MINNESOTA MODEL STANDARDS

THE DEVELOPMENT, TESTING AND EVALUATION OF A PROACTIVE QUALITY ASSURANCE MECHANISM FOR FACILITIES FOR THE MENTALLY RETARDED

FINAL REPORT

A Product of the
Minnesota Management Model for Deinstitutionalization Project
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CHAPTER 1
INTRODUCTION

This report presents the development, pilot-testing, and evaluation of a model quality assurance mechanism for residential programs serving persons who are mentally retarded.

The quality assurance mechanism consists of two integral components. Following this introduction, Chapter 2 first discusses and presents a set of model standards to assess the quality of programs and services for persons who are mentally retarded. The second component discussed in Chapter 2 is a model "proactive" survey process for implementing the model standards. These two products, taken together, address both the streamlining and simplification of the existing complex licensure and certification process, and the assurance of quality residential services.

BACKGROUND

Minnesota's commitment to deinstitutionalization of its mentally retarded citizens has been evidenced by the rapid growth of community-based residential programs (Bock, 1977). Accompanying this rapid growth has been the need for valid and reliable measures to ensure program quality. The deinstitutionalization process in Minnesota has entailed not only moving mentally retarded persons back into the community, but also providing clients with quality services in those community placements and upgrading services in the large state institutions.

The Minnesota State Department of Public Welfare is responsible for assuring that quality services are provided to its mentally retarded citizens. Regulations are one of the tools for ensuring program quality. The widespread concern with monitoring services has resulted in a myriad of state and federal regulations, and the result has been a complex, confusing system with overlapping and sometimes contradictory regulations. The atmosphere surrounding regulations and their implementation has not supported the most effective development of small community residences. Faced with the maze of regulations and review processes, developers of small residences often experience frustration with a system that impedes, rather than encourages their efforts.

Since 1972, Minnesota has required that all state and private residential programs serving more than four mentally retarded persons meet the requirements of a state programmatic license. This license, under Minnesota Department of Public Welfare Rule 34, includes requirements for staffing, program planning, resident activities, administration and resident rights. In addition, these programs must comply with a complementary health license, the Minnesota Department of Health Supervised Living Facility license, which governs the physical and health safety aspects of the facility.

In 1973, Minnesota, in an effort to secure a stable funding base for community residences, elected to participate in the Federal Title XIX Program. Participation in Title XIX of the Social Security Act requires compliance with the federal Intermediate Care Facility/Mental Retardation (ICF/MR) regulations. These regulations govern all aspects of the program, including physical plant, resident and staff activities, medical, and health safety. From the onset, it was apparent that the ICF/MR regulations, based as they were on a medical model, did not most effectively support the community residences' efforts in providing programs based on normalization and the developmental model. Despite a number of revisions in the regulations, the ICF/MR regulations continue to reflect a predominately medical outlook on care and programming for persons who are mentally retarded.

STATEMENT OF THE PROBLEM

The impetus for development of the Minnesota Model Standards was provided by a number of concerns over the plethora of existing state and federal regulations. These concerns were identified by both service providers and state surveying and licensing staff. One major concern, as previously mentioned, has been the medical orientation of regulations of services to mentally retarded persons. For the past decade, programs for mentally retarded persons have attempted to focus on normalization, the developmental model, and reintegration of retarded individuals into the mainstream of community living. It is essential that regulations be valid indicators of service quality and allow the expression of contemporary philosophies and techniques in the provision of services.

A second area of concern has been the duplication of requirements among state and federal regulations. In a number of cases, the same requirement is found in the two state rules and the ICF/MR

regulations. Not only has this duplication necessitated the service provider to spend increased time on surveys rather than in providing services, but has also resulted in duplication of efforts among surveyors.

Finally, the issue of reliable interpretation of regulations has had serious implications for enforcement of requirements and consistency of application. Vague, unmeasurable regulatory criteria have caused difficulties for both surveyors and service providers in terms of a lack of common understanding of expectation for performance. Nonspecific wording has resulted in inconsistent application of standards from one survey team to another and, in some cases, from the same team at different survey times. For example, the state requirement that "staff are responsible for the development and maintenance of a warm, family or homelike atmosphere" requires, at best, a subjective judgment. The state presently does not have objective, measurable criteria to define "homelike atmosphere." Although the requirement is certainly valid to normalization, consistent interpretation is extremely difficult.

A number of problems and concerns have also been identified regarding the process by which state and federal regulations are implemented. Currently, facilities entering the ICF/MR process go through a lengthy and often confusing process to receive certification. Many times, these programs are surveyed without being given prior information regarding content and process of the survey. Preparation for certification is haphazard at best These conditions are resultant of the existing retrospective review process which focuses exclusively on checking for defects or deficiencies in the facility. Survey team members typically do not have specialized expertise in mental retardation, program planning and resource development and thus, generally, are not able to assist the facility in resolving program weaknesses. Traditionally, the whole quality assurance process has been based on a punitive approach toward facility compliance rather than on strengthening program deficits and addressing resolution of those problems. Often it appears that the quality assurance process acts to impede the progress of deinstitutionalization, despite repeated assertions by state and federal officials of their commitment to deinstitutionalization.

