic Medication" revealed insistently implement chemical raint procedures without trying ess restrictive techniques, the use of the above ed little or no evidence that		(non-aversive) response to behaviors that are identiced precursors to more serious behaviors that may result need for restraint. Persons Responsible: Scott Ph.D. L.P., METO Clinical Beth Klute and Julie Patt and QMRPs	fied as s problem in a t TenNapel, Director;
	behavior, 2) to determine to accomplise displaying his or he use consistent pose 4) to use a positive than a manual or necessary.	cipate the maladaptive ermine what the individual was hor communicate by er maladaptive behavior, 3) to itive reinforcement procedures, or less restrictive technique nechanical restraint and 5) to mental alterations would		The facility will impleme quality management proces ensure that the QMRP make changes to client IPPs su adequate treatment veloci maintained for all client	s to s ch that ty is

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IULTIP ILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		240500	B. WING			C	
		24G502				01/17/2008	
	ROVIDER OR SUPPLIER ENDED TREATMENT			14	EET ADDRESS, CITY, STATE, ZIP CODE		
					AMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION	
W 278	Continued From pa	ge 36	W:	278	have experienced use of	f	
		the maladaptive behavior.			restraint. Specifical	ly,	
		examples of incidents where a			monthly data reflecting	the	
		ior was displayed by clients			use of restraints and	=	
		8, #9, and #10 and then was ed by a restraint procedure. In			in treatment will be re	-	
	•	ocumentation does not indicate			by the facility's Clin		
		used "as a last resort."			Director, or other des		
					is a mental health pro:	_	
		nistrative staff was interviewed			with competency in	ressionar	
		8 at 9:30 a.m. and stated that			• •		
		facility are legally committed roperty destruction or physical			psycho-educational trea		
		ay have some degree of self			individuals with develo	_	
		The average stay is based on			disability, with the ol	•	
		ility is able to stabilize a client's			effecting appropriate:		
		vior. Approximately one and a			to the client's IPP in	order to	
	, ,	jo, the facility implemented the restraints for inappropriate			reduce the need for re	straint.	
		bber 2007, the use of			Davida Davida (N.)	2	
		its for emergency situations			Persons Responsible:		
		the ICF/MR. However, the			TenNapel, Ph.D., L.P.,	METO	
		restraints continues to be			Clinical Director		
		ts with Rule 40 programs. In					
		ns, the staff use manual mples of the restraints utilized			The facility increased rec	,,	
		grams include: soft wrist cuffs,			ments for Registered Nurse		
		d leg hobbles (usually used			oversight of restraint use		
		me cases a restraint board.			include direct examination		
		ims start with two minutes of			documentation of the clien		
		and if the client(s) continues to			response to each implement		
	struggie, they are p	ut in mechanical restraints.			of restraint, effective 11-07.		
	Employee (B)/beha	vioral analyst I was			Persons Responsible: Doug	1	
		uary 11, 2008 at 8:10 a.m.,			Bratvold, METO Director; Shirley		
	and stated that eme	ergency restraints are utilized			Davis, R.N., METO Nursing		
		ce to address inappropriate			Supervisor		
		client exhibits a behavior that			5 ap 52 - 2002		
		such as physical aggression aviors, or if a client is					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MU	JETIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		24G502	B. WIN		C 01/17/2008
	NAME OF PROVIDER OR SUPPLIER MN EXTENDED TREATMENT			STREET ADDRESS, CITY, STATE, ZIF 1425 STATE STREET CAMBRIDGE, MN 55008	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
W 278	following techniquing negotiation and curestrain. If the clie that is initiated as the Rule 40 clients Posey soft handour and hobbles are ure of the five clients but one are put in hobbles. Employee (E)/admon January 31, 20 the clients admitted restrained to reduce dangerous or likely. When two specific restrained, related mentioned by the stated that from the reviewed, the risk	perty, the staff utilize the est personal boundaries, reing, then escort, and then in thas a Rule 40 restraint plan, written. The restraints used for shave been metal handcuffs or offs and leg hobbles (the cuffs sed together), or Posey board, in the ICF/MR with rule 40's, all handcuffs (metal or soft) and ininistrative staff was interviewed 08 at 9:30 a.m. and stated that did at the facility should only be be target behaviors that are yet lead to dangerous behavior. It examples of client #3 being to television viewing, were investigator, employee (E) in esounds of the examples analysis (risk of continuing the risks of restraining) is "all out of	W 2	78 Effective 01-08, the increased requirement QMRP oversight of emporance of restraint to include evaluation of factor have contributed to restraint, effective restrictive alternates specific recommendates changes to the client reduce need for furth and communication/consists with members of the Interdisciplinary Testing the legal representations manager. QMRP is recorded on a new form and will be transformed to ongoing file audit persons Responsibles TenNapel, Ph.D., L.E. Clinical Director	nergency use nude enhanced so that may the use of eness of less lives attempted, lions for lit's IPP to ther restraint, ellaboration Expanded eam, including ative and county documentation why developed licked as part lits.
W 285	policy. There shoureviewed and open people who live in policy is intended to people who are another's aggressi with interpersonal observe the practic touched another changerous situation and the changerous situation reviewed and open people who live in policy is intended to people who live in policy is intended to people who live in policy is intended to people who are an another's aggression with interpersonal changerous situation reviewed and the changerous situation reviewed and t	MT OF INAPPROPRIATE	W 2	85	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DRV111

Facility ID: 00293

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CENTERS FOR MEDICARE & MEDICAID SERVICES					0	MB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP		· ·) DATE SURVEY COMPLETED
		24G502	B. WII	NG		C 01/17/2008
NAME OF P	ROVIDER OR SUPPLIER		┵	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	0.17712000
MN EXT	ENDED TREATMENT	г		1	25 STATE STREET MBRIDGE, MN 55008	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
W 285	Continued From p	age 38	W	285	With a policy change	2/26/08
					effective 11-23-07 the	_,_,,
	Interventions to ma	Interventions to manage inappropriate client			facility prohibited the	
	behavior must be employed with sufficient safeguards and supervision to ensure that the					,
					emergency use of mechanic	
	•	d civil and human rights of			restraint of any client p	
	clients are adequa	itely protected.			in the ICF/MR program. Al	1
					staff assigned to the ICF	/MR
	This CTANDARD	in not mot an avidenced by			building have been traine	d to
		is not met as evidenced by:			this change.	
		v and record review, the facility at interventions to ensure safety				
	•	ients (#6, #7, and #9) in the			Barrage Barrage ibla Barra	
		to protect the welfare and			Persons Responsible: Doug	
		nine clients (#2, #3, #4, #6, #7,			Bratvold, METO Director;	
		the sample who were			TenNapel, Ph.D., L.P., ME	TO
		dequate justification and/or			Clinical Director	
	alternative interver	ntions. Findings include:			The facility will change	ito
		ress notes in client #6's medical			policy regarding emergend	=
		11, 2007, at 8:11 a.m. the			use of manual restraint o	
		ome at staff in an aggressive rected client to room. [Client #6]			clients placed in the ICE	?/MR
		came out again within several			program to effect an imme	ediate
		6) then began to grab at staff			reduction in use of restr	raint
		plemented Rule 40, by first			by increasing the standar	rd of
		n an arm bar. [Client #6]			severity of behavior for	
		ar and continued to claw and			-	WILLCII
	grab at staff. [Clier	nt #6] went to his knees but			emergency use of manual	
		Staff then implemented an arm			restraint is indicated.	
		staff did this, [client #6] turned			Specifically, no use of	
		entor to another staff, grabbing			restraint will be prescri	bed
		is moment implementor, felt			for use in response to an	ıy
		eft arm pop. Staff immediately are take down and alerted the			behavior which does not p	ose a
		#6] laid on the ground face			risk of immediate, seriou	
		npted to aggress by grabbing at			12 2	=J1 ·
		left arm had possible injury he			The facility will share	ita
		Staff attempted to keep [client			The facility will change	
	-33,00000 min in	Link the second of the second			policy on emergency use of	o t

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#6] still, especially his left arm. Staff verbally

Event ID. DRV111

Facility ID: 00293

psychotropic medications to

If continuation sheet Page 39 of 65

OLIVIE	10) OI (WILD ON I) L	WINDIONID OF KAIOEO				ONIO NO.	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI			(X3) DATE SURVEY COMPLETED	
			 	uc		C	: {
_	_	24G502	B. WI	NG _		01/17	//2008
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
MNEYT	ENDED TREATMENT			1	425 STATE STREET		Ì
MIN EVI	INDED INCATMENT			(CAMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	ΙX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
W 285	Continued From pa	iae 39	w	 285	ensure that such use is ex	-	
i	·	i) to calm down. [Client #6]			closively for the reductio	n of	(
		but was still struggling. Staff			symptoms of an identified		
		tified R.N." A splint was			psychiatric condition.		
		ent was transported to the					
	hospital by emerge	ncy medical technicians. Client			The facility will revise i	ts	2/26/08
		humerus fracture and was			policy on programmatic use	of	
		pital for pain control after his			restraint (i.e., "Rule 40"		
		plinted. He returned to the			programs) for clients plac	ed in	
		3, 2007. He returned to the			the ICF/MR program to redu	ce the	
	hospital on August 28, 2007 for surgical repair of his fractured arm and returned to the facility on the feeting programmatic restraint use of programmatic restraint						
		no returned to the facility on			by increasing the standard	of	
	August 29, 2007.				severity of behavior for w		{
	According to docum	nentation on incident reports,			of restraint is indicated.		
		7, at 8:30 a.m., client #7			Specifically, no use of re		
		sized swelling right outer			will be prescribed for use		1
		Two bruised areas present.			response to any behavior w		,
		as banging head on floor. Staff			does not pose a risk of im		
		pillow under client's head			serious injury.	mediace,	Ì
	during restraint hov	vever the client would not			serious injury.		
		there." Description of the			All staff assigned to the	TOR/MD	
		client #7 was restrained,			building will be trained t		ì
		ocumentation for Emergency			<u>-</u>	o this	}
		Procedure" form, dated			change.		
		at 8:35 a.m. indicated that					
	***************************************	to take her bath and			Persons Responsible: Doug		
		ent began yelling and			Bratvold, METO Director; S		
	•	When staff entered the attempted to hit staff. The			TenNapel, Ph.D., L.P., MET	0	
		manual restraint in prone			Clinical Director		
		minutes, mechanical restraints					
	•	procedure ended at 8:55 a.m.			Effective 01-08-08 the		2/26/08
		icated that after the restraint			facility implemented a pro		Ì
		7 was "very emotional and			of disclosure, for use at		}
		can't go to work today." The			mission to the facility, i	nvolving	l
		at 9:05 a.m., indicated the			clients, legal representat		
	client was anxious, chair.	and was rocking in the rocking			and members of clients' Ex	panded	

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		24G502	B. WING		01/17/2008
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY STATE, ZIP CODE	
MNEVT	NOTO TOPATMENT		1	125 STATE STREET	
MINICAL	ENDED TREATMENT		C	AMBRIDGE, MN 55008	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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 COMPLETION
W 285	Continued From pa	ge 40	W 285	Interdisciplinary Teams,	2/26/08
	On December 11, 2	2007, at 5:10 p.m. a staff		describing the facility's	2/20/00
		water from client #7's		policy regarding emergency	use
		e client, "came at staff		of restraints, including a	
		lunged at staff, threw a glass		written and photographic	
	of water at staff, ca	me at staff with fists raised."		description of restraints	used
		irm bar take down into a		soliciting concerns from c	
		lient struggled, scratched and		and their teams regarding	
		nutes. The nurse assessment		facility's use of restrain	
		of the client's face and hands		offering consultation with	·
		ven though she yelled she		staff toward identification	
	couldn't breathe. At 5:30 p.m., client #7 was crying and went into her room. Documentation			alternatives to restraint.	
				arcernacives to restraint.	
		said she was "sore." An			
	-	cated that "during emergency		Persons Responsible: Doug	
		was struggling, refusing to out from under her chest, a		Bratvold, METO Director; S	· ·
		ner right elbow due to resisting		TenNapel, Ph.D., L.P., MET	
	on carpeted area."	ier right elbow due to resisting		Clinical Director; Kim Pal	mer
	on curpoted area.			and Connie O'Brien, METO S	ocial
	An incident report	dated September 13, 2007, at		Workers	
		I that after being restrained,			
		nis bedroom and banged his		The facility increased :	require- 2/26/08
		all. He sustained a two		ments for Registered Nu:	rse
	centimeter abrasion	n mid-forehead and a two		oversight of restraint	use to
		n on his right temple.		include direct examinat:	ion and
		ehavior for which client #9		documentation of the cl:	ient/c
		orded on the Documentation			
		of Controlled Procedure form,		response to each implement	
		3, 2007, at 8:10 a.m., client #9 was doing his		of restraint, effective	11-07.
		ed his hamper. Walked to his			
		amper lid, talking to himself		Persons Responsible: Do	ıg
		n said "shot" and went toward		Bratvold, METO Director	;
		ed if he was okay [and]		Shirley Davis, R.N. METO	
		n door." Client #9 was		Nursing Supervisor	
		physical aggression-pulled			
		ed, scratched staffs shoulder			
		uring manual restraint, the			

client struggled for two minutes so mechanical

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED
		24G502	B. WING		C 01/17/2008
NAME OF P	ROVIDER OR SUPPLIER	L	STF	REET ADDRESS, CITY, STATE, ZIP CODE	01/1/2000
MN EXTE	ENDED TREATMENT		į.	425 STATE STREET CAMBRIDGE, MN 55008	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
W 285	Continued From pa	ge 41	W 285		
ŀ		lied. The client continued to		increased requirements	for
		of twenty-nine minutes. The		QMRP oversight of emerg	
1		t 8:44 a.m. At 2:32 p.m., his mental health review [and]		use of restraint to inc	lude
		ot out side he yelled, "pop,		enhanced evaluation of	factors
		to flick his fingers infront of		that may have contribut	ed to
		pidly [and] his body was		the use of restraint, e	ffective-
		the household, grabbed staff		ness of less restrictiv	re
		iers [and] shook her." Client #9		alternatives attempted,	specific
		to physical aggression shoulders (and) began to		recommendations for cha	nges to
		ent struggled for thirteen		the client's IPP to red	luce need
		m. client #9 received two		for further restraint,	and
		IM. The restraint procedure		communication/collabora	tion with
	ended at 2:55 p.m.,	, after 23 minutes.		members of the Expanded	l
	The facility has not	put interventions in place to		Interdisciplinary Team,	
		ate behavior in such a way that		the legal representativ	
		il and human rights of the		county case manager. QN	
		e (#2, #3, #4, #6, #7, #8, #9,		documentation is record	
	and #10) have been	n adequately protected. The		newly developed form ar	
		ity promotes the use of		be tracked as part of o	
		al, and or chemical restraints to		file audits.	лідотіід
		ve behaviors. Clients are put ehaviors without prior less		file audics.	
		ions being implemented.			
		umentation does not show that		Persons Responsible: So	
		reinforcement methods are		TenNapel, Ph.D., L.P.,	WE.I.O
		s. There is documentation that		Clinical Director	
		nts have suffered unfavorable if and mechanical restraints.			
		ation that indicates some of		IPPs for all clients p	
		rs have continued for long		in the facility's ICF/	
		spite the use of manual and		program will be revised	
	mechanical restrain			effect an immediate red	
	Emphasia (ANI-1)	-introduce and the second		in the use of restrain	ts by
		nistrative staff was interviewed 8 at 9:30 a.m. and stated that		increasing the standar	d of
		facility are legally committed		severity of behavior for	or which
				use of restraint is in	dicated.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[` '	JLTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A BUIL			С	
		24G502	B. WIN	G	01	/17/2008	
	ROVIDER OR SUPPLIER ENDED TREATMENT			STREET ADDRESS, CITY, STATE, ZIP CO 1425 STATE STREET CAMBRIDGE, MN 55008	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE	
W 285	aggression, and mainjurious behavior. how quickly the factinappropriate behavior half to two years aguse of mechanical behavior. In Novem restraints in emerging the ICF/MR and Rule 40 programs, staff use manual restraints utilized for include: soft wrist of hobbles (usually usually usu	roperty destruction or physical ay have some degree of self. The average stay is based on illity is able to stabilize a client's vior. Approximately one and a go, the facility implemented the restraints for inappropriate of the restraints for inappropriate of the restraints of the mechanical ency situations were stopped only utilized on the clients with In emergency situations, the estraints only. Examples of the for the Rule 40 programs of the Rule 40 programs of the restraints of the restraining and if the set of the restraining and if the set of the struggle, they are put in onts. Inistrative staff was interviewed and to restraint use have included andcuffs, and one broken arm pority of the bumps, bruises, the head, knees, and elbows at restraints. IT OF INAPPROPRIATE Rule 40 programs IT OF INAPPROPRIATE Rule 41 programs The set of the bumps of the program. It is not met as evidenced by that the review, the facility used in the set of the set of the set of the facility used in the set of the facility used in the set of the	W 2	will be prescribed for response to any behavi does not pose a risk of serious injury. Persons Responsible: SPh.D., L.P., METO Clin Beth Klute and Julie Pand QMRPs The facility's specific constituted committed oriented to changes regarding both emeroprogrammatic use of to ensure their reviapproval process meet revised policy's incommon standard of severity behavior for which unrestraint is indicated Specifically, no use (Continued on attach	cuse in or which of immediate cott TenNapical Direct atten, BA3s ally se will be in policy ency and restraint, ew and ts the reased of se of ed. of	el, or; 2/26/08	
		ropriate behaviors in the reatment to teach, improve, or				ı	

CENTE	19 LOK MEDICAKE	& MEDICAID SERVICES				<u>UND NO.</u>	<u> </u>
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		24G502	B. WII	NG_		1	C 7/2008
NAME OF P	ROVIDER OR SUPPLIER		_l	STR	EET ADDRESS, CITY, STATE, ZIP CODE		772000
					425 STATE STREET		
MNEXI	ENDED TREATMENT			С	AMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	łX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 288	Continued From pa	ge 43	w	 288	IPPs for all clients pl	laced	2/26/08
	=	ate behavior for three of nine			in the facility's ICF/N	I R	, ,
	• • •	#9) in the sample. Findings			program will be revised		
	include:	•			ensure that each client		
					program includes a spec		
		e mental retardation and has a			system of positive (nor		·e)
		al deterioration since e was admitted to the facility in			response to behaviors t		C /
		cific behaviors include biting,			-		
		g, head-butting, hair pulling,			identified as precursor		
		#6's Rule 40 (the facility's		•	more serious problem be		
specially constituted committees' pre-approved				that may result in a ne	eed for	•	
		management practice)			restraint.		
		that if client #6 exhibits signs					
		ng out or touching staff, not			Persons Responsible: So	cott	
		al redirectives, pacing,			TenNapel, Ph.D. L.P.,	OTEM	
		ng, or screaming), the staff will			Clinical Director; Betl	n Klute	
	•	cue to stop the behavior. If the mediately stop, staff will escort			and Julie Patten, BA3s		's
		frediately stop, starr will escort			and darge radion, prior	u.i.u. <u></u>	_
		to engage in the behavior,					
		estrain his arms and apply a			The facility will imple		2/26/08
	RIPP belt to the clie	ent's waist, and staff will apply			quality management prod	cess to	
		client's wrists. A Rule 40			ensure that the QMRP ma	akes	
		s the restraints will be			changes to client IPPs	such	
		e client has zero incidents of			that adequate treatment	t velocit	У
		n, self injury, and PICA (eating er three consecutive months.			is maintained for all	clients	
		g a cue to stop the behavior,			who have experienced u	se of	
		of interventions to modify or			restraint. Specifically		·v
		behaviors. There is no			data reflecting the use		- 1
		velopment of a list of			restraints and progress		
		ors to assist staff in knowing			treatment will be review		
		ht exhibit behaviors. From the					
		resent, client #6 continues to			the facility's Clinica		or,
		nd he continues to be liting these behaviors. The			or other designee who		
		as to stop the "maladaptive			mental health professi		
		idication of how staff would			competency in psycho-e		al
		appropriate behaviors.			treatment of individua	ls with	

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0938-0391	
	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		AULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		24G502	B WING			C 01/17/2008	
	PROVIDER OR SUPPLIER			14	EET ADDRESS, CITY, STATE, ZIP CODE 25 STATE STREET AMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	ΙX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE COMPLETION	
W 288	Continued From pa	ge 44	W	288	developmental disabili the object of effection		
	indicated that he has retardation, autism, client has a history self-injurious behave Client #8's target be attempted behavior to other(s), includin hitting, scratching, lothers, throwing ite manipulating an obsignificant damage construction and or others if thrown or islamming doors an of intent, that may eslapping, hitting, so	record was reviewed and as moderate mental and a brain stem tumor. The of physical aggression, riors, and property destruction, which is a subject that may cause pain or harm go lunging at others, biting, kicking, slapping, pushing ms at people, and spitting; liget in a manner that causes to that object based upon its function, and/or poses risk to used as a weapon; including diacts against self, regardless cause significant injury (i.e.			appropriate revision to client's IPP in order the need for restraint Persons Responsible: Some TenNapel, Ph.D. L.P., METO Clinical Director Effective 01-08, the four creased requirements QMRP oversight of emergy use of restraint to in enhanced evaluation of that may have contributions.	to reduce cott acility 2/26/08 for gency clude factors ted to	
	The client's signs of checking doors, igning vocalizations." Clienthat the client's altered break" with verbal consecutive months. Rule 40 plan revised duration of one year the client's utilization property destruction to zero for three coexhibits any of the sare to cue the client down on the floor. If on the floor the statclient in a prone pohandcuffs to his writing down on the flohandcuffs and legit	surfaces or head banging.)." f agitation include: "running, foring staff directions, and loud at #8's behavior plan indicates rnative to agitation is to "take a cueing 80% of the time for two s. In addition, the client has a d on August 22, 2007, with a r. The objective is to decrease in of physical aggression, and self-injurious behaviors insecutive months. If the client above target behavior satisfication and then apply st and leg hobbles. If the client or independently the hobbles will still be applied.			the use of restraint, ness of less restrictical alternatives attempted recommendations for characteristic that client's IPP to refor further restraint, communication/collabor with members of the Ex Interdisciplinary Team the legal representatic county case manager. Quedoumentation is recornewly developed form a be tracked as part of file audits. Persons Responsible: S	ve , specific anges to duce need and ation panded , including ve and MRP ded on a nd will ongoing	