SOLUTION TO THE PROBLEM

In response to the issues of validity and reliability of regulations and the existing retroactive approach to quality assurance, the Minnesota Department of Public Welfare, Mental Retardation Division was awarded a federal grant from the U.S. Department of HEW, Region V, Developmental Disabilities Office to: (1} develop model standards to assess the quality of residential services for persons who are mentally retarded; and (2) design a model "proactive" survey process for implementing the standards that emphasizes technical assistance and staff development. Project staff was committed to the design of a system that would:

- be easy to understand;
- be easy to regulate;
- be based on valid indicators of program quality;
- yield reliable data on compliance; and
- be based on a positive, proactive model.

MINNESOTA MODEL STANDARDS

The Minnesota Model Standards consist of input and process standards for residential programs serving persons who are mentally retarded. The standards combine all applicable state and federal regulations into one document. The standards in this report constitute a model set, in that they consist of a thorough analysis of existing requirements which sought to preserve the essential features of existing regulations.

The standards are also model because they are conceptually valid, made so by a process that carefully established each one to be discrete, unambiguous, and noncontradictory of the others. Each standard has been judged to be valid according to one or more of the following outcome goals: normalization, the developmental growth of residents, and/or the protection of individual rights. The format of the Minnesota Model Standards reflects an emphasis upon individual program planning to meet assessed deficits in functioning level for each resident through utilization of an interdisciplinary team approach. The standards focus upon ensuring provision of residential services in accordance with the developmental model and the principle of normalization.

The standards have been subjected to reliability tests in an effort to avoid the vague language that makes many of the existing regulations too unreliable for practical use. The process is described in Chapter 2 of this volume. During the analysis of existing regulations, the vague, unmeasurable items were either modified in language and measurement or eliminated from the model set.

Finally, the standards are model in that they address levels above currently mandated mini-mums toward which residential services should aspire, rather than minimum requirements currently

met by all service providers and capable of being implemented immediately in all states.

The standards presented here (Appendix A) are the result of five major reviews and revisions by representatives of the service delivery system, including their pilot testing in 14 Minnesota facilities. Input was gathered from a wide range of representatives from the service delivery system in Minnesota, including consumers, service providers, attorneys, health care professionals, planners, and state and federal regulatory agencies. These standards are based, in large measure, upon an earlier effort by Government Studies and Systems (GSS), Philadelphia, Pennsylvania. The Minnesota Standards continued the GSS project by adapting them to the Minnesota experience and actually field testing their feasibility.

The Model Standards include a number of special features:

- Each standard has been assigned a relative importance value or priority weight in relation to overall assessment of the program.
- A level of compliance has been prescribed for each standard.
- The recording of compliance results allows for the designation of those cases in which the facility exceeds the minimum prescribed level.
- Summary scores can be computed to provide an overall judgment of facility compliance and to indicate need for further technical assistance and staff training.

Although all the items included in the model standards have been judged to be necessary to quality programming, it is generally recognized by professionals that some requirements are more essential than others. The assessment instrument developed is sensitive to these individual differences in importance so that those critical, high priority items carry more weight in the final determination of facility compliance. Chapter 2 describes the rating process that was used for assignment of priority weights.

As previously noted, inconsistencies in the existing quality assurance process have plagued both service providers and regulatory agencies. One of these inconsistencies has concerned the required level of compliance for individual standards. The expected level of compliance is specified for each standard in the model instrument. This indicator serves a number of functions. First, by prescribing a standard level, it objectifies such decision-making by surveying personnel. Second, the standard level assures statewide consistency in compliance judgments. And third, it provides the facility with advance notice of the specific performance expectations for compliance with each item.

The existing pre-model quality assurance system records only compliance or noncompliance with individual requirements. That system does not distinguish among facilities that meet the minimum level and those that, in fact, exceed those minimums. The model standards instrument allows for recording of three possible results: Exceeded the Standard, Met the Standard, or Did Not Meet the Standard. Such records provide the state with descriptive data on the quality of care provided in residential services and may be used to justify promulgation of higher standards of care. For example, if the majority of programs are exceeding the minimum levels, this may be an indication of the opportunity to revise and upgrade those levels. Ongoing review and revision of standards based on these data serves to upgrade the quality of care provided in residential programs. Quality, in this process, is not a static condition; rather, it is defined in terms of a changing, more sophisticated expertise in the field.

MODEL PROACTIVE SURVEY

The survey process for evaluating facility compliance with the Minnesota Model Standards is directed by a "proactive" model which seeks to provide state consultation and assistance to facilities in providing quality programs. The proactive approach consists of ongoing evaluation that begins with the individual resident, includes a multidisciplinary, review of the status of the facility, and has, as its outcomes, staff development and technical assistance in achieving and maintaining compliance with state and federal regulations.

The evaluation of a facility need not be focused exclusively on finding deficiencies. Rather, the emphasis of the proactive survey process is upon the consultative role of a multidisciplinary survey team to assist the facility in strengthening its program. Primary to the proactive approach is the team composition which includes professionals in the field of mental retardation, health care, and physical plant issues.

The proactive evaluation monitoring system described in this report has three major components. They are:

- a self-assessing facility review;
- multidisciplinary on-site review process; and
- a focused staff development program.

A Self-Survey Facility Review

The first phase of the system entails the completion, by all facilities serving mentally retarded clients, of a self-survey facility review instrument.

This instrument is to be completed and submitted to the state agency prior to an on-site review. The self-survey has several purposes. First, it provides an initial record that a facility has complied with all requirements that are mandated by taw, e.g., Life Safety Code. Second, it provides a record of the perceptions of the facility management of the services available to meet client requirements as prescribed by state and federal dictates. It also gives an estimate of facility staff and program deficits. Finally, it allows for forward contingency planning and action in facilities when used as preparation for the on-site multidisciplinary review.

Multidisciplinary Review Process

The current certification process allows the facility administrator a small role in the compliance process prior to receiving a statement of deficiencies based on a survey completed by state agency representatives. The surveyors serve only to review status of facility compliance. The proposed multidisciplinary review process serves several key functions dissimilar to those served by existing surveyors. First the review team is to be comprised of members who represent training in all phases of facility operation, from direct programming to business operations. Key to this team composition is a mental retardation program specialist, a role which is not currently mandated in survey teams. This team composition is important in order to perform the most necessary task of providing ongoing consultation to the facility.

Each facility is to be annually reviewed, with the initial review being conducted as close to the submission of the facility self-survey instrument as possible. The function of the team is to evaluate all aspects of a facility against the standards prescribed and the status of the facility as self-reported. Except for citing deficiencies in nondiscretionary requirements, the function of the multidisciplinary review team is quite different than is typical of review teams currently operating; while weaknesses in program or other procedures should be reported to the facility, the team's main responsibility is to determine a procedure for assisting the facility to meet a requirement, determining the cost/benefit of such a recommendation and submitting this as part of a report to the State Department of Public Welfare and/or Health.

The multidisciplinary staff has the traditional role of reviewing a facility for its compliance with statutory mandates, but a more powerful role is to develop recommendations for staff development and to provide in-depth consultation and technical assistance in complying with the standards. Changes in client development cannot be expected from a facility program that is weak in the support services necessary to move the clients forward.

At the conclusion of the on-site survey, an exit interview is to be held with the facility administrator to review items of non-compliance and to define resources that are necessary to come into compliance. The facility and survey team are to jointly develop a compliance strategy form for resolving assessed deficiencies. The compliance strategy form displays the following information:

- a record of those standards not met by the facility;
- a plan of action to correct referenced deficiencies; and
- a list of the resources necessary to come into compliance, i.e., staff, construction, equipment.

Focused Staff Development Program

Staff development training programs are typically determined for a single facility, with the focus of training being determined by a variety of processes. Some of these training decisions are made from a systematic review of staff, program, and facility needs, but this is not always the case. One of the primary roles of the multidisciplinary team in the present model is to recommend areas of concentration for staff development programs. Their judgment is made after reviewing the facility against its own self-assessment, against state and federal guidelines and mandates, and from each team member's own professional judgments of competency levels evidenced in their review of the facility. This information allows for the Department of Public Welfare training coordinator to develop training for facilities that is of the highest priority for a staff, and to schedule the training by a region or district rather than by a facility-by-facility approach.

Methodologies can be developed to ensure that the specific training components meet the criteria associated with competency-based, field-based training programs. Joe and Meltzer (1976) state: In order to implement any of the recommendations, a conscious manpower training strategy must be instituted to train and retrain workers who provide long-term care services at the local level. In order to assist individual clients to make appropriate decisions regarding service needs and institutional or in-home care, workers must be extremely knowledgeable about the availability of community resources, a client's needs and entitlements and how to orchestrate a service package to meet individual need. Unless there is a considerable effort

to develop a local network of trained workers who share a common language and knowledge, the development of a consolidated financing mechanism or a community care center will have minimal impact on the effective treatment of the client. Related to this is the need to consciously reduce the pervasive professional turf problems in the delivery of LTC services. The absence of a manpower strategy has been the major failure of past efforts to coordinate services, and without it, everything else is rhetoric.

Appendix E contains a model for staff development, "Report on Minnesota Model Standards and Rationale for Training" cluster grouping, and training modules.

In summary, the proactive model requires a change in the traditional role of the State Health and Welfare agencies. The regulatory role and the accompanying deficiency-finding role is an after-the-fact, negative approach. A change in emphasis is required of such agencies in order to assist in the compliance process. The new role dictated by this model is for the State Departments of Public Welfare and Health to be brokers for resources needed to improve programs and facilities for handicapped clients, as determined by a proactive review.

CHAPTER 2

DEVELOPMENT AND METHODOLOGY

This chapter describes the development phase of the model quality assurance mechanism for residential programs serving persons who are mentally retarded. Because the design of the quality assurance mechanism consists of two integral components - model standards and a model proactive survey process — the components' developments will be separately treated here.

DEVELOPMENT, MODEL STANDARDS

The development of the Minnesota Model Standards consisted of a process of researching sources (including previous similar works), winnowing the materials in relation to the requirements for the finished product, securing expert ratings and weights, and assigning levels for compliance.

Sources of Standards

The items in the Minnesota Model Standards are the product of two major activities:

- A discriminate analysis of the existing state and federal regulations applicable to residential programs serving mentally retarded persons; and
- Design of standards which are valid and reliable indicators of program quality as judged by professionals in the field of mental retardation.