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Event ID: DRV111

Facility ID: 00293

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Ph.D., L.P., METO Clinical Director

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CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		24G502	B. WING			C 01/17/2008	
	MN EXTENDED TREATMENT			14	EET ADDRESS, CITY, STATE, ZIP COI 25 STATE STREET AMBRIDGE, MN 55008	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION	
W 288	then the leg hobble another five minute removed. The focu "maladaptive behavistaff would teach, e appropriate behaviors included autism. He has a high self injurious behaviors include pattempts to hurt an other(s). Includes: kicking, slapping, pat people, and spitt behaviors - "acts accause injury (i.e. slabiting self, pounding or head banging.)." indicates that when "agitation" his alternatake "a break." In a 40 plan that was la 2007 with a duration was to decrease his zero for three consincluded cueing the client stopped the bit to go to a quiet sett calming techniques were not stop the behaviors and lie down "stop'	be calm for five minutes and is will be released. After is of calm the handcuffs will be son the plan was to stop the vior" with no indication of how elicit, improve, or strengthen	W	288	IPPs for all clients in the facility's IC will be revised to emediate reduction in restraints by increasing the standard of severity for which use of restraint will be for use in response behavior which does risk of immediate, so Persons Responsible TenNapel, Ph.D., L.I. Clinical Director; It and Julie Patten, BA	CF/MR program effect an im- n the use of asing the y of behavior straint is ally, no use e prescribed to any not pose a serious injury. : Scott P., METO Beth Klute	

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- ['	MULTIPLE	E CONSTRUCTION	(X3) DATE COMP	
		24G502	B. WI	NG		01/	C 17/2008
	ROVIDER OR SUPPLIER			1425	T ADDRESS, CITY, STATE, ZIP CODE S STATE STREET MBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(XS) COMPLETION DATE
W 288	with handcuffs and side when he was 'five minutes his leg and after another fi handcuffs would be directions when asl procedure would corestraining him with The focus on the pi "maladaptive behavior appropriate behavior	then mechanically restrained leg hobbles, and turned to his safe." After he was calm for hobbles would be released we minutes of being calm his released. If the client followed ked to lie down on the floor the ontinue with mechanically in the handcuffs and hobbles. Ian was to stop the wor" with no indication of how elicit, improve or strengthen fors. Inistrative staff was interviewed at at 9:30 a.m. and stated that if at the facility should only be the target behaviors that are to lead to dangerous behavior. Examples of client #3 being to television viewing, were exestigator, employee (E) as sounds of the examples inalysis (risk of continuing the risks of restraining) is "all out of one does not have a "no-touch" of be "household agreements," for negotiation, made by the a household. The "no-touch" of be a therapeutic support for gressor's, the recipient of one, or there are other problems boundaries. If a client failed to be of "no-touch" and simply ent, that would not constitute a	W	288			

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			<u></u>	OMB NO	<u>. 0938-0391</u>
	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE S COMPL	ETED			
		24G502	B. WI	NG		C 01/17/2008	
	PROVIDER OR SUPPLIER		·	14	EET ADDRESS, CITY, STATE, ZIP CODE 125 STATE STREET AMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
CLIE The inappincor plan, this s	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be			289	IPPs for all clients pl in the facility's ICF/N program will be revised ensure that each client	IR l to	2/26/08
		into the client's individual program dance with §483.440(c)(4) and (5) of			program includes a spec system of positive (nor response to behaviors t identified as precursor serious problem behavio	n-aversi chat are cs to mo	
	This STANDARD is not met as evidenced by: Based on interview and documentation review, the facility has failed to incorporate alternative interventions, in place of restraints, into the client's individual program plan for two of nine clients (#8, #9) in the sample. In addition, the facility has failed to change client programs as behavior indicates for two of nine clients (#2, #6) in the sample. Findings include:				may result in a need for Persons Responsible: So TenNapel, Ph.D. L.P., M Clinical Director; Beth and Julie Patten, BA3s The facility will imple	cott METO n Klute and QMR	
	diagnoses includes autism. He has a his self injurious behavious when he gets frustrianning, self injurious directions, and loud behaviors include pattempts to hurt and other(s). Includes: kicking, slapping, pat people, and spitt behaviors - "acts again ause injury (i.e. slabiting self, pounding or head banging.)." indicates that when "agitation" his altern	record was reviewed and his mild mental retardation and istory of physical aggression, iors, and property destruction ated or angry, exhibiting the behaviors, ignoring staff through the vocalizations." His target thysical aggression-"Actual or differ cause pain or harm to bitting, biting, scratching, ushing others, throwing items and at others;" self-injurious painst self that are intended to apping, hitting, scratching, globody parts on hard surfaces. Client #9's program plan the exhibits symptoms of sative to the agitation will be to addition, the client has a Rule			quality management prodensure that the QMRP management is that adequate treatment is maintained for all of who have experienced us restraint. Specifically data reflecting the use restraints and progress treatment will be review by the facility's Clinical Director, or other describes a mental health product with competency in payor treatment of individual developmental disability.	such such clients se of sin ewed ical ignee whose sho-educts with	ly o l ational

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CENTER	13 FUR WEDICARE	& MEDICAID SERVICES	,		· · · · · · · · · · · · · · · · · · ·	OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	AULTIF ILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		24G502	B. WI	NG		C 01/17/2008
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY STATE, ZIP CODE	
				1	25 STATE STREET	
MNEXT	ENDED TREATMENT			C	AMBRIDGE, MN 55008	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
W 289	Continued From pa	ge 48	W	289	object of effecting	
	40 (the facility's spe	ecially constituted committees'			appropriate revision to	the
	pre-approved restri	ctive behavior management			client's IPP in order t	0
		was last updated on			reduce the need for res	straint.
		7 with a duration of one year.				
		to decrease his "maladaptive for three consecutive months.			Persons Responsible: So	cott
		cueing the client to "stop" and if			TenNapel, Ph.D. L.P., M	
		he behavior he would be			Clinical Director	
	directed to go to a	quiet setting and staff would				
		iques. The specific calming			The facility will chang	e its 2/26/08
		ot delineated. If the client did			policy regarding emerge	
		or he again would be cued to			of manual restraint of	-
		on the floor." If the client did			placed in the ICF/MR pr	
		d be manually restrained in a then mechanically restrained				_
		leg hobbles, and turned to his			effect an immediate red	·
		'safe." After he was calm for			in use of restraint by	
		hobbles would be released			ing the standard of sev	
		ve minutes of being calm his			behavior for which emer	-
		released. If the client followed			of manual restraint is	indicated.
		ked to lie down on the floor the			Specifically, no use of	restraint
		ontinue with mechanically			will be prescribed for	use in
		the handcuffs and hobbles. e 40 was not incorporated into			response to any behavio	or which
		alternatives to his maladaptive			does not pose a risk of	
	behavior plan.				serious injury.	·
	DI 1 1/01				- -	·
		record was reviewed and			The facility will chang	ge its
		as moderate mental and a brain stem tumor. The			policy on emergency use	
		of physical aggression,			psychotropic medication	i i
		riors, and property destruction.			ensure that such use is	
	" Client #8's target I	behaviors include: "actual or			exclusively for the red	
		that may cause pain or harm			of symptoms of an ident	
		g: lunging at others, biting,				.1116A
		kicking, slapping, pushing			psychiatric condition.	ļ
		ms at people, and spitting;" ject in a manner that causes				
	manipulating at 00	jeden a manner mat causes				J

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significant damage to that object based upon its

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		AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	<u>. 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	}``	IULTIP ILDI N G	ELE CONSTRUCTION	(X3) DATE S COMPLE	ETED
		24G502	B. WII	NG		1	C
		240502				01/1	7/2008
NAME OF P	ROVIDER OR SUPPLIER			,	EET ADDRESS, CITY, STATE, ZIP CODE		
MN EXTE	NDED TREATMENT				25 STATE STREET AMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 289		ge 49 function, and/or poses risk to used as a weapon; including	W:	289	The facility will revise policy on programmatic restraint (i.e., "Rule	use of	2/26/08
	slamming doors an of intent, that may o slapping, hitting, so	d acts against self, regardless cause significant injury (i.e. ratching, biting self, pounding			programs) for clients program to	olaced to reduce	
	The client's signs o checking doors, ign	surfaces or head banging.)." f agitation include: "running, oring staff directions, and loud			by increasing the stand severity of behavior for	dard of	
	that the client's alte	nt #8's behavior plan indicates rnative to agitation is to "take a sueing 80% of the time for two			use of restraint is inc Specifically, no use of	dicated.	
	consecutive month: Rule 40 plan revise duration of one yea the client's utilization	s. In addition, the client has a d on August 22, 2007, with a r. The objective is to decrease n of physical aggression, and self-injurious behaviors			will be prescribed for response to any behavior does not pose a risk of serious injury.	or which	
	exhibits any of the a are to cue the clien down on the floor. I on the floor, the sta	nsecutive months. If the client above target behaviors staff to stop the behavior and lie f the client does not lie down ff are to manually restrain the			All staff assigned to the ICF/MR building will be trained to this change.		
	handcuffs to his writhe client lies down handcuffs and leg h Once the client is "s	sition and then apply st and hobbles to his legs. If on the floor independently the lobbles will still be applied. safe" he will be turned onto his e calm for five minutes and			Persons Responsible: Do Bratvold, METO Director TenNapel, Ph.D., L.P., Clinical Director	r; Scott	
	then the leg hobble another five minute removed. The use	s will be released. After s of calm the handcuffs will be of the Rule 40 was not e clients plan for alternatives			Effective 01-08, the faincreased requirements QMRP oversight of emergof restraint to include	for gency us	
	autism and deafnes facility in August 20	rate mental retardation, is. She was admitted to the 00. Her behaviors include tables, counters or desk;			evaluation of factors that have contributed to the restraint, effectiveness restrictive alternative	e use of ss of le	ss

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throwing, ripping, or slamming objects; biting or

cutting herself, hitting the wall with her fist; or

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specific recommendations for changes

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		HAND HUMAN SERVICES E & MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-039
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		24G502	B Wit	1G _		C
11115 05 5	DOLUBED AR AUDDUS	246302				01/17/2008
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	
MN EXT	ENDED TREATMENT				425 STATE STREET AMBRIDGE, MN 55008	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT	CTION (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
W 289	Continued From pa	age 50	W	289	to the client's IPP to	reduce
		ers by hitting, biting, scratching,			need for further restra	aint, and
j		pushing, etc. A psychological			communication/collabora	ation with
		February 14, 2006, indicated			members of the Expanded	i
	that client #2 "cont	vior at a high frequency," which			Interdisciplinary Team,	, including
		onth to month and ranges from			the legal representativ	re and
		pisodes. The majority of the			County case manager. QN	MRP
		sidered "minor" in severity.			documentation is record	
		cated that the client is overall			newly developed form ar	nd will be
	_	baseline. "There will most likely			tracked as part of ongo	
		sk" that client #2 will aggress cause considerable harm to			audits.	71.1.g 1110
}		son of informed consents for			dddieb.	
ļ		res dated October 28, 2006 to			Persons Responsible: So	rott
		and October 24, 2007 to			TenNapel, Ph.D., L.P.,	
<u> </u>		ndicates the reasons for the			Clinical Director	METO
		s were basically the same. The			Climical Director	
		icates that restraints are of behavior. The controlled			IDDa for all aligner m	10-04 - 010-10-
		erminated when the client has			IPPs for all clients pl	
		months of "zero physical			the facility's ICF/MR p	· -
		continues to be put in			will be revised to effe	
	restraints (see Tag	128).			immediate reduction in	
	Client #6 has sour	re mental retardation and has a			of restraints by increa	=
1		al deterioration since			standard of severity of	
		le was admitted to the facility in			for which use of restra	aint is
		cific behaviors include biting,			indicated. Specifically	/, no use
		g, head-butting, hair pulling,			of restraint will be pr	rescribed
}	-	#6's Rule 40 methodology			for use in response to	any
]		#6 exhibits signs of agitation uching staff, not responding to			behavior which does not	pose a
]		pacing, perseverating, yelling,			risk of immediate, seri	ious injury.
}		staff will provide the client a				
	cue to stop the beh	avior. If the client does not			Persons Responsible: So	cott
ļ		staff will escort the client to			TenNapel, Ph.D., L.P.,	METO
ļ		rivate place. If client #6			Clinical Director; Beth	
	continues to engag	e in the behavior, staff will			Toll's Dathers Dide and	OMBR

manually restrain his arms and apply a RIPP belt

Julie Patten, BA3s and QMRPs

CENTER	13 FUR MEDICARE	A MEDICAID SERVICES				OMB MC	<u> </u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	IULTIPLE	CONSTRUCTION	(X3) DATE S COMPL	LETED
		24G502	B WII	4G		01/	C 17/2008
NAME OF P	PROVIDER OR SUPPLIER			1	T ADDRESS, CITY, STATE, ZIP CODE		
MN EXT	ENDED TREATMENT				S STATE STREET MBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	JD PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 289	cuff's to the client's indicates the restrathe client has zero aggression, self injuobjects) over three than providing a cuno mention of intenthe client's behavior the development of to assist staff in kneexhibit behaviors. For present, client #6 cand he continues to these behaviors. The stop the "maladaptiof how staff would behaviors. Employee (B)/beha (C)/human services and employee (D)/fonsite on January folient #6's restraints	i, and staff will apply Posey wrists. A Rule 40 addendum aints will be terminated when incidents of physical ury, and PICA (eating inedible consecutive months. Other is to stop the behavior, there is ventions to modify or prevent ors. There is no indication of a list of antecedent behaviors owing when the client might from the day he arrived to continues to exhibit behaviors to be restrained for exhibiting the focus on the plan was to live behavior" with no indication elicit or strengthen appropriate avioral analyst I, employee is support specialist (HSSS), HSSS, were interviewed while 10-11, 2007, and stated that is are not effective, however	W	289			
	written. Employee (E)/admi on January 31, 200 the clients admitted restrained to reduce dangerous or likely When two specific restrained, related to mentioned by the instated that from the reviewed, the risk a	inistrative staff was interviewed as at 9:30 a.m. and stated that d at the facility should only be e target behaviors that are to lead to dangerous behavior. examples of client #3 being to television viewing, were nivestigator, employee (E) e sounds of the examples analysis (risk of continuing the risks of restraining) is "all out of					

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CENTER	KS FUR MEDICARE	& MEDICAID SERVICES				OWR NO	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ULTIPL LDING	E CONSTRUCTION	(X3) DATE SO COMPLE	TED
		24G502	B. WIN	IG		1	C 7/2008
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
MN FXTE	ENDED TREATMENT			142	5 STATE STREET		
				CA	MBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	(D PREF! TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ŲLD BE	(X5) COMPLETION DATE
W 289	Continued From pa whack."	ge 52	W	289			
W 295	policy. There should reviewed and open people who live in a policy is intended to people who are aganother's aggressic with interpersonal to observe the practic touched another cliidangerous situation 483.450(d)(1)(i) PH	YSICAL RESTRAINTS	W	295	IPPs for all clients pl in the facility's ICF/M		2/26/08
	an integral part of a is intended to lead I	ploy physical restraint only as n individual program plan that to less restrictive means of inating the behavior for which ied.			program will be revised to ensure that each client's program includes a specifi system of positive (non-av response to behaviors that		
	Based on interview has failed to utilize reduce the restraint	s not met as evidenced by: and record review, the facility restraints in a manner that will cor eliminate the behavior for (#2, #6, #8, and #9) in the clude:			identified as precursor more serious problem be that may result in a ne restraint. Persons Responsible: So	ehaviors eed for	
	autism and deafnes facility in August 20 clearing objects off throwing, ripping, or cutting herself; hittir trying to injure other kicking, slapping, pi	trate mental retardation, as. She was admitted to the 00. Her behaviors include tables, counters or desk; r slamming objects; biting or ng the wall with her fist; or rs by hitting, biting, scratching, ushing, etc. A psychological ebruary 14, 2006, indicated nues to engage in			TenNapel, Ph.D. L.P., M. Clinical Director; Bethand Julie Patten, BA3s The facility will imple quality management processure that the QMRP machanges to client IPPs that adequate treatment	METO and QMRI ement a cess to akes such	2/26/08

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CENTE	RS FOR MEDICARI	& MEDICAID SERVICES			OMB NO. 0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		24G502	B. WING		01/17/2008
	PROVIDER OR SUPPLIER ENDED TREATMENT		14	EET ADDRESS. CITY, STATE, ZIP COO 125 STATE STREET AMBRIDGE, MN 55008	DE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLÉTION
W 295	fluctuates from mo six to eighty-five epepisodes were con The summary indic functioning at her to always be a high ri- against others and herself. A compari- controlled procedu January 27, 2007 a January 25, 2008 if use of the restraint later document ind necessary to contriprocedure will be to three consecutive	age 53 vior at a high frequency," which inth to month and ranges from bisodes. The majority of the isidered "minor" in severity. cated that the client is overall baseline. "There will most likely sk" that client #2 will aggress cause considerable harm to son of informed consents for res dated October 28, 2006 to and October 24, 2007 to indicates the reasons for the s were basically the same. The icates that restraints are of behavior. The controlled erminated when the client has months of "zero physical 2 continues to be put in	W 295	is maintained for all who have experienced restraint. Specifica data reflecting the restraints and progret treatment will be rethe facility's Clinior other designee who health professional in psycho-educationa of individuals with disability, with the effecting appropriate the client's IPP in the need for restrain	use of lly, monthly use of ess in viewed by cal Director, o is a mental with competency l treatment developmental object of e revision to order to reduce
	restraints (see Tag Client #6 has seve history of behavior November 2006. If May 2007. His spe pinching, scratchin and kicking. Client states that if client (reaching out or to verbal redirectives or screaming), the cue to stop the beh "immediately" stop his bedroom or a p continues to engag manually restrain in to the client's waist cuff's to the client's			Persons Responsible: TenNapel, Ph.D. L.P. Clinical Director With a policy change 11-23-07 the facilit the emergency use of restraint of any cli in the ICF/MR prograt assigned to the ICF/ have been trained to Persons Responsible: Bratvold, METO Direct TenNapel, Ph.D., L.P. Clinical Director	effective 2/26/08 y prohibited mechanical ent placed m. All staff MR building this change. Doug tor; Scott

restrictive behavior management practice)

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		···	OMB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER) '	PLE CONSTRUCTION	(X3) DATÉ SURVEY COMPLETED
			A. BUILDING	G	С
		24G502	B. WING		01/17/2008
NAME OF F	PROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	
MN EXT	ENDED TREATMENT			425 STATE STREET AMBRIDGE, MN 55008	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLÉTION
W 295	Continued From pa	ge 54	W 295	The facility will chang	e its
	addendum indicate	s the restraints will be		policy regarding emerge	ncy use
	terminated when th	e client has zero incidents of		of manual restraint of	clients
		n, self injury, and PICA (eating		placed in the ICF/MR pr	ogram to
		er three consecutive months.		effect an immediate red	-
		g a cue to stop the behavior,		in use of restraint by	
		of interventions to modify or behaviors. There is no		the standard of severit	
		velopment of a list of		behavior for which emer	
		ors to assist staff in knowing			<u> </u>
		ht exhibit behaviors. From the		of manual restraint is	
	_	esent, client #6 continues to		Specifically, no use of	
	exhibit behaviors a	nd he continues to be		will be prescribed for	use in
	restrained for exhib	iting these behaviors. The		response to any behavio	r which
		as to stop the "maladaptive		does not pose a risk of	immediate,
		idication of how staff would appropriate behaviors.		serious injury.	
	Client #9's medical	record was reviewed and his		The facility will chang	e its 2/26/08
		mild mental retardation and		policy on emergency use	of
		istory physical aggression,		psychotropic medication	s to
		iors, and property destruction		ensure that such use is	
		ated or angry, exhibiting		exclusively for the red	
		ous behaviors, ignoring staff I vocalizations." His target		symptoms of an identifi	
		hysical aggression-"Actual or			eu
		d/or cause pain or harm to		psychiatric condition.	
		nitting, biting, scratching,			
		ushing others, throwing items		The facility will revis	
	at people, and spitt	ing at others;" self-injurious		policy on programmatic	use of
		gainst self that are intended to		restraint (i.e., "Rule	40"
		apping, hitting, scratching,		programs) for clients p	laced
		body parts on hard surfaces		in the ICF/MR program to	o reduce
		Client #9's program plan he exhibits symptoms of		the use of programmatic	
		native to the agitation will be to		by increasing the stand	
		ddition, the client has a Rule		severity of behavior fo	
		st updated on September 13,			
		n of one year. The objective		use of restraint is ind	
		"maladantive hehaviors" to		Specifically, no use of	restraint