This project did not examine fire codes and requirements. It was decided to maintain current procedures and keep fire surveys separate from health and program surveys.

The model standards were based in large measure on current federal and state regulations. The following regulations and standards were obtained for use as the basis of item generation for the model standards:

- Minnesota Department of Public Welfare Rule 34;
- Minnesota Department of Health Supervised Living Facility Regulations;
- Federal ICF/MR Regulations;
- Section 504, Vocational Rehabilitation Act;
- Standards for Residential Facilities for the Mentally Retarded, Joint Commission on Accreditation of Hospitals (JCAH); and
- Government Studies and Systems (GSS) Model Standards.

The Government Studies and Systems (Philadelphia, Pennsylvania) standards are a set of model standards for residential services to persons with developmental disabilities, developed under the auspices of a federal HEW grant from Washington, D.C. A description and results of the GSS Model Standards are presented in the July 29, 1977, "Report: Review and Evaluation of Current Standards and Quality Assurance Mechanisms," in two volumes. The GSS standards were judged by a panel of experts in the field of developmental disabilities to be valid, reliable, practical, susceptible to corrective action, and of social/political importance. The GSS standards reviewed 18 different sources from federal laws and accreditation standards, including those of the JCAH, Title XIX Social Security Act, Title XX Social Security Act, American National Standard Institute (ANSI) Specifications for Making Buildings and Facilities Accessible to and Usable by the Physically Handicapped, and the Vocational Rehabilitation Act of 1973.

For the Minnesota analysis, individual requirements from these state and federal documents were recorded on individual 4" x 6" file cards. All 1,023 requirements were admitted to a master item pool as the basis for the quality assurance instrument. Items from the master pool were initially assigned by the project staff into the following ten broad categories via a free sort procedure:

1. Administration
2. Resident Rights
3. Developmental Services/ Programming
4. Health Services
5. Behavior Management
6. Personnel
7. Food Services
8. Resident Records
9. Physical Plant
10. Outcome/Product Standards

Redundant items under each category were grouped together. Staff collapsed the duplications for each regulation into one statement by either: (1) selecting the one regulation best representing the duplications; or (2) rewriting the standard to include the components of all duplications. The duplication sort yielded an item pool of 249 separate requirements.

The Rating Process

With the assistance of staff from GSS, a detailed evaluation protocol was designed to assess the merits of each of the 249 requirements. The evaluation was conducted by a panel of 13 experts in the field of mental retardation. The panel consisted of representatives from state institutions,

community-based residences, developmental achievement centers, Minnesota Department of Public Welfare Licensing Division, Minnesota Department of Health Licensure and Certification Unit, Minnesota Association for Retarded Citizens, parents of mentally retarded persons, and Region V — HEW. In an effort to obtain a representative sample of the continuum of residential services in Minnesota, panel members included a wide range of programs, serving adults and children, profound to mild retardation, medical care to apartment training programs, urban-rural, profit-nonprofit, house parent-shift staff, physically handicapped, and small (six residents) to large (72 residents). The 13 experts who participated on the panel included:

1. Walter A. Baldus, Executive Director of Woodvale, Inc., Austin, Minnesota
2. Joanne DeBerry, Advocate and Parent, Bloomington, Minnesota
3. Steve Larson, Program Director of Sixth Street House, Rochester, Minnesota
4. Wayne Larson, Executive Director of Home ward Bound, Inc., New Hope, Minnesota
5. Peter Sajevic, Executive Director of Nor-Haven Homes, Inc., St. Paul, Minnesota
6. Harold Tapper, Executive Director of Association of Residences for the Retarded in Minnesota, St. Paul, Minnesota
7. Abby Struck, Legislative Liaison of Minnesota Association for Retarded Citizens, Minneapolis, Minnesota
8. Neil Linebaugh, Region V - Department of Health, Education and Welfare, Chicago, Illinois
9. Tinka Messinger, Advocate, Minneapolis, Minnesota
10. Robert Nafie, Director of Washington County Developmental Achievement Center, Woodbury, Minnesota
11. Robert Kotten, Licensor of the Minnesota Department of Public Welfare, St. Paul, Minnesota
12. Ann Swanson, MR Program Director of the Moose Lake State Hospital, Moose Lake, Minnesota
13. David Trapskin, Section Chief of the Minnesota Department of Health, Health Facilities Section, Minneapolis, Minnesota

The objectives of the panel's evaluation of existing regulations were to: identify the valid, reliable, and practical standards; identify and reject the invalid and unreliable items; and identify and revise those standards which could be converted into valid and reliable requirements. Following an eight-hour orientation session by Dr. Hugo Finarelli of Government Studies and Systems, the requirements to be evaluated were distributed equally among three groups of experts, two groups consisting of four consultants and one group of five consultants. The regulations were distributed so that each group of experts received some requirements in each of the following 22 generic categories:

1. Comprehensive Assessments
2. Individual Program Plans and Services
3. Behavior Management
4. Resident Records
5. Legal Rights and Confidentiality
6. Health and Grooming
7. Medications
8. Community Resources
9. Communications
10. Possession and Use of Money
11. Clothing
12. Admission/Discharge
13. Staffing Patterns and Personnel
14. Administration
15. Emergency Procedures
16. Sanitation
17. Physical Plant
18. Shared Living Spaces
19. Bedrooms
20. Toilets and Bathing Facilities
21. Meals and Dining Facilities
22. Federal, State, and Local Codes

Rating of the criteria. Each regulation was rated by the panel of experts according to validity, reliability, and practicality, using two evaluation forms developed specifically for this study: a Criteria Evaluation Form and a Form for Rating a Standard.

The Criteria Evaluation Form (Figure 1) was designed to assist panel experts to objectively rate the regulations according to validity, reliability, and practicality. The Evaluation Form consisted of 16 evaluation measures grouped under the following criteria: Validity (5 measures), Reliability (4 measures), Practicality (4 measures), and Importance (3 ratings).

The definition and component characteristics of each evaluation attribute are presented below, quoted from the consultation of Government Studies and Systems.

- **Validity.** The validity of a criterion is measured by the judged strength of the casual relationship between the criterion and the outcome goals of developmental growth, normalization and the protection of individual rights.

A regulation was determined to be valid if: (a) it was judged to have a casual relationship with the developmental progress of the resident; or (b) it

Figure 1

FORM FOR RATING A CRITERION

1. Validity – Is the criterion a valid indicator of the quality of services being provided?

   ☐ Yes

   ☐ Yes, but only for services provided to persons in the following age groups:

   _____ _____ _____

   ☐ Yes, but only for services provided to persons at the following levels of disability:

   _____ _____ _____

   ☐ Yes, but only for services provided in the following settings:

   _____ _____ _____

   ☐ No

2. Reliability – Is the criterion reliable for use?

   ☐ Yes

   ☐ No, but the criterion would be reliable if modified as follows:

   _____

   _____

   _____

   ☐ No, but the criterion would be reliable if the method of measurement were modified as follows:

   _____

   _____

   _____

   ☐ No

3. Practicality – Is the criterion practical for use?

   ☐ Yes

   ☐ No, but the criterion would be practical for use if the method of measurement were modified as follows:

   _____

   _____

   _____

   ☐ No, but the criterion would be practical for use if the time or frequency of measurement were modified as follows:

   _____

   _____

   _____

   ☐ No

4. Importance – How important is this criterion as an indicator of quality?

   ☐ Class 1 – Full compliance is judged essential to quality (highest priority);
   ☐ Class 2 – The criterion is believed to have a significant impact on quality, but less than full compliance is judged acceptable (medium priority);
   ☐ Class 3 – The criterion was included primarily for educational purposes (lowest priority).

reflects a concern fundamental to the principle of normalization; or (c) is essential to the protection of personal or legal rights of residents. The following definitions were used:

- Developmental Growth. That each individual receive services, in accordance with an individualized program plan, which are designed to increase or maintain the individual's physical, communicative, social, affective, and cognitive development, as manifested in in creased skill levels and achievement of adaptive behaviors.
- Normalization. That persons with develop mental disabilities should experience patterns of daily living as close as possible to the pat terns experienced by the mainstream of society, in environments which likewise are as culturally normative as possible.
- Protection of Individual Rights. That persons with developmental disabilities should enjoy basic human and civil rights and protection from exploitation, neglect, and abuse.
- Reliability. The reliability of a criterion is its ability under different circumstances and over time to accurately measure a specific char- acteristic of a service or program for the developmentally disabled. Component measures of reliability focus on:

    - The accessibility of data to the state agency.
    - Data time lines.
    - Data accuracy.
    - Data availability without infringement of client's rights.
    - Data availability without excessive cost or time expenditure on the part of the service providers or state agency.

The first step in the evaluation process considered the validity of the existing requirement. If the requirement was judged to be not valid to either normalization, developmental growth, or protection of individual rights, it was immediately eliminated from further evaluation and discarded from the model standards.

The second step in completing the Criterion Evaluation Form considered the evident reliability of the regulation. Whenever a standard was judged high in validity, but low in reliability (because of language or measurement problems), the panel attempted to revise the language or to specify measures. If the regulation could not be modified to specify reliable measures, it was eliminated from the model standards. During this step, a number of items judged to be valid were discarded because they could not meet the reliability requirements. One example of an item judged to be valid that was later eliminated due to problems with unreliability was the following state requirement:

> The objective in staffing each living unit shall be to maintain reasonable stability in the assignment of staff, thereby permitting the developing of a consistent interpersonal relationship between each resident and one or two staff members.

Although this regulation was judged to be valid according to normalization and developmental growth, the item did not lend itself to reliable measurement and was thus deleted from the model standards.

The reliability establishment proved to be the most difficult step in the evaluation process. A number of requirements that reflected contemporary philosophy and ideals embraced by professionals in the field of mental retardation were discarded due to poor, or no objective measurement indicators. As a result, the model standards appear to be more austere than existing state and federal regulations, which include philosophy statements. However, the purpose of a quality assurance instrument is to measure performance and services, rather than to serve as an educational or instructional tool. Further, unreliable, subjective items cannot be enforced in any consistent manner, and, therefore, have no place in a meaningful quality assurance instrument

The final test of the existing regulations was for practicality. None of the requirements that survived the validity and reliability tests were discarded due to practicality problems.