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO: 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		24G502	B. Wil	۷G _		01/17/2008
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	
MN EXT	ENDED TREATMENT			l	1425 STATE STREET CAMBRIDGE, MN 55008	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREG (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
W 295	Continued From pa	age 55	W:	295	will be prescribed for	use in
,	zero for three cons	ecutive months. The plan			response to any behavi	or which
		e client to "stop" and if the			does not pose a risk c	of immediate,
		pehavior he would be directed			serious injury.	
		ting and staff would offer			.	
		s. The specific calming			All staff assigned to	the ICF/MR
		ot delineated. If the client did ior he again would be cued to			building will be train	
		on the floor." If the client did			=	ed to this
	•	Id be manually restrained in a			change .	
		then mechanically restrained				
,		leg hobbles, and turned to his			Persons Responsible: D	oug
ļ		'safe." After he was calm for			Bratvold, METO Directo	r; Scott
	five minutes his leg	hobbles would be released			TenNapel, Ph.D., L.P.,	METO
}	and after another fi	ive minutes of being calm his			Clinical Director	
		e released. If the client followed				•
		ked to lie down on the floor,			TIES-21-1-1-1 01 00 11-1	
		ld continue with mechanically			Effective 01-08, the f	
	_	the handcuffs and leg			increased requirements	
		of the Rule 40 was not			oversight of emergency	use of
		ne clients plan for alternatives			restraint to include e	nhanced
	to his maladaptive	benavior plan.			evaluation of factors	that may
]	Client #8's medical	record was reviewed and			have contributed to th	e use of
		as moderate mental			restraint, effectivene	
}		, and a brain stem tumor. The			restrictive alternativ	
		of physical aggression,				=
	self-injurious behav	viors, and property destruction.			specific recommendation	
	" Client #8's target	behaviors include: "actual or			changes to the client'	
		r that may cause pain or harm			reduce need for furthe	r restraint,
		ig: lunging at others, biting,			and communication/coll	aboration
		kicking, slapping, pushing			with members of the Ex	panded
		ms at people, and spitting;"			Interdisciplinary Team	, including
		ject in a manner that causes to that object based upon its			the legal representati	-
		function, and/or poses risk to			case manager. QMRP doc	
		used as a weapon; including			is recorded on a newly	
1		d acts against self, regardless			-	•
		cause significant injury (i.e.			form and will be track	-
		ratching, biting self, pounding			of ongoing file audits	•

<u> </u>	10 1 OIL MEDICALLE	C WEDIONID OF THE				ONID (10. 0000 0001
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1' '	AULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
						l c
		24G502	B. Wi	NG		01/17/2008
	ROVIDER OR SUPPLIER		_	14	EET ADDRESS, CITY, STATE, ZIP CODE 25 STATE STREET	
				C	AMBRIDGE, MN 55008	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
W 295	Continued From pa	ge 56	W	295	Persons Responsible: S	cott
		surfaces or head banging.)."			TenNapel, Ph.D., L.P.	METO
		f agitation include: "running,			Clinical Director	
		oring staff directions, and loud				
		t #8's behavior plan indicates			IPPs for all clients p	laced in 2/26/08
		rnative to agitation is to "take a cueing 80% of the time for two			the facility's ICF/MR	
		s. In addition, the client has a			will be revised to eff	
		d on August 22, 2007, with a			immediate reduction in	
		r. The objective is to decrease				
		n of physical aggression,			of restraints by incre	-
		n, and self-injurious behaviors			standard of severity o	
		nsecutive months. If the client			for which use of restr	
		above target behaviors staff			indicated. Specificall	y, no use
		t to stop the behavior and lie f the client does not lie down			of restraint will be p	rescribed
		f are to manually restrain the			for use in response to	any
		sition. Then apply handcuffs to			behavior which does no	t pose a
		bbles. If the client lies down on			risk of immediate, ser	ious
		ntly the handcuffs and leg			injury.	
		applied. Once the client is				
		ned onto his side. He needs to			Dergong Rognongible: C	cott
		nutes and then the leg hobbles			Persons Responsible: S	
		ter another five minutes of will be removed. The focus on			TenNapel, Ph.D., L.P.,	
		o the "maladaptive behavior"			Clinical Director; Bet	
	•	f how staff would elicit or			and Julie Patten, BA3s	and QMRPs
	strengthen appropr					
	Employee (B)/beha	vior analyst one was				
	interviewed on Janu	uary 11, 2008 at 8:10 p.m. and				
		client exhibits a behavior that				
	could lead to injury	such as physical aggression				
		naviors, or if a client is				
		erty, The staff utilize the				i
		s: personal boundaries,				
		eing, then escort, and then client has a Rule 40 restraint				
		as written. In addition, the				
	•	adividualized However the				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
		24G502	B WII	VG	C 01/17/	2008
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 1425 STATE STREET CAMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
W 295	metal handcuffs or hobbles (the cuffs or Posey board, an ICF/MR with Rule 4 handcuffs (metal or Employee (E)/admit on January 31, 200 the clients admitted restrained to reduce dangerous or likely When two specific restrained, related mentioned by the instated that from the reviewed, the risk a activity versus the risk a	the Rule 40 clients have been Posey soft handcuffs and leg an hobbles are used together), d of the five clients in the 10's all but one are put in Posey) and leg hobbles. Inistrative staff was interviewed 8 at 9:30 a.m. and stated that at the facility should only be a target behaviors that are to lead to dangerous behavior. Examples of client #3 being to television viewing, were exestigator, employee (E) a sounds of the examples inalysis (risk of continuing the lisks of restraining) is "all out of the cole does not have a "no-touch"	W	295		
W 296	policy. There should reviewed and open people who live in a policy is intended to people who are aganother's aggressic with interpersonal beobserve the practic touched another clid dangerous situation 483.450(d)(1)(ii) Photos The facility may emergency measure	d be "household agreements," for negotiation, made by the household. The "no-touch" be a therapeutic support for gressor's, the recipient of on, or there are other problems coundaries. If a client failed to be of "no-touch" and simply ent, that would not constitute a	W	The facility has documentation for strative review use of restraint less intrusive to	rmat and admini process for any , to assure tha	-

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Event (D; DRV111

Facility ID: 00293

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CENTER	13 FUR MEDICARE	A MIEDICAID SERVICES			UNID INU	<u>. บรวด-บวร เ</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	ULTIPLE CONSTRUCTION LDING	(X3) DATE S COMPLI	ETED
			B WIN	4G		С
	···	24G502			01/1	7/2008
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
MN EXTE	ENDED TREATMENT			CAMBRIDGE, MN 55008		
	01011101101101	7514517 05 8551015140150		L 		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
W 296	Continued From pa	ige 58	W 2	296 tried and found to b	e ineffectiv	ле
		s not met as evidenced by:		or reasons why less	intrusive	
		and record review, the facility known client behavior thus		interventions could	not be used.	
	•	ts were unnecessarily utilized				
	in place of alternati	ve interventions for three of		The facility has est		
		, and #9), in the sample.		debriefing process t		
	Findings include:			and provide coaching	, regarding	
	Client #2's modical	record was reviewed and		staff implementation	of restrain	nt.
		is mild mental retardation,				
		tis, osteoarthritis, limited range		IPPs for all clients	placed in	2/26/08
		leg, a history of knee pain,		the facility's ICF/M	IR program	
	and prefers to use	a wheelchair. A review of his		will be revised to e	nsure that	
		plan (IPP) revealed that when		each client's progra	ım includes	
		ed, he displays verbal and		a specific system of	positive	
		n and after he has asked for		non-aversive) respon	ise to	
		increasingly agitated when nim to complete tasks		behaviors that are i		3
		eview of the facility's		precursors to more s		
		Emergency Use of Controlled		behaviors that may r	-	
		d emergency restraints were		need for restraint.	esure in a	
		оп March 29, 2007, May 10,		need for restraint.		
		7, June 23, 2007, multiple		D D '1 1-	0 - 1 1	
		2007, September 6, 2007, and		Persons Responsible:		
	•	2007, for behavior that the cates is likely to re-occur,		TenNapel, Ph.D. L.P.		
		vior should have been		Clinical Director; E		
	anticipated by staff			and Julie Patten, BA	.3s and QMRPs	5
	•	escalate the situation instead				
		tuation. In addition, given the		The facility will im	plement a	2/26/08
		of degenerative arthritis,		quality management p	-	_,,
		knee pain the use of handcuffs is severe. In addition, on		ensure that the QMRP		ies
		ay 10, 2007, and two incidents		to client IPPs such		
		as a result of being physically		treatment velocity i		
		lient #3 hit or shoved the staff		-		
	that were escorting			for all clients who		ıncea
				use of restraint. Sp	-	
	Client #4's medical	record was reviewed and		monthly data reflect	ing the use	of

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) N A. BU		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
L		24G502	B. WII	NG		C 01/17/2008
	PROVIDER OR SUPPLIER ENDED TREATMENT			14	EET ADDRESS, CITY, STATE, ZIP CODE 125 STATE STREET AMBRIDGE, MN 55008	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	X	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE COMPLETION
W 296	asthma, epilepsy, and throwing persocilent's history indicagitated or angry substantial behaviors. A review "Documentation for Procedure" revealed utilized for 50 minus 2007 for touching strying to shove statiwas first manually restrained.	nas mild mental retardation, and a history of poking others onal items at others heads. The cates that when she gets he may display maladaptive	W	296	restraints and progress treatment will be revie the facility's Clinical or other designee who i health professional wit competency in psycho-ed treatment of individual developmental disabilit the object of effecting appropriate revision to client's IPP in order t the need for restraint.	wed by Director, s a mental h lucational s with y, with the the
	diagnoses included autism. According history of physical behaviors, and progets frustrated or a injurious behaviors loud vocalizations." Documentation fo Procedure" revealed utilized on client #\$ 2007, on August 2-2007, for inappropand biting himself, and therefore shoulinterventions implesituation instead of addition, the use of was severe given the Employee (B)/behavioretelesses interviewed on Janand stated that employers and stated that employers in the stated interviewed on Janand stated that employers and province in the stated interviewed on Janand stated that employers in the stated interviewed on Janand stated in the stated interviewed on Janand stated in the stated interviewed on Janand stated in the stated in the stated interviewed on Janand stated in the stated in	d mild mental retardation and to the client's IPP, he has a aggression, self injurious perty destruction. When he ingry, he exhibits "running, self, ignoring staff directions, and "A review of the facility's r Emergency Use of Controlled ed emergency restraints were multiple times on August 5, 4, 2007, and on September 28, riate laughter, hitting himself, The behaviors were knowned have been anticipated and imented to de-escalate the escalating the situation. In f handcuffs and leg hobbles he nature of the behavior. avioral analyst I was uary 11, 2008 at 8:10 a m., ergency restraints are utilized ace to address inappropriate			Persons Responsible: So TenNapel, Ph.D. L.P., M Clinical Director With a policy change effective 11-23-07 the facility prohibited the emergency use of mechanists and the ICF/MR program. Staff assigned to the building have been traited this change. Persons Responsible: De Bratvold, METO Director TenNapel, Ph.D., L.P., Clinical Director	2/26/08 e nical t placed All ICF/MR ined oug r; Scott

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behaviors.

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اً ق معملین معیمی میدادمد : (عام آن الاحتیار محجازی ا

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	<u>. 0938-0391</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Ι΄.	IULTIPL	E CONSTRUCTION	(X3) DATE \$1 COMPLE	
		24G502	B. WII	√G		1	C 7/2008
	PROVIDER OR SUPPLIER			142	ET ADDRESS, CITY, STATE, ZIP CODE 25 STATE STREET IMBRIDGE, MN 55008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 296	Continued From pa	nge 60	W	296			
	on January 31, 200 the clients admitted restrained to reduce dangerous or likely. When two specific restrained, related mentioned by the irreviewed, the risk a activity versus the reviewed and open people who live in a policy is intended to people who are aganother's aggression.	inistrative staff was interviewed 8 at 9:30 a.m. and stated that at the facility should only be target behaviors that are to lead to dangerous behavior. examples of client #3 being to television viewing, were neestigator, employee (E) a sounds of the examples analysis (risk of continuing the risks of restraining) is "all out of the old does not have a "no-touch" doe "household agreements," for negotiation, made by the a household. The "no-touch" of be a therapeutic support for gressor's, the recipient of on, or there are other problems			The facility will chang its policy regarding emuse of manual restraint clients placed in the I program to effect an imreduction in use of resty increasing the stand severity of behavior for emergency use of manual is indicated. Specificate use of restraint will be prescribed for use in restraint which do not not any behavior which do not not not not not not not not not no	of CF/MR mediate traint lard of restrai lly, no e esponse loes not e, seric	
W 304	observe the practic touched another cli dangerous situation	ooundaries. If a client failed to e of "no-touch" and simply ent, that would not constitute a n. SICAL RESTRAINTS	w:	304	The facility will chang		2/26/08
	Restraints must be to cause physical in	designed and used so as not ijury to the client.			policy regarding use of restraint, both emergen programmatic, to ensure staff response to a sit	cy and that	
	Based on interview failed to protect clie a restraint procedu	s not met as evidenced by: and record review, the facility ints from physical injury during re for three of nine clients (#6, lle who had behaviors.			indicating use of manual restraint follows a sequent application of physical beginning with the least intrusive technique like	uential techniq	ues,

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effect significant change in

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		ULTIPLE CONSTRUCTION LDING	(X3) DATE SURVEY COMPLETED
		24G502	8 WII	NG	01/17/2008
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1425 STATE STREET CAMBRIDGE, MN 55008	ODE
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF CO IX (EACH CORRECTIVE ACTIO	N SHOULD BE COMPLETION E APPROPRIATE DATE
W 304	record, on August client "began to cormanner. Staff redirwent in room but caseconds. [Client #6 with force. Staff impleadility's specially or pre-approved restripractice), by first put [Client #6] resisted claw and grab at st knees but continue implemented an art this, [client #6] turn another staff, grabt moment implement arm pop. Staff immander take down and aler laid on the ground that aggress by grabbin had possible injury attempted to keep [left arm. Staff verbacalm down [Client was still struggling. R.N." A splint was a transported to the had technicians. Client fracture and was accontrol after his arm returned to the facilireturned to the hos	ess notes in client #6's medical 11, 2007, at 8:11 a.m. the me at staff in an aggressive ected client to room. [Client #6] ame out again within several 1] then began to grab at staff plemented Rule 40 (the postituted committees' ctive behavior management auting [client #6] in an arm bar, the arm bar and continued to aff. [Client #6] went to his dot fight. Staff then in bar take down. As staff did ed away from implementor to bing and clawing. At this for felt and heard upper left rediately stopped the arm bar ted the other staff. [Client #6] face down but still attempted to go at staff, even though left arm the aggressed with it. Staff (client #6] still, especially his ally prompted [client #6] to #6] calmed down a little but Staff called 9-1-1 and notified applied and the client was nospital by emergency medical #6 had a left distal humerus dmitted to the hospital for pain in was set and splinted. He lity on August 13, 2007. He pital on August 28, 2007 for s fractured arm and returned	W:	more intrusive techn if less intrusive te been tried and are u or if the risk of at less intrusive techn unacceptably high. S the physical techniq with the injury to C would not be the leatechnique and theref be the first to be a barring an unaccepta were not used first. will be trained to t Persons Responsible: Bratvold, METO Director TenNapel, Ph.D., L.P. Clinical Director The facility will improgram of staff debtor the purpose of dewhether each use of restraint was clinical appropriate, i.e., win risk of negative against the risk of the continuation of	gressing to iques only chniques have nsuccessful, tempting iques is pecifically, que associated flient #6 st intrusive ore would not pplied, ble risk if it All staff his policy change. Doug tor; Scott ., METO plement a 2/26/08 riefing, etermining emergency ally as balanced impact allowing the
	According to docume on October 12, 200	nentation on incident reports, 7, at 8:30 a.m., client ckel sized swelling right outer		behavioral situation triggered the use of and fully adherent to policy. Debriefing w	restraint, o facility

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CENTER	RS FOR MEDICAR	E & MEDICAID SERVICES			OMB NO. 0938-039
	OF DEFICIENCIES OF CORRECTION	CIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE SURVEY COMPLETED	
		24G502	8 WIN	VG	C 01/17/2008
	ROVIDER OR SUPPLIER	,		STREET ADDRESS. CITY. STATE, ZIP C 1425 STATE STREET CAMBRIDGE, MN 55008	ODE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF TAG		ON SHOULD BE COMPLETION E APPROPRIATE DATE
W 304	Client reportedly wattempted to move during restraint ho permit it to remain behavior for which recorded on the "Duse of Controlled October 12, 2007, client #7 was asked medication. The client was put in a position. After two were applied. The Documentation in procedure, client #6 crying, stating shed nurse assessments."	Two bruised areas present. It is banging head on floor. Staff or pillow under client's head wever the client would not there." Description of the client #7 was restrained, Documentation for Emergency Procedure" form, dated at 8:35 a.m. indicated that and ient began yelling and when staff entered the attempted to hit staff. The manual restraint in prone minutes, mechanical restraints procedure ended at 8:55 a.m. dicated that after the restraint for the restr	W:	Administrative Office Day within 60 minute each use of emergence Data regarding this will be incorporated facility performance monitoring plan. Persons Responsible: Bratvold, METO Direct TenNapel, Ph.D.,L.P. Clinical Director The facility will im program of debriefing aftercare for client each use fo emergence matic restraint, that appropriate to the	cer of the es following ey restraint. debriefing d into the e improvement Doug etor; Scott , METO splement a 2/26/08 eg and es, following ey or program- et is

On December 11, 2007, at 5:10 p.m. a staff person was getting water from client #7's refrigerator when the client, "came at staff yelling." The client "lunged at staff, threw a glass of water at staff, came at staff with fists raised." Staff executed an arm bar take down into a manual hold. The client struggled, scratched and yelled for twenty minutes. The nurse assessment indicated the color of the client's face and hands remained normal even though she yelled she couldn't breathe. At 5:30 p.m., client #7 was crying and went into her room. Documentation indicated the client said she was "sore." An incident report indicated that "during emergency restraint [client #7] was struggling, refusing to take her right arm out from under her chest, a

The facility will implement a 2/26/08 program of debriefing and aftercare for clients, following each use fo emergency or programmatic restraint, that is appropriate to the developmental level of the client, for the purpose of minimizing emotional anguish, through assisting the client to understand the circumstances giving rise to the need for restraint or emergency medication, and identifying strategies or modifications to the client's IPP or program environment that might reduce the need for future use of restraint or emergency medication.

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CLIVIL	10 I ON MEDICARE	G MEDICAID SERVICES		_		OND 110. 0330-0331		
	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) M		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
						С		
		24G502	B WII	₩G		01/17/2008		
	PROVIDER OR SUPPLIER			1.	REET ADDRESS, CITY, STATE, ZIP CODE 425 STATE STREET			
				C	AMBRIDGE, MN 55008			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION		
W 304	Continued From pa	_	W	304	Debriefing will be condu	ucted 2/26/08		
		ner right elbow due to resisting			by staff assigned to each	ch		
	on carpeted area."				client's living unit, an	nd will		
	A : atal a 4	datad Cantambas 12 2007 at			be guided by a written p	olan		
		dated September 13, 2007, at distinct data.			developed by the client			
		nis bedroom and banged his			treatment team and monit			
	head against the wall. He sustained a two centimeter abrasion mid-forehead and a two				for appropriateness by the QMRP.			
		n on his right temple.			Domanna Domannikla a			
		pehavior for which client #9			Persons Responsible: Scott			
		orded on the Documentation			TenNapel, Ph.D., L.P., N			
		of Controlled Procedure form,			Clinical Director; Beth			
		3, 2007, at 8:10 a.m., client #9 was doing his			and Julie Patten, BA3s a	and QMRPs		
		ed his hamper. Walked to his						
	•	amper lid, talking to himself			With a policy change eff	Eective 2/26/08		
		n said "shot" and went toward			11-23-07 the facility pr			
		ed if he was okay [and]			the emergency use of med			
	opened his bedroom	m door." Client #9 was			restraint of any client			
		physical aggression-pulled				_		
		ed, scratched staffs shoulder			in the ICF/MR program. A			
		uring manual restraint, the			assigned to the ICF/MR h	•		
	restraints were app	two minutes so mechanical lied. The client continued to			have been trained to thi	s change.		
		of twenty-nine minutes. The			Persons Responsible: Dou	ıq		
		t 8:44 a.m. At 2:32 p.m., his mental health review [and]			Bratvold, METO Director;	-		
		ot out side he yelled, "pop,			TenNapel, Ph.D., L.P., M			
		to flick his fingers infront of			Clinical Director	IB10		
		pidly [and] his body was			Clinical Director			
		the household, grabbed staff						
		lers [and] shook her." Client #9			The facility will change			
		to physical aggression			policy regarding emergen			
		shoulders [and] began to			of manual restraint of o	=		
		ent struggled for thirteen m. client #9 received two			placed in the ICF/MR pro	gram to		
		IM. The restraint procedure			effect an immediate redu	t an immediate reduction in		
	ended at 2:55 p.m.,				use of restraint by incr	easing		
	r				the standard of severity			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	-	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF COMPLET		TED	
	24G502	8 WIN	IG		ı	C 7/2008
NAME OF PROVIDER OR SUPPLIER MN EXTENDED TREATMENT			1425	FADDRESS, CITY, STATE, ZIP CODE STATE STREET IBRIDGE, MN 55008	_1	,, <u>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</u>
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
on January 10, 2008 the injuries related to redness from the ha (client #6). The major	nistrative staff was interviewed 8 at 10:15 a.m. and stated that to restraint use have included andcuffs, and one broken arm ority of the bumps, bruises, e head, knees, and elbows	W 3	ma Sp w: re do	or which emergency use of anual restraint is indicepted for use of rill be prescribed for uses as posses to any behavior to see the second posses as a risk of interious injury.	ated. estraint e in which	
			po ps to ex os	ne facility will change olicy on emergency use of sychotropic medications of ensure that such use it acclusively for the reduct symptoms of an identification.	f s tion	2/26/08
			por reference properties that the by see of specific with the properties of specific with the properties of the properti	ne facility will revise olicy on programmatic usestraint (i.e., "Rule 40 rograms) for clients placed in the ICF/MR program to reduce use of programmatic revision of the standard everity of behavior for the restraint is indicated pecifically, no use of restraint is indicated pecifically, no use of response to any behavior the seponse to any behavior the seponse to any behavior the seponse a risk of interious injury.	e of ded in uce estraint d of which use estraint e in which	2/26/08
			((Continued on attached sh	eet)	