The expert consultants were requested to rate the items into one of three categories according to their relative importance:

- Class 1 — Full compliance is judged essential to quality (highest priority);
- Class 2 — The criterion is believed to have a significant impact on quality, but less than full compliance is judged acceptable (medium priority); or
- Class 3 — The criterion was included primarily for educational purposes (lowest priority}.

This priority ranking process was later discarded in favor of a more refined weighting system. The weighting process used is discussed later in this chapter under the heading Assignment of Weights.

Rating the standards. Regulations associated with quantitative criteria were subjected to a second evaluation, using the Form for Rating a Standard (Figure 2). These regulations had been first rated by the panel for validity, reliability, and practicality, according to the Form for Rating a Criterion. The Form for Rating a Standard was designed with the assistance of Government Studies and Systems "to measure the appropriateness of

Figure 2
FORM FOR RATING A STANDARD

1. Universally – Should the standard(s) set with respect to the given criterion be different for:
   (a) services provided to persons of different ages?
   ☐ Yes ☐ No
   If yes, for what different age groups must different standards be set?

   _____

   _____

   (b) services provided to persons at different levels of disability?
   ☐ Yes ☐ No
   If yes, for what different levels of disability must different standards be set?

   _____

   _____

   (c) services provided in different settings?
   ☐ Yes ☐ No
   If yes, for what different settings must different standards be set?

   _____

   _____

   If answers to all parts of question 1 were no (in other words, if one standard will suffice), complete steps 2 through 4 one time. If the answer to any part of question 1 was yes, repeat steps 2 through 4 for each age group, each level of disability and each setting of concern.

2. Stringency – Does the candidate standard represent a level of performance which is:
   ☐ less than minimally acceptable
   ☐ minimally acceptable
   ☐ more than minimally acceptable, but less than optimal
   ☐ optimal
   ☐ more than optimal
   (an optimal level of performance is n achievable level beyond which further improvement would be impossible or would necessitate a wasteful use of resources)

3. Appropriate Range of Performance – On the basis of the response to question 2, define:
   (a) a minimally acceptable level of performance with respect to the underlying criterion

   _____

   _____

   _____

   (b) an optimal level of performance with respect to the underlying criterion

   _____

   _____

   _____

4. Desired Level of Performance – Given the minimal and optimal levels of performance specified in question 3, define:
   (a) a desired and achievable level of performance appropriate for current use (that is, define a standard appropriate for current use with respect to the underlying criterion).

   _____

   _____

   _____

the prescribed levels of performance indicated by the associated standards." It provided for both Yes/No and open-ended responses relating to:

- Universality of the Requirement (three questions)
- Stringency (one question)
- Appropriate Range of Performance (two questions regarding minimum and optional levels)
- Desired Level of Performance

The questions regarding range and level of performance provided space for the experts to suggest estimates of attainable levels, and identification of minimal acceptable levels which would improve the standard.

Based on the results of the panel's evaluation, project staff deleted, retained, or revised the standards which were then cycled back to the panel. Five major reviews and revisions by the panel and additional professionals produced a set of 141 items for pilot testing. The fifth revision included input from wider representation of the service delivery system, including attorneys, RN's, physicians, behavior management specialists, county welfare departments, fire marshal, broader facility representation, additional state health and welfare licensers and surveyors, dieticians, and human service planners.

Assignment of Weights

Through a Q-Sort by experts, each model standard was assigned a relative importance value or priority weight according to its judged representation of program quality. The purpose of assigning weights to the standards was to allow for sensitivity in the quality assurance instrument so that those items judged to be of high importance would carry more weight in the overall compliance summary judgment. It is important that priority weights of standards be assigned in a logically consistent and defensible manner; assigning scale weights is nevertheless a matter of subjective judgment by professionals responsible for program quality and outcomes. Because regulations impact many kinds of professionals and entail considerable capital investments, it was considered of great importance to use systematic, representative, group processes involving persons impacted by regulations in the establishment of relative weights. The method selected for doing this was Q-Sort, a method widely used in needs assessment studies and likely to be familiar to respondents.

Q-Sort is a method for arriving at comparative rankings of multiple items. Participants or respondents must evaluate standards individually, but in the context of other items, and assign them to locations in a fixed distribution approximating the normal. In a Q-Sort, therefore, most items receive mid-range priorities, with fewer assigned to the highest and lowest categories (Nunnally, 1967). A strength of the Q-Sort approach to weighting is the method forces professionals to discriminate among the various regulations, systematically.

Nunnally (1967) indicated that the Q-Sort is the most economical procedure for arriving at comparative rankings and is a useful compromise between two needs:

- The need to have precise differentiation made among the stimuli, as done in the method of pair comparisons, and
- The need to have comparisons made among the members of a large set of stimuli...

In the present study, 30 experts were involved in the sorting and ranking of the 141 generic regulations. The weight scores ranged from a high score of 7.78 to low score of 2.85 on a 10-point scale of importance.

Three standards scored a high score of 7.78. They were defined as follows.

Comprehensive Assessments. Each resident must receive a comprehensive behavioral assessment at least once a year. The annual assessment must objectively describe the behavioral status of the resident and must include participation of facility staff, the resident, and the parent or legal guardian, if the resident is not a legally independent adult.