ID		
Prefix Tag	Action Taken as Part of Plan of Correction	Expected Date of Completion
W122 (Cont.)	The facility will change its policy regarding emergency use of manual restraint of clients placed in the ICF/MR program to effect an immediate reduction in use of restraint by increasing the standard of severity of behavior for which emergency use of manual restraint is indicated. Specifically, no use of restraint will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury.	2/26/08
	The facility will change its policy on emergency use of psychotropic medications to ensure that such use is exclusively for the reduction of symptoms of an identified psychiatric condition.	
	The facility will revise its policy on programmatic use of restraint (i.e., "Rule 40" programs) for clients placed in the ICF/MR program to reduce the use of programmatic restraint by increasing the standard of severity of behavior for which use of restraint is indicated. Specifically, no use of restraint will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury.	
	All staff assigned to the ICF/MR building will be trained to this change.	
	Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D., L.P. METO Clinical Director	
	Effective 01-08-08 the facility implemented a process of disclosure, for use at admission to the facility, involving clients, legal representatives, and members of clients' Expanded Interdisciplinary Teams, describing the facility's policy regarding emergency use of restraints, including a written and photographic description of restraints used, soliciting concerns from clients and their teams regarding the facility's use of restraint, and offering consultation with clinical staff toward identification of alternatives to restraint.	2/26/08
	Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D., L.P. METO Clinical Director; Kim Palmer and Connie O'Brien, METO Social Workers	
	The facility increased requirements for Registered Nurse oversight of restraint use to include direct examination and documentation of the client's response to each implementation of restraint, effective 11-07.	2/26/08
	Persons Responsible: Doug Bratvold, METO Director; Shirley Davis, R.N. METO Nursing Supervisor	
 	Effective 01-08, the facility increased requirements for QMRP oversight of emergency use of restraint to include enhanced evaluation of factors that may have contributed to the use of restraint, effectiveness of less restrictive alternatives attempted, specific recommendations for changes to the client's IPP to reduce need for further restraint, and communication / collaboration with members of the Expanded Interdisciplinary Team, including the legal representative and County case manager. QMRP documentation is recorded on a newly developed form and will be tracked as part of ongoing file audits.	2/26/08
	Persons Responsible: Scott TenNapel, Ph.D., L.P. METO Clinical Director	

ID		
Prefix	Action Taken as Part of	Expected Date
Tag	Plan of Correction	of Completion
W122 (Cont.)	IPPs for all clients placed in the facility's ICF/MR program will be revised to effect an immediate reduction in the use of restraints by increasing the standard of severity of behavior for which use of restraint is indicated. Specifically, no use of restraint will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury. Persons Responsible: Scott TenNapel, Ph.D., L.P. METO Clinical Director; Beth Klute and Julie Patten, BA3s and QMRPs	2/26/08
	The facility implemented a staff training initiative to increase staff skill in positive behavior management (alternatives to restraint) effective December 14, 2007. All staff currently assigned to the ICF/MR program will receive this training. This training has also been added to the new employee orientation curriculum, and to the annual staff refresher training curriculum.	2/26/08
	The facility implemented a staff training initiative to increase staff awareness of the adverse impact of restraint use effective December 20, 2007. All staff currently assigned to the ICF/MR program will receive this training. This training has also been added to the new employee orientation curriculum, and to the annual staff refresher training curriculum.	
	Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D., L.P. METO Clinical Director; Pam Zimmerman, Staff Development Coordinator	
W266 (Cont.)	restraint is used in emergencies only as absolutely necessary to protect the safety of clients or others; and ensure that restraints are designed and used so as not to cause injury to the client. The facility will ensure compliance with this standard through actions specified in responses to tags W268, W278, W285, W288, W289, W295, W296 and W304. Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D., L.P., METO	2/26/08
	Clinical Director	
W268 (Cont.)	curriculum, and to the annual staff refresher training curriculum. The facility implemented a staff training initiative to increase staff awareness of the adverse impact of restraint use effective December 20, 2007. All staff currently assigned to the ICF/MR program will receive this training. This training has also been added to the new employee orientation curriculum, and to the annual staff refresher training curriculum. Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D., L.P. METO Clinical Director; Pam Zimmerman, Staff Development Coordinator	2/26/08
W285 (Cont.)	restraint will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury.	2/26/08
	Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D., L.P. METO Clinical Director	
	The facility's specially constituted committee will be oriented to changes in policy regarding both emergency and programmatic use of restraint, to ensure their review and approval process meets the revised policy's increased standard of severity of behavior for which use of restraint is indicated. Specifically, no use of restraint will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury.	2/26/08
	Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D., L.P. METO Clinical Director	* · · · · · · · · · · · · · · · · · · ·
		

ID Prefix Tag	Action Taken as Part of Plan of Correction	Expected Date of Completion
W296 (Cont.)	The facility will change its policy on emergency use of psychotropic medications to ensure that such use is exclusively for the reduction of symptoms of an identified psychiatric condition.	2/26/08
	The facility will revise its policy on programmatic use of restraint (i.e., "Rule 40" programs) for clients placed in the ICF/MR program to reduce the use of programmatic restraint by increasing the standard of severity of behavior for which use of restraint is indicated. Specifically, no use of restraint will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury.	
	All staff assigned to the ICF/MR building will be trained to this change.	
	Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D., L.P. METO Clinical Director	
	Effective 01-08, the facility increased requirements for QMRP oversight of emergency use of restraint to include enhanced evaluation of factors that may have contributed to the use of restraint, effectiveness of less restrictive alternatives attempted, specific recommendations for changes to the client's IPP to reduce need for further restraint, and communication / collaboration with members of the Expanded Interdisciplinary Team, including the legal representative and County case manager. QMRP documentation is recorded on a newly developed form and will be tracked as part of ongoing file audits.	2/26/08
	Persons Responsible: Scott TenNapel, Ph.D., L.P. METO Clinical Director	
	IPPs for all clients placed in the facility's ICF/MR program will be revised to effect an immediate reduction in the use of restraints by increasing the standard of severity of behavior for which use of restraint is indicated. Specifically, no use of restraint will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury.	2/26/08
	Persons Responsible: Scott TenNapel, Ph.D., L.P. METO Clinical Director; Beth Klute and Julie Patten, BA3s and QMRPs	
W304 (Cont.)	All staff assigned to the ICF/MR building will be trained to this change. Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D., L.P. METO Clinical Director	2/26/08

ID Prefix	Action Taken as Part of	Expected Date
Tag	Plan of Correction	Expected Date of Completion
W304 (Cont.)	The facility will change its policy regarding emergency use of manual restraint of clients placed in the ICF/MR program to effect an immediate reduction in use of restraint by increasing the standard of severity of behavior for which emergency use of manual restraint is indicated. Specifically, no use of restraint will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury.	2/26/08
	The facility will change its policy on emergency use of psychotropic medications to ensure that such use is exclusively for the reduction of symptoms of an identified psychiatric condition.	
	The facility will revise its policy on programmatic use of restraint (i.e., "Rule 40" programs) for clients placed in the ICF/MR program to reduce the use of programmatic restraint by increasing the standard of severity of behavior for which use of restraint is indicated. Specifically, no use of restraint will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury.	
	All staff assigned to the ICF/MR building will be trained to this change.	
	Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D., L.P. METO Clinical Director	
	The facility increased requirements for Registered Nurse oversight of restraint use to include direct examination and documentation of the client's response to each implementation of restraint, effective 11-07.	2/26/08
	Persons Responsible: Doug Bratvold, METO Director; Shirley Davis, R.N. METO Nursing Supervisor	
	Effective 01-08, the facility increased requirements for QMRP oversight of emergency use of restraint to include enhanced evaluation of factors that may have contributed to the use of restraint, effectiveness of less restrictive alternatives attempted, specific recommendations for changes to the client's IPP to reduce need for further restraint, and communication / collaboration with members of the Expanded Interdisciplinary Team, including the legal representative and County case manager. QMRP documentation is recorded on a newly developed form and will be tracked as part of ongoing file audits.	2/26/08
	Persons Responsible: Scott TenNapel, Ph.D., L.P. METO Clinical Director	
	IPPs for all clients placed in the facility's ICF/MR program will be revised to effect an immediate reduction in the use of restraints by increasing the standard of severity of behavior for which use of restraint is indicated. Specifically, no use of restraint will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury.	2/26/08
	Persons Responsible: Scott TenNapel, Ph.D., L.P. METO Clinical Director; Beth Klute and Julie Patten, BA3s and QMRPs	

]	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	_	(X2) MULT A. BUILDIN B. WING	NG	(X3) DATE SI COMPLE	ETED
		00293	<u> </u>			01/1	7/2008
	ROVIDER OR SUPPLIER		1425 STAT	TE STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
5 000	144.56 and/or Minn 144.653, this correct pursuant to a surve found that the deficit herein are not corrected shall with a schedule of the Minnesota Departments of the Minnesota Departments of the Minnesota Departments of the number and MN Ruindicated below. We several items, failuritems will be considered the most part ruassessment of a fir violated during the corrected. You may request a that may result from orders provided that the Department with notice of assessment of a fir violated during the corrected. You may request a that may result from orders provided that the Department with notice of assessment of a fir violated during the corrected. You may request a that may result from orders provided that the Department with notice of assessment of a fir violated during the corrected. You may request a that may result from orders provided that the Department with notice of assessment of a fir violated during the corrected.	hether a violation has compliance with all erule provided at the ule number or MN Stathen a rule or statute re to comply with any lered lack of compliance upon re-inspection vale will result in the ne even if the item that initial inspection was hearing on any assent non-compliance with a written request is hin 15 days of receipent for non-compliance with a written request is hin 15 days of receipent for non-compliance with cility Complaints completed, which began on sota Extended Treatming correction order in are completed, please of the form for your mal to the Minnesota	issued ion, it is cited violation rdance rule of tag atute contains of the nce. with any at was ssments the these made to tof a ce. the npeted a January ment is issued. e sign and ecords	5 000	Minnesota Department of Health documenting the State Licensing Correction Orders using federal Tag numbers have been assigne Minnesota state statutes/rules for Supervised Living Facilities. The assigned tag number appear	software. d to r	
	Monitoring, Office of	lth, Division of Comp of Health Facility Con ace, Suite 220; P.O.	nplaints;		far left column entitled "ID Prefix The state statute/rule number an corresponding text of the state st	d the	! :
	epartment of Health	DER/SUPPLIER REPRESEN			TITLE		(X6) DATE

DRV111

STATE FORM

If continuation sheet 1 of 29

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		[` '	IPLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		00293		A. BUILDIN B. WING _		C 01/17/2	2008
NAME OF F	ROVIDER OR SUPPLIER	<u></u>	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
1425 S				TE STREET OGE, MN 55			
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5 000	Continued From pa	 ige 1	-	5 000			
	64970, St. Paul, Mi	nnesota 55164-0970			out of compliance is listed in the "Summary Statement of Deficie column and replaces the "To Coportion of the correction order. column also includes the finding are in violation of the state statuthe statement, "This Rule is not evidenced by." PLEASE DISREGARD THE HE OF THE FOURTH COLUMN W STATES, "PROVIDER'S PLAN CORRECTION." THIS APPLIES FEDERAL DEFICIENCIES ONL WILL APPEAR ON EACH PAG THERE IS NO REQUIREMENT SUBMIT A PLAN OF CORRECTION." STATE STATUTES/RULES.	ncies" omply" This gs which ate after met as ADING HICH OF S TO LY. THIS E. TO TION	
5 700	Residents shall be defined in the Vulne "Maltreatment" mea section 626.5572, sintentional and non physical pain or injuconduct intended to distress. Every resinontherapeutic che except in fully docu authorized in writing resident's physician period of time, and	1 Subd. 14. RES. RIG reatment. free from maltreatme erable Adults Protections conduct describe subdivision 15, or the therapeutic infliction oury, or any persistent or produce mental or educt shall also be fre mical and physical re- mented emergencies grafter examination be of for a specified and I only when necessary	ent as ion Act. d in of course of emotional e from estraints, s, or as y a imited to	5 700			

If continuation sheet 2 of 29

STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER			A. BUILDING	PLE CONSTRUCTION	COMPL	(X3) DATE SURVEY COMPLETED C	
		00293		B. WING		l l	17/2008
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
MN EXTE	ENDED TREATMENT			TE STREET GE, MN 550	08		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
5 700	Continued From pa	ge 2	-	5 700			
	by: Based on documenthe facility failed to from unnecessary of the forten of eleven clienths, #9, #10, and #1 include:	ent is not met as evintation review and intensure that clients wildrugs and physical reents (#1, #2, #3, #4, 1) in the sample. Fin	erview, ere free estraints #6, #7, dings				
	The following examples show a chronic use of restraints to control client behaviors that are prompted by staff behavior and/or are not threatening to the health of individuals. In addition, when the clients are restrained their arms are handcuffed behind their back with either metal handcuffs or soft Posey wrist restraints, and their legs are crossed and hobbled (a hobble is a nylon strap that is wrapped around a client's lower legs, tightened, and secured with Velcro) with a RIPP (brand name) restraint.						
	2003. His diagnose disorder, conduct d developmental disoretardation. He has aggression and sevhead injuries. According Controlled Proce 23, 2007 to April 23 manual restraints, pfollowing mechanica board (a client is pure on a board), RIPP serestraining a client's (wrist restraints). The Controlled Procedu to December 29, 200	rder, and mild menta	ective all aultiple d Consent January lized he restraint estrained for PP cuffs for ember 30 ent # 1's				
		without permission, s					

STATE FORM

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If continuation sheet 3 of 29

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIEI IDENTIFICATION NUM		(X2) MULTI A. BUILDIN B. WING		COMPL	(X3) DATE SURVEY COMPLETED C	
		00293		B. WING_		01/	17/2008	
NAME OF	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY,	STATE, ZIP CODE			
MN EXT	ENDED TREATMENT		1425 STAT					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
5 700		cking, scratching, bit		5 700				
	repeated and force	f injurious behavior in ful hand-to-head ead-to-surface hitting;						
	informed consent in	sores and eye gougin	ent					
	without permission,	I aggression or touch staff would immedia of controlled procedu	tely					
	and ceased resisting	pard until the client w	ed in					
	client to go to a qui	rior, staff would prom et area. If he refused escort him to the are	the first					
	verbally prompt him refused to relax on	n to lie down and related to the high tension tension to the high tension tens	x. If he ed to					
	restrained using a F	s behaviors, client #1 RIPP Restraint Board e use of RIPP cuffs o	. Staff					
	to assist them in se arms. In addition to	curing the client's ha physical restraints, t	nds and he					
	dated December 15	for Psychotropic Med 5, 2007 to December #1 received the follo	14, 2008,					
	Depakote 3000 (up Clozaril 600 (up to 9	to 4000) milligrams a 900) milligrams a day	a day, , Geodon				ļ ļ	
	200 milligrams a day, Haldol 1 (up to 10) milligram a day and Zoloft 100 (up to 200) milligrams a day.							
		ption program (a less e) was added to clier					ļ	
	program on July 31, 2007. If the client touched others or spit directly on others, up to two times in		uched o times in				: 1	
	an hour, staff would direct the client a safe distance away from others, but where he could still observe others. Staff would inform the client				(;	
	on others was inapp	without permission/s propriate and that his emented. Staff would					-	
et - B	program was implement of Health		unect				·	

			A. BUILDING		COMPL	
	00293			- 	01/1	7/2008
		1425 STA	TE STREET			
(EACH DEFICIENCY	MUST BE PRECEDED BY	FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
the client to sit on the 3 minute criteria of directly on others 3 implement the RIPF and inform the client criteria." If the client serious self-injurious restraints, staff wou restraint board. State RIPP wrist restraint exhibited aggression client, touching other considered aggress. The Informed Constorm indicated that of aggression from 4, 2001, "his baseli incidents of physical 1, 2007 to Novembindicates that the client state of the considered that the client of the considered considered that the client of the considered considered that the client of the considered considered considered considered considered considered client of the	the floor and inform he calm. If the client toutimes in an hour, stapped in aggress at engaged in aggress as behavior while in the sprocedure if the client would also implement the floor towards others. For each of the controlled Procedure if the client would also implement above the should sion. The for Controlled Procedure if the client would also implement above the should sion. The for Controlled Procedure if the devent and the period. The had sale aggression from November 15, 2007. The formient had thirteen incident and thirty-one in the baseline period. The procedure is the for Controlled dated December 15, dicated that the facilities are the formitted that the facilities are the form of Aprivation Procedures was restrained on the special procedures was restrained on the special procedures.	ched/spit off would estraints of me wrist of ent the ent the ent was ocedures incidents February oxember oxemb	5 700			
						
	ROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa the client to sit on ti 3 minute criteria of directly on others 3 implement the RIPI and inform the clien criteria." If the clien serious self-injuriou restraints, staff wou restraint board. Sta RIPP wrist restraint exhibited aggressic client, touching othe considered aggress The Informed Cons form indicated that of aggression from 4, 2001, "his baseli incidents of physica 1, 2007 to Novemb indicates that the cl touching others from February 4, 2001, " from November 1, i indicated that the cl touching others The "Informed Con Procedures" form, March 14, 2008, inc continues to use the and cuffs for client: "Documentation for Aversive and/or De indicated client #1 v dates, for his target *On February 9, 20 resident phone roof	OD293 PROVIDER OR SUPPLIER ENDED TREATMENT SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMAL Continued From page 4 the client to sit on the floor and inform his 3 minute criteria of calm. If the client tou directly on others 3 times in an hour, state implement the RIPP mechanical wrist reand inform the client of the 5 minute "cacriteria." If the client engaged in aggress serious self-injurious behavior while in the restraints, staff would then implement the restraint board. Staff would also implem RIPP wrist restraints procedure if the client exhibited aggression towards others. For client, touching others above the should considered aggression. The Informed Consent for Controlled Preform indicated that client #1 had eleven of aggression from January 22, 2001 to 4, 2001, "his baseline period." He had sincidents of physical aggression from Notential aggression from Notential aggression from January 22, 2001 to 4, 2001, "his baseline period." He had sincidents of physical aggression from Notential aggression for Notential aggression from Notential aggression for	PROVIDER OR SUPPLIER ENDED TREATMENT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 the client to sit on the floor and inform him of the 3 minute criteria of calm. If the client touched/spit directly on others 3 times in an hour, staff would implement the RIPP mechanical wrist restraints and inform the client of the 5 minute "calm criteria." If the client engaged in aggression or serious self-injurious behavior while in the wrist restraints, staff would then implement the RIPP wrist restraints procedure if the client exhibited aggression towards others. For this client, touching others above the shoulder was considered aggression. The Informed Consent for Controlled Procedures form indicated that client #1 had eleven incidents of aggression from January 22, 2001 to February 4, 2001, "his baseline period." He had six incidents of physical aggression from November 1, 2007 to November 15, 2007. The form indicates that the client had thirteen incidents of touching others from January 22, 2001 thru February 4, 2001, "his baseline period." Data from November 1, 2007 to November 25, 2007 indicated that the client had thirty-one incidents of touching others from January 22, 2001 thru February 4, 2001, "his baseline period." Data from November 1, 2007 to November 25, 2007 indicated that the client had thirty-one incidents of touching others from January 22, 2001 thru February 4, 2001, "his baseline period." Data from November 1, 2007 to November 25, 2007 indicated that the client had thirty-one incidents of touching others from, dated December 15, 2007 to March 14, 2008, indicated that the facility continues to use the RIPP restraint board, straps and cuffs for client #1's target behaviors. "Documentation for Implementation of Approved Aversive and/or Deprivation Procedures" forms indicated client #1 was restrained on the following dates, for his target behaviors: "On February 9, 2007, client #1 walked into the resident p	DOP CORRECTION DO293 STREET ADDRESS, CITY, S 1425 STATE STREET CAMBRIDGE, MN 550 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION) Continued From page 4 the client to sit on the floor and inform him of the 3 minute criteria of calm. If the client touched/spit directly on others 3 times in an hour, staff would implement the RIPP mechanical wrist restraints and inform the client of the 5 minute "calm criteria." If the client engaged in aggression or serious self-injurious behavior while in the wrist restraints, staff would then implement the RIPP wrist restraints procedure if the client exhibited aggression towards others. For this client, touching others above the shoulder was considered aggression. The Informed Consent for Controlled Procedures form indicated that client #1 had eleven incidents of aggression from January 22, 2001 to February 4, 2001, "his baseline period." He had six incidents of physical aggression from November 1, 2007 to November 15, 2007. The form indicates that the client had thirteen incidents of touching others from January 22, 2001 thru February 4, 2001, "his baseline period." Data from November 1, 2007 to November 25, 2007 indicated that the client had thirty-one incidents of touching others from January 22, 2001 thru February 4, 2001, "his baseline period." Data from November 1, 2007 to November 25, 2007 indicated that the client had thirty-one incidents of touching others. The "Informed Consent for Controlled Procedures" form, dated December 15, 2007 to March 14, 2008, indicated that the facility continues to use the RIPP restraint board, straps and cuffs for client #1's target behaviors. "Documentation for Implementation of Approved Aversive and/or Deprivation Procedures" forms indicated client #1 was restrained on the following dates, for his target behaviors: "On February 9, 2007, client #1 walked into the resident phone room and "touched peer." Client	A BUILDING B WING O0293 STREET ADDRESS, CITY, STATE, ZIP CODE 1425 STATE STREET CAMBRIDGE, MN 55008 SUMMARY STATEMENT OF DEFICIENCIES (SACH DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES (SACH DEFICIENCY) CONTINUED FROM DATE OF DEFICIENCIES (SACH DEFICIENCY) CONTINUED FROM DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TOO CONTINUED FROM DATE THE client to sit on the floor and inform him of the 3 minute criteria of calm. If the client touched/spit directly on others 3 times in an hour, staff would implement the RIPP mechanical wrist restraints and inform the client of the 5 minute "calm criteria." If the client engaged in aggression or serious self-injurious behavior while in the wrist restraints, staff would also implement the RIPP wrist restraints procedure if the client exhibited aggression towards others. For this client, touching others above the shoulder was considered aggression from January 22, 2001 to February 4, 2001, "his baseline period." He had six incidents of physical aggression from November 1, 2007 to November 15, 2007. The form indicates that the client had thirteen incidents of touching others from January 22, 2001 thru February 4, 2001, "his baseline period." Data from November 1, 2007 to November 25, 2007 indicated that the client had thirty-one incidents of touching others. The "Informed Consent for Controlled Procedures" form, dated December 15, 2007 to March 14, 2008, indicated that the facility continues to use the RIPP restraint board, straps and cuffs for client #1's target behaviors. "Documentation for Implementation of Approved Aversive and/or Deprivation Procedures" forms indicated client #1 was restrained on the following dates, for his target behaviors: "On February 9, 2007, client #1 walked into the resident phone room and "touched peer." Client	ODE CORRECTION ODESTIFICATION NUMBER: ODESTIFICATION

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM			(X2) MULTII	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		00293		B. WING		I	7/2008
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MN EXT	ENDED TREATMENT			TE STREET GE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
5 700		ly restrained (no spe		5 700			
	noted) from 3:09 p. client was "complet staff person. He wa (again no specifics p.m., for a total of 5 client was restraine "screaming, crying 4:24 p.m. client #1 40 on board " again screaming and swe restrained until 5:04 Client #1 was restrained "Rule 40 screaming and swe 5:23 p.m., after 18 received Benadryl, milligrams IM at 5:04 *On February 12, 2 mechanically restrained until 10:5 *No February 12, 2 mechanically restrained until 10:5 At 2:14 p.m., client "came up to the tab pounded his head upounded his h	m. to 3:24 p.m. Whe ely released" he touch is re-restrained mechanoted) from 3:29 p.m. on minutes. During the dit was noted that he and swearing " at stawas restrained per he for " yelling, crying, earing at staff." He was restrained one more time at 5:10 p.m., client #10 on board" for "yelling aring." He was release minutes. Client #1 also 25 milligrams and At 100 p.m. on the form 8:30 a.m. on the target behavior as sock. At 10:14 a.m. ouching staff. He was restrained be also to touch peers belonto [sic] table with form per sing the form, at otal of 20 p.m., client #1 was restrained belonto [sic] table with form, at otal of 20 p.m., client #1 was restrained belonto [sic] table with form, at otal of 20 p.m., client #1 was restrained belonto [sic] table with form, at otal of 20 p.m., client #1 was restrained belonto [sic] table with form, at otal of 20 p.m., client #1 was restrained belonto [sic] table with form, at otal of 20 p.m., client #1 was restrained belonto [sic] table with form, at otal of 20 p.m., client #1 was restrained belonto [sic] table with form, at otal of 20 p.m., client #1 was restrained belonto [sic] table with form, at otal of 20 p.m., client #1 was restrained belonto [sic] table with form, at otal of 20 p.m., client #1 was restrained belonto [sic] table with form.	n the ched a nanically, n. to 4:14 e time the e was aff. At is "Rule as inutes. on I was 19, ased at so ivan, 2 to 8:55 or was client #1 s minutes. ecause he longings, orce." He minutes estrained ce. The edoor."				
	He was released from the restraint at 4:45 p.m. *On February 15, 2007, client #1 was mechanically restrained for 50 minutes, from 8:00 a.m. to 8:50 a.m., for walking up to a peer and touching him twice. During the restraint procedure, client #1 was crying, screaming, and						' ! !
		received Haldol, 5 m ram at 8:40 a.m. The					1

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU 00293		A. BUILDING	LE CONSTRUCTION			
NAME OF E	PROVIDER OR SUPPLIER	00293	STREET ADD	RESS. CITY. S	TATE, ZIP CODE		17/2000	
MAN EXTENDED TREATMENT			1425 STAT	TE STREET GE, MN 5500				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		DEFICIENCY MUST BE PRECEDED BY FULL PREFIX			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
	a.m. to 9:40 a.m. A crying. At 9:45 a.m another 50 minutes Ativan, 1 milligram crying and swearin three prior impleme program), client #1 released at 11:00 a *On February 17, 2 mechanically restra a.m. to 9:40 a.m. fo During the restraint crying and swearin continued and clier a.m. to 10:30 a.m. Benadryl at 10:22 a restraints from 10:3 a.m. Benadryl at 10:22 a restraints from 10:58 a.m. for not 'procedure continue from 11:20 a.m. to *On March 23, 200 restrained from 9:5 touching staff. He was restrained and to 11:30 a.m. At 11 The client continued At 12:25 p.m. the couching "staff's was restrained until 1:18 was restrained for the was restrained for the was restrained until *On May 29, 2007, May 29, 2007,	another 50 minutes, gain, he was yelling he was re-restraines, until 10:35 a.m. He at 10:10 a.m. The cg at staff. At 10:40 a.m. tations of his Rule was restrained. He was restrained. He was atter 20 minutes	and ed for received lient was .m. (after 40 was s. from 8:50 a sock. was .ule 40 was from 9:40 lligrams of nued in . The g during as given at aint strained tes. hanically for g people 0:40 a.m. as given. The 2:08 a.m. for son until e client taff was on until e client ger. He tes. anically	5 700				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NUI			A BUILDING	PLE CONSTRUCTION	COMPL	(X3) DATE SURVEY COMPLETED C	
		00293		B. WING			7/2008
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
MN EXTE	ENDED TREATMENT			TE STREET Ge, MN 550	08		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
5 700	antecedent noted wimmediately reached talk." Client #1 was 11:56 a.m. for touch staff was holding it. from 12:19 p.m. to walked into a staff of the staff." *On November 20, mechanically restrated." *On November 20, mechanically restrated." *On throwing a client was restrained p.m. for throwing a restrained from 12: touching a peer on And the client was 7:13 p.m. for touch hour period." In summary, between December 26, 2000 times for touching a (including 12 times during a restrained), he was re-restrained from 12: touching a restrained from the was restrained from the was restrained from the was restrained from the was restrained from the client receiving physical restraints. Client #1 was obseignuary 11, 2008.	et behavior was note vas, "[client #1] sat de for staff as staff carestrained from 11:1 hing a "staff's walkie! The client was restr 12:33 p.m. as, "[client #1] was sined from 10:15 a.m. rag in a peer's face. It de from 11:56 a.m. to staff's face. The client was restrained from 6:58 ing staff "for the 3rd", client #1 was restrained from 6:58 ing staff "for the 3rd", client #1 was restrained from 5 to 65 minutes ained many other times to uching. However of restraint were ofter and there were examined many with a staff person, the walked to a with a staff person the walked to a with a walked to a with a staff person the walked to a with a walked to a walked to a with a walked to a walk	own then ame up to 0 a.m. to 0 a.m. to 1 ained at #1] y touched It to 10:30 The 12:11 at was for shoulders. p.m. to time in an ained 143 at m down at ly, he sponse, each are for as noted an one mples of h the am on and from	5 700	DEFICIENC	Y)	
dinnesota D	and walls. The staff	t switches, electrical f person asked the cl ems, and client #1's	ient to				1

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIF A. BUILDING B. WING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 01/17/2008	
	ROVIDER OR SUPPLIER ENDED TREATMENT		1425 STA	DRESS, CITY, S TE STREET GE, MN 550	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
5 700	was to touch the was Client #2 has mode autism, and deafne "Documentation For Aversive And/Or Dorevealed the follow "On April 15, 2007 eating and hit her ecued to "stop," but and hit the table withe client to "stop a client threw her pla and was restrained cuffs for four minutindicated that the uproperty destruction "On May 4, 2007 at the rocking chair wher right forearm of with a closed fist, by kicked an end table laid down on the flocient was put in leg four minutes. The finterventions were comments indicate appropriate. *On May 5, 2007 at obsessing about shopping." At lunch food and was told a food. The staff explable to go shopping May 4, 2007. Client all dishes toward strestrained in accord (the facility's special pre-approved restri	all one more time. erate mental retardati ess. A review of the fa or Implementation Of eprivation Procedure	acility's Approved s, " 2 was e was e request taff cued Then the te table soft wrist comments vas due to te. was in then hit it the wall " and Then she ted". The uffs for o other visory traints was 2 "awoke r no more y more d not be ors" on nd threw hen 40 plan hittees' gement	5 700			

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If continuation sheet 9 of 29

ł	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1, ,	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
l				A. BUILDIN	G		С	
		00293		B. WING _		I	17/2008	
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
	NDED TREATMENT			TE STREET				
			CAMBRIL	OGE, MN 550	J08 			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
	soft Posey cuffs for comments indicated was in accordance appropriate. *On May 17, 2007 rocking in her chair her leg." Then the leg and kicked the neastop and calm down restrained in soft comminutes. Supervisor use of the restraint and the restraint of the res	e restrained behind her four minutes. The set that the use of the with her program and at 5:28 p.m., client #2 rewhen she slapped to client laid down on the folient laid down on the rest staff. She was corn, "she refused" and suffs and hobbles for some comments indicated as was appropriate. If at 12:27 a.m., client a home visit that was need medication set us to go to bed and that he next day. Client #2 she wanted to be tucent into her room [and walls with hands with urt hands. (Also threw in but, stopped on ow a laid down on the flow was put in restraints soft cuffs and her legislates. The supervised that the use of the lat 4:13 p.m., client #2 ting her snack when of water and "shoved Client #2 was told to was restrained for teet ime she was restrained for the light injurious behavior), nutes. The client was	upervisory restraints d were 2 "was he wall, hit e floor ued to was six d that the #2 was sip. Staff it "work" 2 ked into d began a enough dresser in w/o for per the Her si were bry restraints 2 was she "a box of "stop" in slapping	5 700	DEFICIEN	JCY)		
Minnesota De		ents indicated that the	e use of				; ! !	

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If continuation sheet 10 of 29

	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER: A. BUILDING COMPI		(X3) DATE S COMPL			
		00293		B. WING		01/1	17/2008
NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MN EXT	ENDED TREATMENT			TE STREET GE, MN 550	008		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
5 700	Continued From pa	ge 10		5 700			
	*On July 25, 2007, sitting at her work to corner of the table a floor, biting her lips for her to stop. She minutes. No documutilized other than hindicated the use of Client #2 was again six minutes becaus was "kicking at staff indicated that her brelease from restrai was again impleme restraint was approrelease from her Ruattempted to escort when she started," Staff redirected her staff and was restrabeing calm for two if for a headache and household. Superviuse of restraints was "On July 29, 2007 a painting at the table being upset. Then stable." She was put hobbles for five minuser implemented. indicated the use of and warranted give exhibited. *On August 21, 200 at the table, shoved across the table. She minutes with Posey hobbles, in accorda During the time she	at 2:34 p.m., client #2 able hitting her hand and banging her knee and hand "hard". Sta was restrained for to entation of restraining bobble. The supervise if the restraint was ap restrained at 2:49 p e she punched the flag. If "Supervisory comments, the restraint pro- intent and the use of the priate. At 2:58 p.m., alle 40 restraints, staff ther back to her house minor" self injurious to stop. She began to sined for six minutes, minutes she was give escorted back to the sory comments indice	on the e on the aff signed welve g device or propriatem., for oor and nents ter cedure the after f sehold, behavior. kicking After en Imitrex e ated the was as of ng off the aint and rentions onts propriate se #2, while ble, eight eg plan. kicked				
<u>!</u>	epartment of Health						

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If continuation sheet 11 of 29

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
				A. BUILDING B. WING	·	_	С	
		00293		D. WING _		01/1	17/2008	
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
MN EXTE	ENDED TREATMENT			TE STREET GE, MN 550	008			
								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
5 700	Continued From pa	age 11		5 700				
5 700	After being calm for released. Supervisuse of the restraint appropriate. No oth implemented prior of the control of the contro	r four minutes she was ory comments indicated per her Rule 40 was her interventions were to the restraint. mental retardation, and prefers the facility's remergency Use of the facility's remergency Use of the following: 7 at 6:59 p.m., client and yelled at staff. Top and maintain bout on his bedroom. Client and yelled at staff. Top and maintain bout on his bedroom. Client ized by two staff, when it is elbows, with the tothe ground in a proper stomach) was perhe was manually and and for 21 minutes of the diameter of the staff, swearing at 4:14 p.m., client #3 and gat staff, swearing aff." The client was account him. He hit staff	his left o use a Controlled #3 was he watch was not he staff indaries t #3 hit " (a popply goal of one formed in the staff indaries t #3 hit " (a popply goal of one formed in the staff indaries in the staff in the staff indaries in the staff indaries in the staff	3 700				
	to stay away from a	at 6:20 p.m. client #3 a peer that was sitting ked at peer's feet." T	on the				i :	
# D	enartment of Health	——————————————————————————————————————						

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 01/17/2008	
		00293		B. WING			
NAME OF F	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	STATE, ZIP CODE		
MN EXT	ENDED TREATMENT		1425 STAT				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE: 'MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
5 700	"possible" that he "in Client #3 was asked floor. Client #3 was two minutes. *On June 23, 2007 "swearing, refusing peers/staffs space then "slapped" a stand. He was then and wrist cuffs for 2 *On August 5, 2007 stopped in wheelch not redirect to move and/or considered." "several times to m wheelchair." Client cuffs and leg hobble "struck staff with fisindicate when the c documentation did the client's physical 6:00 p.m., "[client # out of view of TV in refused, he was be he was being escor staff." The client was minutes then restrated hobbles for 43 minutes then restrated hobbles for 45 minutes	ing at the peer, and imay have grazed peed to stop and lie down then manually restrated at 5:43 p.m., client # directionsinvading [with] wheelchair." Thaff's forearm with an restrained with leg held minutes. If at 3:55 p.m., client # air in front of office, at included, cueing the ove" and "escort by perfect the struck staff. How indicate that it was like aggression to reocci all was asked 3 times dayroom. The fourthing escorted to his rotted to room [client # air manually restraine ined with wrist cuffs at the struck staff.	ers feet." In on the sined for 3 was The client open obbles #3 "was and would tives tried eclient oushing hand ter he on did not ever, the kely for our. At the storm weight of the storm	5 700			
	anartment of Health						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIES IDENTIFICATION NUM			(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00293		B. WING			<i>7/</i> 2008
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
MN EXT	ENDED TREATMENT		-	TE STREET GE, MN 550	08		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
	Continued From pa *On September 26, was watching the teasked the client if h programs. Client #3 and turned the televithen attempted to the staff of	ge 13 2007 at 8:22 p.m., or elevision and a staff preserved to do one of turned away from the vision up. The staff purn the television offer person's hand and ed the staff person to fer person then attempt and put his/her had to pull the plug and or against the wall. The purpose of the preserved with the purpose of poking others are of the procedure of the purpose of poking others are of the procedure of the purpose of poking others are of the procedure of the purpose of poking others are of the procedure of the purpose of poking others are of the purpose of poking others are of the procedure of the purpose of th	client #3 person of his ne staff erson and client d stated o leave pted to and client #3 the client s then put d. The released or the eoccur." vas "staffs sthma, and s. A or e" I was or 50 ent ang staff	5 700			
•	her room or take a "attempted to talk w bothering her." *On May 30, 2007 a her room "hitting the room and "tried kitchen." An arm ba	shower or bath. The // [client #4] about what 6:26 p.m., the client e door." Then she cato shove staff to get ar takedown was imposthe floor. The client was constant to the client was staff to get the floor. The client was staff to get the floor.	staff nat was it was in me out of into the lemented				

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If continuation sheet 14 of 29

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PRO IDEN		R/CLIA MBER:	(X2) MULTIF A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C	
		00293				01/	7/2008
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
MN EXT	ENDED TREATMENT			TE STREET OGE, MN 550	08		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
5 700	Continued From pa	ige 14		5 700			
	manually then mec of 50 minutes (the sare not documented indicates "Other Alt considered" included down and relax or the Client #6 has sever history of behaviora November 2006. He May 2007. A review "Documentation for Procedure" and "Documentation for Procedure" and "Documentation" reveale "Upon arrival to the admission, May 7, 2 to bite and kick staff restraint was impleted to struggle and attection was in restrait to the mechanical of the mechanical of 10 milligrams of Hamand 50	hanically restrained fispecific mechanical red). The documentation remarks the staff told the contake a bath or show the mental retardation all deterioration since the was admitted to the violation of the facility's remergency Use of Cocumentation of Psychotral.	estraints on slient to sit wer. and a e facility in Controlled ergency opic entempting chanical continued sion." The naddition s given Ativan cularly ent "was ne client At 6:20 hing his is hands washclother client an open ome along and leg 50 ed to licates he at kicked				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING B. WING		COMPL	(X3) DATE SURVEY COMPLETED C	
		00293				01/	17/2008	
NAME OF P	NAME OF PROVIDER OR SUPPLIER			DRESS, CITY, S	TATE, ZIP CODE			
MN EXT	ENDED TREATMENT			TE STREET Ge, MN 550	08	_	_	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
5 700	was used and both mechanical restrair response to physical in restraints for 50 magnetic for 5	emergency manual at were implemented al aggression. The cominutes. It was a common to the death of the cominutes. It was put in mechants. At 10:20 a.m. om to go to the ing to hit staff and diverbal prompt [client as put in leg hobbles inutes. During restration on the lay 9, 2007, client #6 was restrained for the lay 10, 2007, client #6 was restrained for the lay 10, 2007, client #6 was remove and kicking, and the lay 10, 2007, client #6 was remove and kicking, and the lay 10, 2007, client #6 was remove and kicking, and the lay 10, 2007, client #6 was remove and kicking, and the lay 10, 2007, client #6 was remove and kicking, and the lay 10, 2007, client #6 was remove and kicking, and the lay 10, 2007, client #6 was remove and kicking, and the lay 10, 2007, client #6 was remove and kicking, and the lay 10, 2007, client #6 was repeated lay 10, 2007, client #6 was remove and kicking, and the lay 10, 2007, client #6 was remove and kicking, and the lay 10, 2007, client #6 was remove and kicking, and the lay 10, 2007, client #6 was repeated lay 10, 2007, client #6 was remove and kicking, and the lay 10, 2007, client #6 was remove and kicking, and the lay 10, 2007, client #6 was remove and kicking, and the lay 10, 2007, client #6 was remove and kicking, and the lay 10, 2007, client #6 was remove and kicking, and the lay 10, 2007, client #6 was remove and kicking, and the lay 10, 2007, client #6 was remove and kicking, and the lay 10, 2007, client #6 was remove and kicking, and the lay 10, 2007, client #6 was remove and kicking, and the lay 10, 2007, client #6 was remove and kicking, and the lay 10, 2007, client #6 was remove and kicking, and the lay 10, 2007, client #6 was remove and kicking, and the lay 10, 2007, client #6 was remove and kicking, and the lay 10, 2007, client #6 was remove and kicking, and the lay 10, 2007, client #6 was remove and kicking and the lay 10, 2007, client #6 was remove and kicking and the lay 10, 2007, client #6 was remove and kicking and the lay 10, 2007, client #6 was remove and kicking	in lient was "slapped d staff" being ake down hanical , client #6 d kick a and int he afloor. 6 hit a aut in a all cuffs 50 % as h a closed ake down dicated ed. The each obble as y touching manual lient #6 in office ual	5 700				

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	MENT OF DEFICIENCIES LAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER			(X2) MULTIF A. BUILDING B. WING	PLE CONSTRUCTION		ETED C
		00293	OTDEET AD	20500 0171/ 0	TATE ZID CODE		17/2008
	PROVIDER OR SUPPLIER ENDED TREATMENT		1425 STA	TE STREET GE, MN 550	TATE, ZIP CODE		
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5 700	given 10 milligrams client #6 "hit staff w bar takedown was i was put in handcuff *At 11:17 p.m. and client #6 was hitting manually restrained 12:30 p.m., client # He was put in a Post for 45 minutes. At 12 milligrams of Ativa *Documentation on client #6 was restra 2:40 p.m., client #6 Seroquel. Client #6 implementations to (no specific behavior (eating inedible objection) follow-up by a nurse was re-implemente Seroquel was minimal client #6 was given milligrams of Benace behavior indicated agitation/aggression minutes." *Client #6 was put i June 5, 2007 at 10 grabbing, pinching, (fingers in mouth, bto aggress when re	of Zyprexa IM. At 5: ith handslaps." A doing mplemented and cliefs and hobbles for 30 and the client of sand hobbles for 30 at 1:28 p.m., on May 2 a staff and the client of each time for 2 min 6 tried to pinch and goey restraint with leg :20 p.m., client #6 wan IM. June 2, 2007, indicatined at least seven to was given 100 milling had "four Rule 40 day for physical aggrors identified) and Pleets). A note written as indicated client #6's dat 4:17 p.m. and the mally effective. At 7:1 2 milligrams of Ativating IM. The "precipitation was "three more Rule, each lasting nearly nechanical restrain:09 for "physical aggination, not calming, colleases attempted."	uble arm ent #6 21, 2007, was utes. At grab staff. hobbles as given ated that imes. At rams of ession CA" as s Rule 40 e 5 p.m., n and 50 ating le 40's for y 50 nts on ression; sSIB ontinues The client	5 700			
innesota D	received Ativan 2 milligrams at 10:45 a.m. *Documentation for June 12, 2007 indicates that client #6 was "given the Ativan (2 milligrams at 2:45 p.m.) immediately after release of restraint while in his room." The precipitating behavior indicated was "aggression toward staff, refusal to redirect with verbal cues." (No specific behaviors were identified on the form.) *Documentation regarding client #6 for June 18,						: : : : :

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE	OVIDER/SUPPLIER/CLIA NTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	00293		B. WING _		•	7/2008	
NAME OF PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY,	STATE, ZIP CODE			
MN EXTENDED TREATMEN	r 		TE STREET GE, MN 550			 	
PREFIX (EACH DEFICIEN	ATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
5 700 Continued From			5 700			1	
times] this afternor aggression/agitat time held." At 5:0 milligrams of Ativibre Benadryl IM. A for indicates that one "shortly after med "Documentation in 2008, at 1:08 p.m. took a shower, structured to his room. Client keep his hands to to his room. Client kick/scratch/slap mechanical restration actual outcome in release criteria, a continued to aggrest 8, 2008, document was "in Rule 40 heafter 50 minutes." Client #6 was me of one hour and for Client #7 has mild the facility's "Doctor of Controlled Processor of Controlled Proc	on-each one longer in p.m. client #6 was given and 50 milligrams of low-up note written at Rule 40 was implemented in a client #6 "woke up from the dicates that on January, client #6 "woke up from the dicates client was escored to a staff multiple times." It was implemented in the was implemented in the was implemented in the client #6, "did the tempted release at 50 tess." At 1:58 p.m., on the tation indicated that could, reimplemented Rule was released at 2 thanically restrained for the was released at 2 than the was rel	length of ven 2 of 8:00 p.m. ented ary 8, rom nap, re getting down and orted back. "A The not meet 0 minutes, January lient #6 ule 40 :48 p.m. or a total review of ency Use ollowing: lient #7 staff ne 3" so nt de her nad tried offered alk. An differed alk. An difference in the staff of the inutes.					