Individual Program Plans and Services. There must be an annual individualized program and treatment plan for each resident which is based on the needs identified in the annual comprehensive behavioral assessment and upon other appropriate information.

Behavior Management. The facility must have written policy and procedures for the behavior management of residents that:

a. Are directed to the goal of maximizing the growth and development of the residents, and
   (1) Provides that the least restrictive method, which is effective, must be used;
   (2) Provides that positive methods for con trolling behavior must be given primary consideration;
b. Are available to parents/guardians;
c. Are available in each living unit to staff and residents;
d. Provide for resident participation, as appropriate, in the formulation of such policies and procedures;
e. Prohibit corporal punishment, verbal and physical abuse, and the withdrawal of use of food as punishment; and
f. Prohibit residents from disciplining other residents.

The lowest weight (2.85) was assigned to the following requirements:

Health and Grooming. There must be:

a. Monthly weighting of residents;
b. Quarterly measurement of height, until the age of 18 years;
c. Maintenance of height and weight records.

The 22 generic categories received the following weights, averaged within each category.

Individual Program Plans & Services	6.23
Behavior Management	6.21
Possession & Use of Money	6.07
Comprehensive Assessments	5.76
Medications	5.30
Staffing	5.20
Shared Living Spaces	5.09
Community Resources	5.05
Communications	5.05
Emergency Procedures	5.00
Resident Records	4.97
Legal Rights	4.96
Toilets & Bathing Facilities	4.84
Bedrooms	4.62
Clothing	4.62
Admission/Discharge	4.57
Federal, State & Local Codes	4.50
Meals & Dining Facilities	4.43
Administration	4.36
Health & Grooming	4.28
Sanitation	4.14
Physical Plant	3.86

(NOTE: Because each category consists of several standards, the averages cited here do not go as high or as low as do the separate standards described above.)

Expected Level of Compliance

In addition to the priority weight, a minimum level of compliance has been prescribed for each standard. A standard compliance formula was developed to yield a determination of the facility's performance for each item in terms of three attainment levels: Exceeded, Met, or Not Met. A modified standard scoring procedure similar to goal attainment scaling was used to derive an overall standard profile with the model standards.

Goal Attainment Scaling (Kiresuk & Sherman, 1968) was designed as a management oriented evaluation system addressed to the problem: "How to measure outcomes in the mental health enterprise — a diffuse, complex, evolving conglomerate of beliefs and activities that would not hold still for measurement" (Kiresuk, 1973, p. 12). The scaling was designed for use in situations where multiple treatment goals of varying priority or importance existed and where there was a need for an open-ended methodology stemming from constant evolutionary changes in the goal structures. In addition to relative weighting and open-ended-ness, Goal Attainment Scaling includes the idea of scorable expected outcomes for each goal (scale).

Although designed to be a method for evaluating the effectiveness and impact of individual treatment programs in the mental health field, Goal Attainment Scaling is well suited to assessing a facility's compliance with a set of regulations. Regulatory standards can be considered the official articulation of a service quality goal and the degree of a facility's compliance with a standard or goal attainment. Each regulation or standard, like a treatment goal, can be assigned its own relative weight in recognition of the fact that no two standards are of equal importance to program quality.

Furthermore, in judging a facility's compliance with formal regulations, the ultimate decision that has to be made is unidimensional. At the extreme end of the review process, a general judgment must be made: "Is the facility in or out of compliance with the regulations governing its operation?" "Is the facility out of compliance to a degree sufficient to jeopardize its eligibility to continue to provide services to the developmentally disabled?"

At the state agency level, where one is involved with the assessment of a large number of facilities, it is desirable to be able to compare all of the facilities within the state or within a planning region with a standard compliance yardstick. Goal Attainment Scaling is well suited to this purpose because it yields a standard total score for each facility. Yet at the same time, no information concerning a facility's compliance status with any single regulation is lost.

To conduct Goal Attainment Scaling, several things were required:

- A Series of Scales. These are the Model Standards previously described.
- A Relative Weight for Each Scale. These were derived through Q-Sort procedures described in the preceding section,
- Scale Attainment Levels (Scores). These are descriptors of the degree of compliance with a regulation. From two to three levels of compliance may be attached to each scale (standard), scored from +1 to +3. Compliance can be scored dichotomously if it is logical to do so for a given regulation, e.g., where particular equipment is available or unavailable at the facility. Each scale can have its own scoring system.
- The Weighted Average Intercorrelation of the Scales. Although "in most circumstances it will be sufficient to assume a value of, say,

p=.3 without further justification" (Kiresuk & Sherman, 1968), the present study used an empirically derived intercorrelation.