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STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER A BUILDING B. WING 00293 01/17/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1425 STATE STREET MN EXTENDED TREATMENT CAMBRIDGE, MN 55008 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) 1D (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 5 700 | Continued From page 18 5 700 review by the QMRP (Qualified Mental Retardation Professional), indicated that a "Rule 40 program will be implemented, likely to reoccur." *A review of the facility's "Documentation For Implementation Of Approved Aversive And/Or Deprivation Procedures, "revealed the following: *On December 21, 2007 at 9:10 p.m., client #7 was "arquing w/ staff about her recovery[programing], when told she had to restart she started screaming at staff [and] kicked the wall very hard." The client was put in manual then mechanical restraints, leg hobbles and wrist cuffs, for 28 minutes due to property destruction, "kicking the wall." The client "screamed and cried" for 18 minutes before she was calm. The supervisory comments indicated that the implementation of the restraints was in accordance with client #7's program. *On December 24, 2007 at 8:28 a.m., staff entered client #7's room to wake her for work. The client "screamed 'leave me alone' and swung [at and] kicked [at] staff." The client was cued to "stop" and then she was restrained in wrist cuffs and leg hobbles for 18 minutes. For the first eight minutes client #7 cried and struggled. The supervisory comments indicated that the use of the restraints was appropriate. Client #8 has moderate mental retardation. autism, a brain stem tumor, and seizure disorder. A review of the facility's "Documentation For Implementation Of Approved Aversive And/Or Deprivation Procedures," revealed the following: *On September 9, 2007 at 7:20 p.m., client #8, "ran to bathroom and threw his socks in the shower, then ran to his bedroom and slammed his door." Staff cued the client to "walk and not

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throw objects or slam doors because that is property destruction." As a result the client ran

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) P		R/CLIA MBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00293		B. WING			C 1 7/2008		
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	TATE, ZIP CODE	<u></u>			
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
5 700	out of his bedroom bedroom and slamm handcuffed and his of 10 minutes. The indicated that the usuas appropriate be behaviors is slamm *On September 27, "ran through the horefused to let staff the ritually pounded cued the client to "snot to run also cu "slapped at staff's high pitcher. He ran into door." The client waleg hobbles for 39 minutes the client "yelled, and tried to *On September 30, "ran up to the wall, head on the floor asslammed the door." "stop [and] not pour client's Rule 40 was hand cuffed and his restrained for 15 minutes the staff for five min *On October 5, 200	and into another "unmed that door. The collegs were hobbled for supervisory commerces of the Rule 40 rescause one of the targing doors. 2007 at 4:56 p.m., couse with pitcher of whave pitcher, and one on walls with both first op and put pitcher of ed not to hit walls." Contains when they ask bathroom and slammas restrained in hand minutes. For the first struggled, scratched get up." 2007 at 7:50 p.m., copounded on it, banged to his room and slammar to his room and slammar to his room and same the door. It is implemented and his legs were hobbled, inutes and during his ried to bite, kick, and another.	client was or a total of the straints get client #8 rater. He ce he did, st." Staff down and Client #8 red for the med cuffs and 29 kicked, client #8 red his or client, "The re was restraint I scratch the was strestraint the straint t	5 700	DEFICIENC				
	was refusing to get staff and was then cuffs for 10 minutes supervisory commet the restraints was a * On October 11, 20 refused to attend hi was rocking in a ch	oproximately 20 minuout. He slammed the put in leg hobbles and for property destructions indicated that the appropriate. 257 p.m., clies mental health revieus when he "sudden" the bedroom and bearth.	e door on Id hand Ition. The Ie use of Int #8 Iew and Ity jumped						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C	
		00293				01/1	7/2008
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5 700	The client "banged the phone room, are the bathroom door, against the wall of "was calm instantly on the ground." He hobbles were applied minutes. The superstrained in wrist of minutes for "proper aggression." The distaff gave him a version documentation of the documentation of the documentation. The indicate that the usappropriate. Client #9 has mild a brain lesion. A resupersive And/Or Direvealed the follow "On October 25, 20 became "agitated" "home 3." The client (specific location in prompted to "stop [was restrained first for a total of 46 mindoes not indicate if back at home 3. The indicate that the usappropriate.	" on the door and the ad linen closet, and so, and he dropped" the the phone room. The when staff asked his was then hand cuffered. He was restrained to the was approported to the cuffs and leg hobbles and prompt not to signation does not indicate that the cuff required the restraints. However, as indicate that the cuff request prior to the legislation of the restraint was a supervisory commental retardation, a view of the facility's or Implementation Of the privation Procedure	slammed e phone e client, im to lay ed and leg ed for 10 dicated priate. ent #8 was is for 10 hysical tes that am the cate the the lient laid e restraint nents s sutism, and f Approved es," ht #9 ng to his ait himself saff and nanically tation utside or nents s	5 700			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
	İ	00293 B. WING		1	7/2008		
NAME OF F	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY,	STATE, ZIP CODE		
MN EXT	ENDED TREATMENT		1425 STAT CAMBRIDG				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
5 700	walls, toilet and his negotiations to stop documented). He wand hand cuffs for comments indicate was appropriate. *On December 11, #9 took two bowls conly one bowl. The his hands. Then he times. He was restrand cuffs for 37 m comments indicated was appropriate. *On August 5, 2007 watching T.V. and I client bit, slapped, a force." Staff interve what was wrong, wi [and] calm down." SThe client complied then put in leg hobb of 17 minutes. He was appropriate in the restraint implements was appropriate likelihood this behaves as a possible. In addition, client #9 was a while watching televicient became self in documented). Staff the client "aggresse was cued to calm doundaries. The stage of the stage was cued to calm doundaries. The stage was cued to calm doundaries. The stage was cued to calm doundaries. The stage was cued to calm doundaries. The stage was cued to calm doundaries. The stage was cued to calm doundaries. The stage was cued to calm doundaries. The stage was cued to calm doundaries. The stage was cued to calm doundaries. The stage was cued to calm doundaries.	ge 21 wer and "pounding" own head. Staff utilize (the specific negotial as restrained with lead of the state of the use of the result of cereal, he was cue client slammed the trained with leg hobble inutes. The supervised that the use of the result of the use of t	on the red ations not g hobbles ervisory estraints fter client d to take able with ad three es and ory restraints #9, "was e." The strong ed him irself, or a total ren in he was tion of at the te client's don't marks on 11:35 ropriately, the ot ate" and e client taff	5 700			

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If continuation sheet 22 of 29

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		 	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C	
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hobbles noted to was being "attempted hobbles p.m. for a document "encouratake dee *On Aug removed Client #9 forearm. client to mouth an does not directive and then leg hobb indicates of "self in An attem restraints p.m. his	d and place for a total of be crying a g held" in a ed to grab and wrist of an addition tation indige client to be started to Staff intermite down and listening indicate if s. A double the reside les for 50 in that the conjurious be apt was made and he "krestraints"	ted in wrist cuffs and of 50 minutes. The cland trying to relax, but a prone position and staff [and] get up." Touffs were reapplied and ten minutes. The cates that the plan werest in room, listen	ient was it, "he the client he leg at 12:25 ras to, to music, er t #9's feet. Ind bite his sking the y his mentation he staff was used uffs and entation because ession." ent from at 7:11 nother 21	5 700				
Ativan IM *On Sepreceived aggressi his chee Staff atte was "esc kept grat for 12 mi handcuff physicall	tember 28 Ativan bed ve." At 2:30 ks and put empted "vectorted to ro obling at standers, mai s and leg by y aggressi 0 has mod	, 2007 at 12:55 p.m. cause he was "agitate 6 p.m., client #9 was ting hands toward method by staff but [the caff." The client was remaily then mechanic hobbles because he we and hit staff.	client #9 ed [and] "pinching outh." ne client client] estrained cally with was					
for 12 m handcut physica Client #	ni ff ll!	ninutes, ma ffs and leg h lly aggressi 10 has mod autism, he	ninutes, manually then mechanic ffs and leg hobbles because he lly aggressive and hit staff. 10 has moderate mental retarda autism, he has a history of bitin	ninutes, manually then mechanically with ffs and leg hobbles because he was lly aggressive and hit staff. 10 has moderate mental retardation and autism, he has a history of biting people,	ninutes, manually then mechanically with ffs and leg hobbles because he was lly aggressive and hit staff. 10 has moderate mental retardation and autism, he has a history of biting people,	ninutes, manually then mechanically with ffs and leg hobbles because he was lly aggressive and hit staff. 10 has moderate mental retardation and autism, he has a history of biting people,	ninutes, manually then mechanically with ffs and leg hobbles because he was lly aggressive and hit staff. 10 has moderate mental retardation and autism, he has a history of biting people,	

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(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 00293 01/17/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1425 STATE STREET** MN EXTENDED TREATMENT CAMBRIDGE, MN 55008 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) 5 700 5 700 Continued From page 23 making himself throw-up, and becoming increasingly agitated when others attempt to interact with him. Client #10 was discharged from the facility on November 7, 2007. A review of the facility's "Documentation For Implementation Of Approved Aversive And/Or Deprivation Procedures," revealed the following: *On February 28, 2007 at 8:03 p.m., client #10 was restrained for ten minutes in handcuffs and hobbles because he bit his hand. *On March 6, 2007 at 7:59 p.m., client #10, "was given a snack. He began spitting on kitchen table. Staff cued the client to stop spitting and to go to his room and calm down. While in his room he began vomiting on his floor and urinated. He was also laughing for no reason." He spit and vomited on staff and was restrained for 14 minutes in handcuffs and hobbles. *On March 9, 2007 at 10:09 a.m., client #10 was restrained for six minutes in leg hobbles and handcuffs because he "bit self." At 12:38 p.m., client #10 was exhibiting "excessive laughing" and he spit water. He was "encouraged to calm [and] resume work x 3." He was restrained for 14 minutes in handcuffs and leg hobbles for "spitting/emesis directed at staff." At 6:25 p.m.. client #10 spit in a staff person's face. He was cued to lay down and he complied and was restrained for six minutes. *On March 13, 2007 at 1:17 p.m., client #10 was restrained in handcuffs and hobbles for ten minutes because he bit the back of his left hand and made it bleed. The documentation indicates that other interventions were "NA" (not applicable). *On March 17, 2007 at 4:41 p.m. client #10 was restrained in hand cuffs and hobbles for six minutes for biting his hand. The documentation indicates that there was "no time" for any other

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interventions.

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 01/17/2008 00293 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1425 STATE STREET MN EXTENDED TREATMENT CAMBRIDGE, MN 55008 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 5 700 i Continued From page 24 5 700 *On March 18, 2007 at 1:58 p.m., client #10 was restrained for six minutes in leg hobbles and hand cuffs because he bit the back of his left hand after being directed to calm down. The documentation indicates that the client laid down on the floor on his own, and was restrained. *On March 19, 2007 at 5:02 p.m. client #10 was in his room "self stimulating." Staff told the client to "relax and calm." The client bit his left hand through his shirt. He was told to lay down on the floor and he complied. He was "calm" but restrained for six minutes in handcuffs and leg hobbles *On March 20, 2007 at 12:00 p.m., client #10 was restrained after he had an emesis and spit it at staff and then was restrained for fourteen minutes in handcuffs and leg hobbles. *On March 20, 2007 at 7:14 p.m., client #10 was restrained in leg hobbles and handcuffs for six minutes for biting his hand after staff told him not to bite himself. *On March 20, 2007 at 9:14 p.m., client #10 bit a "pre-existing wound" on his hand and he was restrained for six minutes in leg hobbles and handcuffs. Documentation indicated that there were no other interventions available prior to the utilization of the restraints. *On March 27, 2007 at 4:55 p.m., client #10 was asking repetitive questions and was asked to "relax" in his room. The client bit himself on the hand and he was restrained for 12 minutes in handcuffs and leg hobbles. *On April 3, 2007 at 9:28 p.m., client #10 was making "loud vocalization for 10 - 15 minutes." He was told to "quiet, take breaths, [and] go to sleep." The client bit the back of his hand and slapped his leg three times. The client was restrained for six minutes in leg hobbles and hand cuffs. *On April 4, 2007 at 10:18 a.m., client #10 was at

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY,	STATE, ZIP CODE		
MN EXT	ENDED TREATMENT		1425 STAT				
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5 700	his day program and front of face making instructed to contine hands to calm." The his shirt. He was meandcuffs and leg handcuffs for a so. The client was mechanically restrated handcuffs for six materials and shadcuffs for six materials and leg handcuffs for six materials for six	Ind he was "wiggling he proises." The client we his work, "or to site client bit his hand the echanically restrained to 7.45 p.m., client #10 proom, making loud not lah" The client was relax." The client bit as finished with leg hobbles inutes. It 11:35 a.m., client #10 proom with this left hand. The client with leg hobbles inutes. It 11:35 a.m., client #10 proof in shirt and bit his left hand bit his	was on his nrough d with es. O was bises, s cued to an "old lient laid aff to do hen s and 10, "was ling by his lie on the hirt." The estrained nutes. at the use O, "was ut nothing d him to ent spit in then and hand mments as per his O bit his it his g his lif twice mented). and	5 700			

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		00293		B. WING _			7/2008
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY,	STATE, ZIP CODE		
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Appendix C DHS Licensing Citations

INVESTIGATION MEMORANDUM Department of Human Services Division of Licensing' Public Information

Report Number: 20074279 Date Issued: April 4, 2008

License Number: 804294 (245B-RS)

Name and Address of Program Investigated: Minnesota Extended Treatment Options (METO) 1235 Hwy 293 Cambridge, MN 55008

Investigator(s):

Amy Petersen with Pat Afwerke, Deb Amman, Dawn Bramel, Rita Maguire, Mary Truax Human Service Licensors
Division of Licensing
Minnesota Department of Human Services
PO Box 64242
St. Paul, MN 55164-0242
(651) 215-1588

Suspected Licensing Violations Reported:

<u>Allegation number 1</u>: METO uses coercion to obtain informed consent for the use of controlled procedures by telling legal representatives that unless they consent to the use of the controlled procedure METO will not serve the consumer.

Allegation number 2: METO's Individual Program Plans (IPPs) developed for the use of controlled procedures do not meet the required standards for assessment, content, and review, including the failure to obtain a report from the physician on whether there are existing medical conditions that could result in the demonstration of behavior for which a controlled procedure may be proposed or should be considered in the development of an IPP for controlled procedure use.

Allegation number 3: METO staff use controlled procedures for staff convenience and not based on the standards and conditions for use of the procedures to increase adaptive skills and decrease target behaviors, e.g., consumers are told that if they do not stop engaging in a behavior that a controlled procedure will be used and that no efforts to teach an alternative behavior are used.

Allegation number 4: METO staff implement controlled procedures on an emergency basis for staff convenience without the consumers' behavior meeting the criteria for use, i.e., immediate intervention is needed to protect the person or others from physical injury or to prevent severe property damage that is an immediate threat to the physical safety of the person or others, and METO fails to complete the required review and reporting when a controlled procedure is used on an emergency basis.

It was alleged that for one consumer (C1), METO used controlled procedures (manual and mechanical restraints) on C1 on an emergency basis on 17 occasions since March 26, 2007, without consulting C1's primary care physician on whether the restraints would be medically contraindicated and without consideration of C1's diagnosed seizure condition. A formal IPP for the use of the controlled procedures was still not developed after the first 15 uses.

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It was alleged that for one consumer (C2), METO used controlled procedures (manual and mechanical restraints) on C2 without consulting with the primary care physician on whether the restraints would be medically contraindicated due to C2's diagnosed sensory hearing loss and did not assess whether C2's sensory hearing loss was related to C2's behavior or how staff needed to accommodate the hearing loss when implementing a controlled procedure.

It was alleged that for one consumer (C3), METO staff used controlled procedures (manual and mechanical restraints) on C3 without consulting with the primary care physician on whether the restraints would be medically contraindicated due to C3's diagnosis of asthma.

It was alleged that for one consumer (C4), METO staff used controlled procedures (manual and mechanical restraints) on C4 without consulting with the primary care physician on whether the use of the restraints were medically contraindicated due to C4's diagnosed seizure disorder and "brain stem dermoid tumor." METO staff threatened C4 that a controlled procedure would be used if C4 did not stop pounding on a wall or slamming the door, without their first trying another less restrictive method to redirect or prevent the target behavior.

It was alleged that for one consumer (C5), METO staff used controlled procedures on an emergency basis 15 times prior to developing an IPP for its use. The legal representative signed an informed consent form for the use of the controlled procedure conditional on METO implementing the procedures according to the modifications to the plan that the legal representative wrote on the consent form. METO implemented the procedure as written, not as modified and consented to by the legal representative. METO did not attempt to otherwise have the IPP modified with review and approval by the interdisciplinary team.

Investigation Procedure:

Onsite visit: November 26, 2007

Documents reviewed:

Consumer records for C1:

- Individual Service Plan (ISP) dated March 2005
- Risk Management Plan (RMP) dated July 13, 2007
- Physical exam (PE) reports dated July 6, 2005, May 17, 2006, and July 2, 2007
- Individual Program Plans (IPP) dated July 13, 2007
- Emergency Use of Controlled Procedure (EUCP) reports 26 reports dated August 11, 2005 to August 27, 2007

Consumer records for C2:

- ISP dated September 19, 2007
- RMP dated September 19, 2007
- PE reports Admission and Annual 7 reports dated August 30, 2000 August 13, 2007
- Medical Information in Behavior Management Program Using Controlled Procedures dated June 25, 2007
- IPP dated September 19, 2007
- IPP Rule 40 Addendum dated February 23, 2007, revised September 17, 2007
- IPP/CP Informed Consents- 6 quarterly consents dated October 28, 2006-October 27, 2007
- IPP/CP use reports 18 reports dated April 15, 2007 October 28, 2007
- IPP/CP quarterly reports 6 reports dated April 2006 September 2007

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- IPP staff in-service records dated January 2006 November 2007
- EUCP reports 5 reports dated April 14, 2004- October 6, 2006

Consumer records for C3:

- ISP dated August 30, 2007
- RMP dated August 30, 2007
- Physical Exam reports dated August 10, 2005, July 19, 2006, August 17, 2007
- IPP dated August 30, 2007
- IPP Rule 40 Addendums dated August 29, 2005, September 1, 2005, August 3, 2007
- IPP/Controlled Procedure (CP) Informed Consents 12 quarterly consents dated August 19, 2005-October 13, 2007
- IPP/CP use reports 22 reports, dated June 7, 2007 November 18, 2007
- IPP/CP quarterly reports dated May-July 2007, Aug-Oct 2007
- IPP staff in-service records dated September 2005 October 2007
- Education/Treatment Objectives dated August 30, 2007

Consumer records for C4:

- RMP dated November 27, 2006
- PE reports dated November 8, 2006 and October 29, 2007
- Medical Information in Behavior Management Program Using Controlled Procedures dated June 25, 2007
- IPP dated November 27, 2006
- IPP Rule 40 Addendum dated November 22, 2006, revised May 7, 2007, revised August 22, 2007
- IPP/CP Informed Consents 4 quarterly consents dated February 10, 2007 September 16, 2007
- IPP/CP use reports 19 reports dated September 4, 2007 October 14, 2007
- IPP/CP quarterly reports 4 reports dated November 2006 July 2007
- IPP staff in-service records dated November 2006 October 2007
- EUCP reports dated November 8, 2006 December 2, 2006
- Psychotropic Medication Addendum dated October 22, 2007
- Emergency Use of Psychotropic Medication report 4 reports dated November 19, 2006 November 21, 2006
- Education/Treatment Objectives dated November 29, 2006
- Annual Plan Summary dated November 27, 2006

Consumer records for C5:

- 45-Day meeting notes dated September 24, 2007
- PE report dated August 10, 2007
- IPP dated September 24, 2007
- IPP Rule 40 Addendum dated September 24, 2007
- IPP informed consent dated October 11, 2007
- Education/Treatment Objectives dated September 24, 2007
- IPP use report dated November 14, 2007
- EUCP reports 15 reports dated August 10, 2007 September 13, 2007
- EUCP reports completed after IPP/CP consent -5 reports October 22, 2007 December 3, 2007
- IPP staff in-service records dated November 2007
- E-mail correspondence between C5's Legal Representative and METO (provided by FM5) dated

- Use of Emergency Controlled Procedures at Minnesota Extended Treatment Options, including Pictures of Mechanical Restraints used on Emergency Basis at METO (Interdisciplinary Team Guide, no date or policy number)
- Emergency Use of Controlled Procedures (Manual and Mechanical Restraint) (Policy Number 3503, effective November 26, 2007)
- Emergency Use of Controlled Procedures (Manual and Mechanical Restraint) (Policy Number 3503, effective February 7, 2008)
- Use of Controlled Procedures in Behavior Management (Policy Number 3504, effective December 19, 2006).
- Therapeutic Intervention/ Personal Safety Techniques (Policy Number 3505, effective March 28, 2007)
- METO Therapeutic Intervention and Physical Safety Techniques Protocol (Procedure 3505 Appendix A, not dated)
- Therapeutic Intervention Instructor Guidelines for Role, Distribution, Selection, Training, and Position Description (Procedure 3505 Appendix B, not dated)

The program's forms:

- Documentation for Implementation of Approved Aversive and/or Deprivation Procedures including Directions for Documentation (Form 31032, dated November 2007)
- Documentation for Emergency Use of Controlled Procedure (Form 31025, dated November 2007)
- Documentation for Emergency Use of Controlled Procedure (Form 31025, dated January 2008)

Interviews (conducted between November 20, 2007, and March 24, 2008):

- Two facility administration staff (FA1 and FA2)
- DHS-DSD Rule 40 Coordinator (P2)
- C2's case manager (CM2) via telephone
- C2's family member and legal representative (FM2) via telephone
- C3's case manager (CM3) via telephone
- C4's case manager (CM4) via telephone
- C4's family member and legal representative (FM4) via telephone
- C5's case manager (CM5) via telephone
- C5's family member and legal representative (FM5) via telephone

Pertinent Information/Summary of Findings:

Minnesota Extended Treatment Options (METO) is located at what had been the Cambridge Regional Treatment Center campus. It consists of 8 program units or "homes" in four buildings. Each building is licensed by the Minnesota Department of Health as a Supervised Living Facility. Homes 3 and 4 are in one building and are ICF/MR certified. This building is also licensed by DHS as a Residential Services program. The other buildings are not ICF/MR certified but are subject to DHS licensing standards as Residential Services, not ICF/MR certified.

Minnesota Rules, parts 9525.2700 to 9525.2810 govern the use of controlled procedures in programs serving people with developmental disabilities that are licensed by the Department of Human Services (DHS).

Rule part 9525.2750, subpart 1, which governs the standards for controlled procedures, states that:

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> The controlled procedure is proposed and implemented only as part of a total methodology specified in the person's individual program plan. The individual program plan has as its primary focus the development of adaptive behaviors. The controlled procedure approved represents the lowest level of intrusiveness required to influence the target behavior and is not excessively intrusive in relation to the behavior being addressed.

Rule part 9525.2770, subpart 2, which governs requirements for the emergency use of controlled procedures states that:

Emergency use of controlled procedures must meet the conditions in items A to C.

- A. Immediate intervention is needed to protect the person or others from physical injury or to prevent severe property damage that is an immediate threat to the physical safety of the person or others.
- B. The individual program plan of the person demonstrating the behavior does not include provisions for the use of the controlled procedure.
- C. The procedure used is the least intrusive intervention possible to react effectively to the emergency situation.

Rule part 9525.2780, subpart 1, which governs requirements for obtaining informed consent states that:

Except in situations governed by part 9525.2730, subpart 3 or 9525.2770, the case manager must obtain or reobtain written informed consent before implementing the following:

- A. a controlled procedure for which consent has never been given;
- B. a controlled procedure for which informed consent has expired. Informed consent must be obtained every 90 days in order to continue use of the controlled procedure; or
 - C. a substantial change in the individual program plan.

If the case manager is unable to obtain written informed consent, the procedure must not be implemented."

In addition, rule part 9525.2780, subpart 4, requires information identified in items A-K to be provided by the case manager to the legal representative as a condition of obtaining informed consent, and states in part that:

- Consent obtained without providing the information is not considered to be informed consent.
- The case manager must document that the information was provided orally and in writing and that consent was given voluntarily.
- The information must be provided in a nontechnical manner and in whatever form is necessary to communicate the information effectively and in a manner that does not suggest coercion.

FA1 and FA2 provided the following information during an interview:

FA1 and FA2 denied that legal representatives were coerced into providing consent for the use of controlled procedures. FA1 and FA2 stated that it would not be possible for them to not serve a consumer admitted to METO as they were under commitment to the METO program and would be served regardless of consent. FA2 stated that there were difficulties in obtaining consent for the use of a controlled procedure with a former consumer and with a current consumer, C5.

METO's Therapeutic Intervention/Personal Safety Techniques Procedure (Procedure Number 3505; 171 Effective Date March 28, 2007) provides the following information:

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- The definition of "Therapeutic Intervention" states in part that therapeutic intervention is, "A form of intervention which consists of early identification of potential crises; prevention through verbal, non-verbal, and non-physical methods [Emphasis added]."
- The definition of "Personal Safety Techniques" states in part that a personal safety technique is, "Application of external physical control by employees to clients who become aggressive despite the preventive strategies attempted."

For C1:

C1 was admitted into METO on June 30, 2005, under civil commitment and assigned to Home 4, the ICF/MR building. C1 does not have an Individual Program Plan (IPP) for the use of controlled procedures. However, controlled procedures were used on an emergency basis a total of 26 times between August 11, 2005 and August 27, 2007, 15 of which occurred between May 7, 2007 and August 27, 2007. These occurrences included manual restraints using "arm bar takedowns" and prone holds, and mechanical restraints using "cuffs" and "hobbles."

The purpose statement of METO's Emergency Use of Controlled Procedures (Manual and Mechanical Restraint) Procedure Number 3503, dated November 26, 2007, states in part that, "Exception: The only controlled procedure as defined in Minnesota Rules 9525.2740 that can be used in an emergency with a client assigned to the ICF-MR building shall be manual restraint. Staff may use emergency manual, and if necessary, mechanical restraint, with clients assigned to Non ICF-MR buildings." However, in both the EUCPs implemented for C1 mechanical restraints were used on eight separate occurrences between June 15, 2006 and June 26, 2007.

C1's Risk Management Plan (RMP) dated May 22, 2007, states C1 engages in maladaptive behaviors that "may frustrate others and promote physical abuse." C1 "pokes others," throws personal items (pillows, stuffed animals, art supplies) "at people and at their head," and C1 "refuses to leave areas when directed." C1 engages in "self-abusive behaviors of scratching (breaking the skin), kicking or banging his/her head on the cement floor or wall for hours." The plan to reduce the risk as stated in the RMP is for C1 to participate in a maladaptive behavior reduction program that combines learning alternatives to expressing anger, anxiety, and fear with adaptive coping strategies. The RMP does not address the previous use emergency use of controlled procedures.

A physical examination and health assessment completed for C1 on July 6, 2005, by METO's registered nurse (RN) / Certified Nurse Practitioner (CNP), identifies "seizure disorder" under past medical history and includes the statement, "No contraindications to emergency manual restraint. May use prone hold and switch to side lying after control gained." A handwritten note was added to that form dated December 14, 2005, stating, "No contraindications to mechanical or manual intervention measures. Should be side lying after initial control is obtained."

C1's physical examination and health assessment completed on May 17, 2006, by the RN/CNP also identifies "seizure disorder" and includes the statement, "No contraindications to mechanical or manual intervention measures. Should be side lying after initial control is obtained." C1's physical examination and health assessment completed on July 2, 2007, by METO's attending physician, identifies "seizure disorder, controlled," "seasonal allergies, controlled," and includes the statement, "No contraindication therapeutic intervention procedures."

C1's ISP dated March 2005 identified C1 as having asthma. C1's RMP dated May 22, 2007, identifies C1 having a history of asthma under physical limitations. The action plan to reduce or eliminate risk of harm due to the vulnerability states that, "[C1] participates in self administration of medications. Part of the training is to self report symptoms." This diagnosis is not identified on any of the physical examination and health assessments completed by METO.

Notes from the Interdisciplinary Team (IDT) quarterly meeting dated June 1, 2007, state in part that: "Since a visit to the group home, several weeks ago, [C1] has shown a significant increase in target behaviors requiring emergency restraint. [C1] has also expressed slight perseveration on handcuffs and being held." A note on the EUCP report dated August 27, 2007, states, "QMRP to develop R40." As of March 31, 2008, a Rule 40 Addendum to the IPP for the use of controlled procedures has still not been developed.

There were multiple EUCP reports completed by staff persons who initiated the emergency controlled procedures that did not document that all criteria for emergency use were met or that the reviewing and reporting requirements were met for each use (refer to attached table of EUCP reports for C1). In general the reports failed to:

- adequately describe the incident leading to the emergency use;
- document evidence that immediate intervention was needed to protect C1 or others from physical injury or to prevent severe property damage that is an immediate threat to the physical safety of C1 or others;
- document evidence that the controlled procedure used was the least intrusive intervention possible to react effectively to the emergency situation;
- document if or when the EUCP report had been sent to all members of the expanded IDT, and for those involving manual and mechanical restraint if they had been sent to METO's internal review committee for review, within seven calendar days of the emergency use of the controlled procedure; and
- document if or when the expanded IDT conferred on the emergency use of the controlled procedures, including whether the EUCP reports were sent to all members of the expanded IDT and that the expanded IDT defined the target behavior for reduction or elimination in observable and measurable terminology; identified the antecedent or event that gave rise to the target behavior; and if they identified the perceived function the target behavior served; and determined what modifications should be made to the existing individual program plan so as to not require the use of a controlled procedure.

For C2:

C2 was admitted to METO on August 28, 2000, under civil commitment and assigned to Home 4, the ICF/MR building. C2 has an Individual Program Plan (IPP) for the use of controlled procedures that was initially developed and approved for use by METO on October 28, 2006. Addendums to the initial IPP were made on February 23, 2007, and September 17, 2007. C2's IPP includes the use of manual and mechanical restraints using Posey© mobile restraint strap with (soft) cuffs at the wrists behind the back and a Ripp© leg hobble at the ankles.

Informed consent for the use of the controlled procedures was given by C2's legal representative, FM2, on October 27, 2007. FM2 checked off on the form that, "I voluntarily consent to the use of the identified controlled procedure(s)." The legal representative's comment section of the form was left blank. This is consistent with all informed consents obtained quarterly since October 28, 2006.

CM2 provided the following information during an interview:

FM2 has not objected to or raised questions or concerns about the use of the controlled procedures by METO for C2 at the time the IDT's annual progress review meetings and has provided voluntary consent for the use of the controlled procedures on an ongoing basis.

FM2 provided the following information during an interview:

FM2 stated that controlled procedures were first implemented two years ago and did not include the use of mechanical restraints. Sometime in the last year the use of manual and mechanical restraints were added to the IPP which includes the use of soft cuffs for the hands and a rip hobble at the ankles. FM2 said that, "No one contacted me about the changes [adding the use of mechanical restraints as a controlled procedure], they were written in the quarterly reports I received. I read about it in the methodology sections. I was surprised to see this so I asked them questions about what they would be doing and why they made the change. They explained the use of the soft Posey cuffs and the rip hobble and that their use would not cause injury to [C2]." FM2 added, "I don't remember discussing the use of the Posey cuffs or the rip hobble, but I did consent to their use." FM2 stated that s/he had not been pressured or coerced into giving consent for the use of the mechanical restraints.

An annual physical examination and health assessment was completed for C2 by METO's attending physician, on August 13, 2007. "Sensorineural hearing loss, bilateral" is listed under medical history and includes the statement, "No contraindication to emergency use of mechanical or manual intervention procedures." This is consistent with past physical examinations and health assessments completed by METO.

A Medical Information in Behavior Management Program Using Controlled Procedures form for C2 signed by METO's attending physician on June 25, 2007, describes the target behaviors to be reduced or eliminated and the type of hold and restraint to be used in response. The physician answered no as to whether there is "any medical evidence that a non-psychiatric medical condition(s) could result in the demonstrating of the target behavior(s) or should be considered in the development of the behavior management program." The physician also answered no as to whether the use of a controlled procedure or manual or mechanical restraints were medically contraindicated.

C2's IPP Rule 40 Addendum Assessment Review provided the following information:

- Under the Medical Conditions section C2's hearing loss identified as well as "severe migraine headaches." Also that, "[T]he onset of a migraine headache may be an antecedent for any of the target behaviors listed above."
- Under the Communicative Intent/Function section C2 is identified as being "non-verbal, utilizing a limited amount of American Sign Language and picture /communication boards to communicate [his/her] wants and needs." Also, "Due to [C2's] communication deficits, others in [his/her] environment sometimes have difficulty understanding [him/her], [s/he] may become frustrated by the delay in attaining a desired outcome from the interaction. This frustration may contribute to [his/her] demonstration of target behaviors."

C2's Risk Management Plan identifies C2 as being vulnerable because s/he does not independently inform staff that s/he is ill. The plan to reduce this risk is for staff to observe C2 for signs and symptoms of illness, particularly for migraines, and that staff initiate asking how C2 is feeling.

C2's IPP directs staff persons to use sign language and picture boards when communicating with C2 when implementing the IPP. Additionally, C2 is not required to verbalize him/herself during restraint to be released, and staff are to communicate verbally and through American Sign Language throughout the use of a controlled procedure. The IPP does not direct staff to ask C2 how s/he is feeling or if s/he is experiencing a migraine.

C2's IPP Rule 40 Addendum for the use of controlled procedures (IPP) identifies three categories of target behavior: property destruction, major self injury, and physical aggression. The antecedents identified for these behaviors include minor self-injury and stalking. If C2 exhibits antecedent behavior staff must give a signed and verbal cue to C2 to stop the behavior and staff must communicate through signing and use of the picture board to identify the source of agitation and will remedy the situation if possible. Staff must redirect C2 to an "appropriate alternative (i.e. take deep breaths to calm down, ask staff to help, rocking in a rocking chair, or going for a walk)." If C2 discontinues the antecedent behavior staff must provide behavior specific positive feedback. If C2 does not respond to the less restrictive interventions and proceeds to a target behavior staff must implement the controlled procedures in accordance with the instructions in the IPP which is initiated by staff signing, "stop the behavior" and a verbal and signed prompt must be given that C2 should lie down on the floor in a prone position. If C2 refuses to lie down, "staff will use approved therapeutic techniques to restrain [him/her] on the floor in a prone position."

Once the mechanical restraints are applied staff must roll C2 onto his/her side.

A review of 18 "Documentation for Implementation of Approved Aversive and/or Deprivation Procedures" reports completed by staff following the use of a controlled procedure with C3 between April 15, 2007 and October 28, 2007, provided the following information:

For a controlled procedure implemented on April 15, 2007, the reports states that staff cued C2 to stop [antecedent behavior] and staff "asked [him/her] to go to [his/her] room to calm down." Being sent to his/her room is not identified as a less intrusive intervention to be implemented prior to implementing a controlled procedure.

Prior to the development and approval of the IPP for the planned use of controlled procedures, emergency use of controlled procedures (EUCP) were implemented at least twice, once on February 22, 2006, and again on October 6, 2006. It was not documented for the October 6, 2006, emergency use that the property destruction was severe enough to create an immediate threat to the physical safety of the person or others. Neither report form documented if or when the expanded IDT conferred on the emergency use of the controlled procedures, including whether the EUCP reports were sent to all members of the expanded IDT and that the expanded IDT defined the target behavior for reduction or elimination in observable and measurable terminology; identified the antecedent or event that gave rise to the target behavior; if they identified the perceived function the target behavior served; and determined what modifications should be made to the existing individual program plan so as to not require the use of a controlled procedure.

Date	Mechanical or Manual Restraint	Duration	Behavior
02/22/2006	Mechanical "cuffs and Hobble"	6 min	flipping tables co-workers were sitting at; banging head on floor; kicking at staff
10/06/2006	Mechanical "cuffs and Hobble"	11 min	destroying things in his/her room

The purpose statement of METO's Emergency Use of Controlled Procedures (Manual and Mechanical Restraint) Procedure Number 3503, dated November 26, 2007, states in part that, "Exception: The only controlled procedure as defined in Minnesota Rules 9525.2740 that can be used in an emergency with a 175

client assigned to the ICF-MR building shall be manual restraint. Staff may use emergency manual, and if necessary, mechanical restraint, with clients assigned to Non ICF-MR buildings." However, in both the EUCPs implemented for C2 mechanical restraints were used.

For C3:

C3 was admitted into METO on August 9, 2005, under civil commitment and assigned to Home 8, a non-ICF/MR building. C3 has an Individual Program Plan (IPP) for the use of controlled procedures that was initially developed and approved for use on August 29, 2005. Addendums to the initial IPP were made on September 1, 2005, and August 3, 2007. C3's IPP includes the use of manual and mechanical restraints using a Posey® mobile restraint strap with (soft) cuffs and metal handcuffs to be used at the wrists behind the back, a Ripp® leg hobble at the ankles, and mobile restraints using a Posey® transportation belt at the waist with wrists locked into wrist restraints.

For each of the last four informed consents obtained from C3's legal representative for the use of the controlled procedures, dated March 8, 2007, through January 11, 2008, C3's legal representative consistently checked off on the informed consent form that consent was given voluntarily or that consent was given according to the conditions identified by the legal representative in the comment section of the consent form. In each situation where the legal representative indicated consent was given according to comments, the comment section of the form was left blank.

CM3 provided the following information during an interview:

C3's legal representatives visit C3 a couple of times a year but have not attended any of the interdisciplinary team (IDT) meetings at METO for C3 and have not raised concerns or questions regarding the use of controlled procedures for C3 by METO. C3's legal representatives have provided voluntary consent for the initial IPP proposing the use of a controlled procedure and have renewed consent for ongoing use of the controlled procedures on a quarterly basis since then.

C3's physical examination and health assessments dated August 10, 2005; July 19, 2006; and August 17, 2007, each identified "past history of asthma" under the medical history. Each was conducted and signed by METO's Registered Nurse (RN) / Certified Nurse Practitioner (CNP).

C3's physical examination and health assessment dated August 10, 2005, includes the statement; "No contraindication to emergency manual restraint. May hold prone until control is gained and then place in side-lying position." A handwritten note on this document signed by the RN/CNP dated December 14, 2005, states, "No contraindication to emergency use of mechanical or manual intervention measures. Should be held side-lying after initial control is obtained."

C3's physical examination and health assessments dated July 19, 2006, and August 17, 2007, include the statement, "No contraindication to emergency use of mechanical or manual intervention measures. Should be held side-lying after initial control is gained."

A Medical Information in Behavior Management Program Using Controlled Procedures form for C3 signed by METO's attending physician on February 9, 2006, describes the target behaviors to be reduced or eliminated and the type of hold and restraint to be used in response. The physician answered no as to whether there is "any medical evidence that a non-psychiatric medical condition(s) could result in the 176 demonstrating of the target behavior(s) or should be considered in the development of the behavior

management program." The physician also answered no as to whether the use of a controlled procedure or manual or mechanical restraints were medically contraindicated.

C3's IPP Rule 40 Addendum for the use of controlled procedures (IPP) identifies three categories of target behavior: verbal threats of physical aggression, physical aggression, and property destruction. The IPP does not identify specific antecedents for these behaviors. However, the IPP does state in part that, "[C3] has a history of aggression and of threatening others with weapons and a past history of assault. Based upon the information available upon admission, [C3's] threats are best viewed as serious and, if not immediately controlled, imminently dangerous to staff." And, "Historically [C3] has engaged in significant aggression which has frequently resulted in injury to family, peers and/or caregivers. The team determined that early intervention in the escalation cycle would have the greatest likelihood of decreasing the frequency and intensity of aggression. Verbal aggression was noted to frequently occur prior to aggression so it was specifically targeted for skill replacement. Due to [C3's] physical size as well as [his/her] aptitude for injuring others, the team determined that manual restraint is not the safest mode of restraint for [C3] due to the difficulty in applying consistent, constant pressure. National data also suggest that manual restraint poses a greater risk of serious injury to clients. Mechanical restraints were therefore evaluated by the team. Due to [C3's] size and strength, it was determined that of the restraint modalities likely to be effective, handcuffs and a hobble would be the simplest, quickest, and least intrusive method of restraint."

The IPP does not identify any other antecedent to verbal aggression. However, when C3 makes a verbal threat, the IPP directs staff to first verbally redirect C3 to "use self-control, per [his/her] social skills program, and identify and resolve whatever conflict or upset has resulted in the threat" prior to implementing the use of a controlled procedure. If the redirection fails and the threats of physical aggression continue, staff are directed to implement the use of the mechanical restraints which is initiated with "a verbal cue to get down on the floor/ground." And, "At least three staff will restrain and immobilize [C3] prone on the floor using approved TI/PST [Therapeutic Intervention/Personal Safety Techniques] techniques [sic]." Once the mechanical restraints are applied, "Staff may suggest that [s/he] roll to [his/her] side if that is more comfortable for [him/her] that [sic] being prone."

A review of 22 "Documentation for Implementation of Approved Aversive and/or Deprivation Procedures" reports completed by staff following the use of a controlled procedure with C3 between June 7, 2007 and November 18, 2007, provided the following information:

On June 6, 2007, two separate reports were completed for the implementation of a single controlled procedure. The first report documented the procedure as starting at 11:30a.m. and ending at 12:20p.m., lasting a total of 50 minutes, at the end of which the steel "hand cuffs removed @ 12:20 & still in soft cuffs." It is not clearly stated that leg hobbles were used but notation on the first report states that at 12:15p.m., "criteria not met -ankle released," which would indicate that leg hobbles were used. The second report documents the restraint starting at 12:25p.m. and ending at 12:40p.m. when C3 "met release criteria." The second report states that the antecedent behavior was, "Rule 40 - Released from cuffs (hard), put in soft cuffs." The second report states the procedure lasted 15 minutes.

Minnesota Rules, part 9525.2750, subpart 1, item I, requires that when mechanical restraint is used the person must be given an opportunity for release from the mechanical restraint and for motion and exercise of the restricted body parts for at least ten minutes out of every 60 minutes that the mechanical restraints are used. Further, C3's IPP states in part that, "[S]hould the mechanical restraint exceed one hour, [C3] MUST be provided with the opportunity to freely move each limb that is being restricted for ten minutes. Should [C3] aggress at any time upon release, a new episode of restraint will be initiated."

Based on the documentation provided in the two reports the total time of the single procedure was 65 minutes; that soft cuffs were applied during the first report period and their use continued through the second; and that during the 65 minute procedure there is no documentation that C3 was given an opportunity for release from the mechanical restraint and for motion and exercise of the restricted body parts for at least ten minutes out of every 60 minutes that the mechanical restraints are used.

Neither report documented whether a staff person remained with C3 during the time C3 was in the mechanical restraint restricting three or more limbs.

For C4:

C4 was admitted into METO on November 6, 2006, under civil commitment and assigned to Home 8, a non-ICF/MR building. C4 has a current Individual Program Plan (IPP) for the use of controlled procedures initially developed on November 22, 2006. Addendums to the IPP were made on December 6, 2006, May 7, 2007, and August 22, 2007. C4's IPP includes the use of manual and mechanical restraints using Posey® mobile restraint strap with (soft) cuffs and metal handcuffs at the wrists behind the back and a Ripp® leg hobble at the ankles.

The informed consent forms for the IPP signed by C4's legal representative on February 10, 2007, April 27, 2007, July 23, 2007, and September 16, 2007, all were checked that informed consent was given voluntarily. The comment section of each informed consent form was left blank by the legal representative. The informed consent form signed by C4' legal representative on October 13, 2007, indicated the information was provided orally both at a meeting and by telephone but did not indicate when the required information was provided orally.

CM4 provided the following information during an interview:

C4's legal representatives were involved in every step of the development of the IPP and have voluntarily given consent for the use of the controlled procedures without coercion by METO. The legal representatives feel C4 receives excellent care at METO and, "If they felt [C4] wasn't being taken care of they would not hesitate to contact me or anyone to else to raise concerns." And, "If the family felt [s/he] was [s/he] was being mistreated in any way they would let me or someone else know"

FM4 provided the following information during an interview:

Consent has been given voluntarily for the use of the controlled procedures at METO. The procedures are used only when needed and when less restrictive measures are not successful. Some controlled procedures previously used by METO have been discontinued as they are no longer needed "because [s/he] has improved over the last year." FM4 reported that if staff were implementing controlled procedures improperly that, "We go every weekend and know most of the staff. If something were happening we would probably notice."

C4's physical examination and health assessment completed by METO's RN/CNP on November 8, 2006, identified C4's seizure disorder and a brain stem dermoid tumor under the medical diagnoses and included the statement, "No contraindication to emergency use of mechanical or manual intervention measures." C4's physical examination and health assessment dated October 29, 2007, also lists seizure disorder and the brain stem dermoid tumor under diagnoses and includes the statement, "No contraindication to the 178se of mechanical or manual restraint procedures."

A Medical Information in Behavior Management Program Using Controlled Procedures form for C4 signed by METO's attending physician on June 25, 2007, describes the target behaviors to be reduced or eliminated and the type of hold and restraint to be used in response. The physician answered no as to whether there is "any medical evidence that a non-psychiatric medical condition(s) could result in the demonstrating of the target behavior(s) or should be considered in the development of the behavior management program." The physician also answered no as to whether the use of a controlled procedure or manual or mechanical restraints were medically contraindicated.

C4's IPP Rule 40 Addendum for the use of controlled procedures (IPP) identifies three categories of target behavior: physical aggression, property destruction, and self injurious behaviors. The antecedents identified for these behaviors include "signs of agitation (running, checking doors, ignoring staff directions, loud vocalizations)." If C4 exhibits antecedent behavior staff must give a verbal cue to C4 to stop the behavior and staff must attempt to identify the source of C4's agitation and remedy the situation if possible. Staff must redirect C4 to an appropriate alternative behavior. If C4 does not respond to the less intrusive interventions and proceeds to a target behavior staff must implement the controlled procedures in accordance with the instructions in the IPP which is initiated with a "verbal prompt to 'stop the behavior' and to lie down on the floor in a prone position." If C4 refuses to lie down on his own staff must "use approved therapeutic techniques to restrain him/her on the floor in a prone position." Once the mechanical restraints are applied staff must roll C4 to a side-lying position.

The IPP did not include documentation describing how intervention procedures incorporating positive approaches and less intrusive procedures have been tried, how long they were tried in each instance, and possible reasons why they were unsuccessful in controlling the behavior concern. The LH simply stated "Alternative Training" and that the factors limiting effectiveness were "communication deficits."

A review of 18 "Documentation for Implementation of Approved Aversive and/or Deprivation Procedures" reports completed by staff following the use of a controlled procedure with C4 between September 4, 2007 to October 14, 2007, provided the following information:

For controlled procedures implemented on 09/11/2007, 09/17/2007, 09/19/2007, 09/21/2007, 09/27/2007, 09/30/2007, 10/05/2007, 10/08/2007, two on 10/11/2007, and 10/15/2007, there was no documentation that staff attempted to help C4 identify the source of agitation that lead to the antecedent behavior or to remedy the situation. In these incidents staff only directed C4 to stop whatever antecedent behavior had been documented.

For a controlled procedure implemented on 09/21/2007 there was documentation indicating that the staff person's behavior or direction may have caused the target behavior when C4 was directed to take a shower instead of a bath. There was not documentation why C4 could not choose between a bath or a shower to justify this choice being eliminated.

Prior to implementation of the IPP for the planned use of controlled procedures, emergency use of controlled procedures (EUCP) occurred eight times between November 8, 2006 to December 2, 2006. During that same period there were four instances of emergency initiation of a psychotropic medication—Haldol 5mg, Ativan 2mg, and Benadryl 50 IM. METO failed to meet the reviewing and reporting requirements for the EUCPs. There was evidence that when staff persons implemented an EUCP with C4, that the reporting and review requirements were not followed. There was no evidence in the materials reviewed that documented that the case manager conferred with METO about the initial EUCP.

For C5:

C5 was admitted to METO on August 10, 2007, under civil commitment and assigned to Home 1, a Non-ICF/MR Building. C5 has an IPP for the use of controlled procedures initially developed on September 24, 2007. C5's IPP includes manual and mechanical restraints using time out and "therapeutic interventions" as needed to "escort [C5] to [his/her] room/quiet table."

C5's IPP for the use of a controlled procedure did not include a report from C5's primary physician identifying whether there is any medical evidence that a non-psychiatric medical condition(s) could result in the demonstrating of the target behavior(s) or should be considered in the development of the behavior management program; or whether the use of a controlled procedure or manual or mechanical restraints were medically contraindicated.

METO's notes from the "45-Day Meeting" form [initial IDT meeting required 45-days after service initiation] dated September 24, 2007, stated that C5's legal representatives "were notified that the frequent implementation of emergency controlled procedures required to manage [C5's] risk to self and others necessitates a programmatic response." Also, that "although [FM5] previously noted preference for the Time Out procedure, at this meeting [s/he] appeared disturbed by the idea of Time Out." However, C5's legal representative was reassured that s/he would receive a written program to review prior to implementation of any IPP for the use of a controlled procedure, but was "notified that in the meantime, the emergency use of controlled procedures would continue to be implemented per policy as needed to keep [C5] and others safe."

On the informed consent form for the IPP signed by FM5 on October 11, 2007, FM5 wrote that informed consent for the use of controlled procedures was being given "to the Rule 40 addendum w/o [sic] use of any mechanical devices and/ or mechanical restraints." The informed consent form does not identify alternative procedures that have been attempted, considered, and rejected as not being effective or feasible. Instead it identifies the less intrusive measures staff will take prior to implementing the controlled procedure. The consent form also does not identify the extent to which the target behavior is expected to change as a result of implementing the procedures.

FM5 provided the following information during an interview:

FM5 did feel as if s/he was being forced to sign the consent form for the use of the controlled procedures. FM5 found the use of manual or mechanical restraints personally aversive. However, FM5 reviewed the IPP and signed the consent on October 11, 2007, for the use of room time out only with the contingency stated in the comment section that s/he only agreed "to the Rule 40 addendum w/o [sic] use of any mechanical devices and/ or mechanical restraints."

CM5 provided the following information during an interview:

CM5 felt that FM5 had not been coerced into providing consent; s/he felt METO had given FM5 the option of consenting to an IPP for the use of a controlled procedure. In addition, CM5 indicated that FM5 took "forever" to sign the consent for the IPP and there was no force used to obtain the consent.

In an e-mail dated October 3, 2007, from a facility staff person (P1) to FM5 regarding documents requiring signature by the legal representative states in part, "It is imperative that you return these documents, with signature ASAP."

In an e-mail dated October 4, 2007, from P1 to FM5, regarding the same documents identified in the October 3, 2007, e-mail states in part: "[C5's] treatment is stalled because we do not have signed signatures on anything we have given you. I will be calling [CM5] again today to begin [C5's] treatment."

In an e-mail dated October 5, 2007, from CM5 to FM5, states in part: "It is my understanding that you have received the information [all documents addressed in 10/04/2007 e-mail from SP3 to FM5], and returned the forms with your signatures. If you have not done this yet, it is very important that you do sign the forms and return them to METO ASAP. I understand and agree that you should have time to review the plans before you give your consent. However, it is very important that you give your consent to allow METO to work with your [son/daughter] in order to help [him/her] resolve some of [his/her] issues." And "I spoke to [P1] today and it is my understanding that your [son's/daughter's] therapist will not work with [him/her] until you have consented to the plans. In addition, METO may take the stance that if the plans are not approved, then they could have [him/her] discharged from their facility. I certainly hope it does not come to that."

The IPP Rule 40 Addendum for the use of controlled procedures (IPP) as consented to by FM5 provided the following information:

The antecedents identified for these behaviors include signs that C5: "may be frustrated or agitated."
"Staff will encourage [C5] to use a skill learned in START group, SAFE group, individual therapy, or
[s/he] may choose an activity provided by [his/her] Occupational Therapy Assessment." If C5 refuses,
staff will ask C5 whether there is anything C5 wants to talk about." If C5 refuses to use calming
techniques and engages in any of the target behaviors, the criteria has been met for implementation of the
controlled procedure at which point staff deliver a verbal prompt to "stop the behavior."

The IPP then allows for the use of time out and the use of "approved therapeutic techniques to escort [C5] into [his/her] room/quiet table." The IPP did not provide for release from time out as required, specifically that "release is contingent on the person's stopping or bringing under control the behavior that precipitated the time out and must occur as soon as the behavior that precipitated the time out abates or stops." Under "Staff Response" for the "Behavior" section of the IPP, staff are directed to do the following:

- "1. Deliver a verbal prompt to stop the behavior " and
- "2. If [s/he] complies, inform [him/her] that 5 minutes of calm is expected before Time Out is discontinued."

This contradicts the directives under "Staff Response" for the "Release Criteria" section of the IPP, which directs staff to do the following:

"1. After [C5] stops the behavior(s) that precipitated the Time Out, inform [him/her] that [s/he] has met the criteria to discontinue Time Out and advise [him/her] that [s/he] may leave [his/her] 181 bedroom/quiet table."

C5's IPP Rule 40 Addendum for the use of controlled procedures (IPP) identifies four categories of target behavior: Major self-injurious behavior, physical aggression, major property destruction, and "AWOL" (absent without leave).

A review of the "Documentation for Implementation of Approved Aversive and/or Deprivation Procedures" reports completed by staff following the use of a controlled procedure with C5 between October 22, 2007 and December 5, 2007, provided the following information:

Only one in six uses of controlled procedures included use of time out. The other five occurrences included the use of manual and mechanical restraints

Date	Mechanical or Manual Restraint	Duration	Effort to lessen every 15 min	Behavior	Time Out Used
10/22/2007	EUCP manual-arm bar take down, prone hold; mechanical-cuffs and hobble No documented attempt to use time out	27 min	no	unable to go to church; physical aggression (undefined) Staff tried "negotiation" and "offered positive alternatives"	no
10/22/2007	EUCP manual-arm bar take down, prone hold No documented attempt to use time out	2 min	n/a	yelling; physical aggression (undefined) Staff tried "negotiation" and "positive alternatives"	no
11/01/2007	EUCP manual-arm bar take down, prone hold No documented attempt to use time out	4 min	n/a	arguing w/ peer & not accepting redirection from staff person (SP); shoved SP Staff tried "negotiation" and "offered positive alternatives" form states "met release criteria" but there is no "release criteria" identified in the IPP	no
11/02/2007	EUCP manual-arm bar take down, prone hold No documented attempt to use time out	2 min	n/a	AWOL, attempt to hit DP; physical aggression - AWOL Staff "tried block exit" "negotiation" and	no
11/14/2007	IPP AS WRITTEN time out	6 min	n/a	swinging fists at staff Staff tried "verbal prompt to calm" and to use "skills per Rule 40">	yes
12/05/2007	EUCP manual-arm bar take down No documented attempt to use time out	5 min	n/a ·	struck peer on back right shoulder; during escort to room for time out C5 struck the staff Staff "attempted to talk with C5	no

Documentation for each use of a mechanical restraint was completed on METO's "Documentation for 182 Emergency Use of Controlled Procedure." The two EUCP forms dated October 22, 2007, and the one

dated November 1, 2007, do not indicate that immediate intervention was required to protect the physical safety of the person or others and the use of those controlled procedures did not meet the criteria for emergency use.

C5's IPP include provisions for the use of time out and the use of "therapeutic intervention techniques" to escort C5 to time out when needed. The informed consent obtained for the use of the controlled procedure explicitly stated that the consent did not include consent to the use of mechanical restraints or devices. There was no evidence that METO attempted to revise the IPP and receive approval to include manual and mechanical restraints. No evidence that the EUCP reports were sent to the expanded IDT for review or that the expanded IDT conferred on the emergency uses as required.

Prior to the development and approval of the IPP for the planned use of controlled procedures, emergency use of controlled procedures (EUCP) occurred 15 times between August 10, 2007 and September 13, 2007. For four of those reported uses it was not clearly documented that immediate intervention was required to protect the person or others from harm or to prevent severe property damage that is an immediate threat to the physical safety of the person or others.

- EUCP report dated September 11, 2007, identified "property destruction throwing & tipping over chairs" as the behavior necessitating the emergency use of manual and mechanical restraints which included using a prone hold and leg hobbles. There is no documentation that the procedure was necessary to prevent severe property damage that is an immediate threat to the physical safety of the person or others.
- EUCP report dated September 13, 2007, identified "physical aggression toward staff" as the reason necessitating the emergency use of manual and mechanical restraints, which included use of "ankle hand cuff and leg hobble" but there is no further documentation of what C5 was doing that required immediate intervention to protect others from harm.
- EUCP reports dated September 9 and 10, 2007, identified "AWOL" and "trying to go AWOL" as the reason necessitating the emergency use of manual restraint. In both instances C5 was outside but it was not documented whether C5 was near the entrance of the campus (METO's campus is fenced at the perimeter) and at risk of leaving the campus and entering the street unsafely.
- For all EUCP reports it was not clearly documented if or when the EUCP report had been sent to all members of the expanded IDT, and for those involving manual and mechanical restraint if they had been sent to METO's internal review committee for review, within seven calendar days of the emergency use of the controlled procedure.
- For all EUCP reports it was not documented if or when the expanded IDT conferred on the emergency use of the controlled procedures, including whether the EUCP reports were sent to all members of the expanded IDT and that the expanded IDT defined the target behavior for reduction or elimination in observable and measurable terminology; identified the antecedent or event that gave rise to the target behavior; if they identified the perceived function of the target behavior served; and determined what modifications should be made to the existing individual program plan so as to not require the use of a controlled procedure.

Dispositions:

<u>Allegation 1</u>: METO uses coercion to obtain informed consent for the use of controlled procedures by telling legal representatives that unless they consent to the use of the controlled procedure METO will not serve the consumer.

Following interviews with case managers and family members/legal representatives and a review of informed consent documents, it is not evident that METO coerced legal representatives into giving consent for the use of controlled procedures for consumers C2-C4. For C5 there was evidence that METO disregarded the conditions of informed consent obtained from FM5, but it is inconclusive as to whether METO used coercion to obtain the consent from FM5.

Disposition: Inconclusive.

Allegations 2: METO's Individual Program Plans (IPPs) developed for the use of controlled procedures do not meet the required standards for assessment, content, and review, including the failure to obtain a report from the physician on whether there are existing medical conditions that could result in the demonstration of behavior for which a controlled procedure may be proposed or should be considered in the development of an IPP for controlled procedure use.

A review of the IPPs for C2-C5 was conducted and it was determined that their IPPs were not in full compliance with the requirements under rule part 9525.2760.

Disposition: Violations determined.

Allegation 3: METO staff use controlled procedures for staff convenience and not based on the standards and conditions for use of the procedures, e.g., consumers are told that if they do not stop in engaging a behavior that a controlled procedure will be used and that no efforts to teach an alternative behavior are used.

A review of the IPPs and the controlled procedure implementation reports for consumers C2-C5 was conducted and it could not be determined that staff implemented controlled procedures for staff convenience; however, it was determined that the facility was not in full compliance with requirements under rule part 9525.2750.

Disposition: Violations determined.

Allegation 4: METO staff implement controlled procedures on an emergency basis for staff convenience without the consumers behavior meeting the criteria for use, i.e., immediate intervention is needed to protect the person or others from physical injury or to prevent severe property damage that is an immediate threat to the physical safety of the person or others, and METO fails to complete the required review and reporting when a controlled procedure is used on an emergency basis.

For consumers C1, C2, C4, and C5, EUCP reports were reviewed and it was determined that for some emergency uses, the controlled procedures were not implemented, reviewed, or reported as required under rule part 9525.7770.

Disposition: Violations determined.

Action Taken by Program:

- The program revised the *Documentation for Emergency Use of Controlled Procedure* (Form 31025, dated January 2008) to incorporate conferring with the EIDT by the QMRP following an EUCP.
- The program revised the Emergency Use of Controlled Procedures (Manual and Mechanical Restraint) (Policy Number 3503, effective February 7, 2008), placing increased emphasis on

Table 1 Consumer 1

Documented Emergency Use of Controlled Procedures

Date	Mechanical or Manual Restraint	Duration	Behavior	
08/11/2005	manual - arm bar take down	15 min	Attempted to grab and hit staff person (SP)	
08/15/2005	manual - arm bar take down	1 min	Moving in on SP, tapping SP on shoulder	
08/26/2005	manual - arm bar take down	20 min	Running AWOL from work station x2	
09/08/2005	manual - prone hold	5 min	Shoved SP	
09/26/2005	manual - arm bar take down	1 min	Striking out at SP x2	
10/31/2005	manual - arm bar take down	2 min	Hit SP with back of hand	
11/02/2005	manual - arm bar take down	3 min	Hit SP with open hand	
11/07/2005	manual - arm bar take down	2 min	Came at SP with hand raised	
06/15/2006	manual & mechanical - cuffs & hobble	39 min	Physical aggression (undefined)	
03/26/2007	manual & mechanical - cuffs & hobble	15 min	Kicked wall with force	
05/07/2007	manual - arm bar take down	20-30 sec	Stood on SP's toes	
05/19/2007	manual & mechanical - cuffs & hobble	50 min	Came at SP, tried to push SP over	
05/24/2007	manual & mechanical - cuffs	50 min	Physical aggression (undefined)	
05/28/2007	manual & mechanical - cuffs & hobble	12 min	Shoved SP	
05/30/2007	manual & mechanical - mech not ID'd	50 min	Shoved SP	
05/30/2007	manual & mechanical - cuffs & hobble	17 min	Poking SP, moving in on peer	
05/31/2007	manual - arm bar take down	1 min	Pushed SP x2	
06/02/2007	manual - arm bar take down	1 min	Touched SP, was blocked, came at SP again / Physical aggression (undefined)	
06/02/2007	manual - arm bar take down	1 min	Poked SP, was blocked, came at SP again / Physical aggression (undefined)	
06/04/2007	manual - arm bar take down	1 min	Touched SP, was blocked, came at SP again / Physical aggression (undefined)	
06/12/2007	manual - arm bar take down	1 min	Threw keys at SP's head	
06/21/2007	manual & mechanical - cuffs & hobble	14 min	Kicked door, staff began to empty C1's room, C1 slammed drawer on SP's fingers	
06/26/2007	manual & mechanical - cuffs & hobble	27 min	Banging head on door with force	
06/26/2007	manual - arm bar take down	2 min	Pinching SP, Banging head on door with force	
08/23/2007	manual - arm bar take down	11 min	Grabbing at SP; Physical aggression (undefined)	
08/27/2007	manual - arm bar take down	12 min	Trying to touch peers & SP and slamming furniture ["QMRF to develop R40"]	

Init	ial & Date
Omb. Review Dir. of Client	and amend to be recommended and the best of the section of the sec
Svc. Review Children's Spec. or MRS Review Intake to Data	
Base	

Appendix D Informational Web Site Links

Informational Web Sites

TASH http://www.tash.org

National Association of Councils on Developmental Disabilities http://www.nacdd.org

National Down Syndrome Society http://wwwndss.org

Autism National Committee http://www.autcom.org

The Arc of the United States http://www.thearc.org

Appendix E

Original Table of Restraints from the 10/29/2007 Site Visit

METO Chart Review October 29, 2007**

Record #	Rule 40 Restraint/Emergency Restraint*	
1	13	
2	4	
3	23	
4	1	
5	2	
6	19	
7		
8	17	
9	18	
10	16	
11	61	
12	42	
13	8	
14	10	
15	15/ <mark>37</mark>	
16	3	
17		
18	3	
19		
20	13	
21	1	
22		
23		
24	15	
25	53/ <mark>2</mark>	
26	1	
27	1	
28	1	
29	12	
30	1	
31		
32		
33		
34		
35		
36		
37	1	
38		
39		
40		

^{*}Numbers in Blue (Left) are Rule 40 procedures, numbers in Red (Right) are classified as emergency use of restraints

^{**} These numbers only came from the current working files. Many of the clients had archived records showing many more restraints when a further review was completed. For example one client had 299 restraints in 2006.