Kiresuk and Sherman's (1968) formula for a standardized score is:

$$\text{(Compliance Index)} = 50 + \frac{10 \sum_{i=1}^{n} w_i x_i}{\sqrt{(1-\rho) \sum_{i=1}^{n} w_i^2 + \rho \left(\sum_{i=1}^{n} w_i\right)^2}}$$

where:

- w_i = the regulation; weight
- x_i = the compliance score (rating) for the regulation. (In rating a facility's compliance with a regulation, the model standards provided for three levels: exceeded (+1); met (0); or not met (−1)).
- ρ = the weighted average intercorrelation of the regulations, in this case, empirically determined as .19

The Compliance Index resulting from the use of the above formula, is a T score with a SD ≈ 10 and an $\bar{X}$ of 50. The standard deviation will vary from 10, somewhat, according to the value of ρ. Nevertheless, all Composite Compliance Scores for a group of facilities will be scaled to a uniform standard deviation.

PROACTIVE SURVEY PROCESS

The second component of the model quality assurance mechanism is the survey process — the implementation of the model standards. Standards cannot be viewed in isolation from their actual implementation. A quality assurance mechanism must also take into account who is enforcing standards and how they are enforced.

The "how" of the enforcement process that is described here is said to be proactive. By that term is meant that the survey team acts in a forward direction, toward the improvement of facility operation, rather than in a backward direction, discovering how the facility is out of compliance. The self survey part of the process is also proactive, in that it can well serve to bring the facility into compliance before the site visit by the team takes place.

The "who" of enforcement is a team of skilled consultative people who are able to assist the facility in its improvement.

The multidisciplinary team review process thus serves several key functions. First, the review team is defined to be comprised of members whose qualifications represent all phases of facility operation, from direct programming to business operations. Second, the annual review, closely following the completion of the self survey, compares the facility's operations to the standards and to the findings of the self survey. Third, while facility weaknesses are noted and reported, the team's main responsibility is to determine procedures for the facility to meet its requirements, to determine the costs and benefits of its recommendations, and to submit these determinations as part of its report to the State Department of Public Welfare,

In some facilities a program, or a part of a program, may be seen as exemplary. The team would, in such a case, determine how to make this into a demonstration and training site and estimate the cost of doing so. Assurance that the exemplary program would not be weakened by the additional strain on its staff would be part of that cost.

Determination of Team Composition

The survey team composition and member qualifications are critical factors in the implementation of any quality assurance system. Two research activities led to the formulation of the survey team and their qualifications. A letter of request was mailed to all state mental retardation program directors for information regarding state surveying procedures and team composition. Team composition and qualifications were also required from Region V, HEW, the Joint Commission on Accreditation of Hospitals (JCAH), the Minnesota Department of Public Welfare Licensing Division, and the Minnesota Department of Health Licensure and Certification Unit. Following analysis of information from these sources, staff recommendations for the survey team composition and qualifications were circulated to the panel of 13 experts (page 8, Chapter 2), for review and comment. Based on these comments, a survey team comprised of three professionals was defined.

Generic qualifications. All team members were seen as needing seven basic or generic qualifications in order for the team to operate effectively. These qualifications were defined to be:

- Thorough knowledge of the regulations and ability to interpret and explain standards to residential providers.
- Ability to gather and interpret data and information and skill in preparing letters, documents, and reports.
- Ability to organize and carry out assignments.
- Ability to present ideas effectively orally or in writing.
- Ability to work effectively with a wide variety of health and developmental professionals

within and without the government structure.

- Ability to provide consultation and appropriate resources to residential providers.
- Ability to enforce laws and regulations with firmness and impartiality.

The Mental Retardation Program Specialist was defined to need, in addition to the seven generic qualifications, the following:

- Understanding of the Normalization Principle, Developmental Model, Least Restrictive Environment, and Individualized Program Planning.
- Familiarity with behavioral assessment instruments.
- Competence in developing individualized program plans based on behavioral assessment with measurable goals and objectives.
- Competence in generating methods for achieving goals and objectives in the individualized program plan.
- Ability to evaluate residents progress toward the goals and objectives in the individualized program plan.
- Knowledge of legal rights of residents.
- Knowledge of administrative policies and practices in facilities serving the mentally retarded.
- A Bachelor's Degree and at least six months experience working with persons who are mentally retarded, or
- Five years experience in a professional capacity working with persons who are mentally retarded.

The Health Care Evaluator, in addition to the seven generic qualifications, was defined to need:

- Knowledge of basic health services as they relate to the field of public health and to residential programs for persons who are mentally retarded.
- Knowledge of laws governing medication administration, labeling, storing, orders, and record keeping.
- Knowledge of preventive and emergency health practices.
- Current licensure as a registered nurse with the State Board of Nursing.

The Public Health Sanitarian was defined to need, in addition to the seven general qualifications, the following:

- Knowledge of the principles of public health involved in the transmission of disease.
- Knowledge of laws and requirements governing sanitary conditions and practices, including lodging places serving food and beverage.
- Knowledge of water supply sanitation.
- Knowledge of sewage treatment and disposal.
- Ability to supervise and conduct an educational program in environmental sanitation.
- A Bachelor's Degree and six months experience as an aid, technical, or other professional capacity in an environmental health-related program; or
- Three or more years' experience in an aide, technical, or professional capacity in an environmental program, a health-related capacity, or other related setting, or academic preparation at the associate degree level and registration or licensure in any of the engineering, technical, or sanitation fields.

These three, then, were defined as the appropriate members of a survey team which could carry out a proactive survey of benefit to the service provider and useful for compliance and improvement of services.

CHAPTER 3
IMPLEMENTATION

The Model Standards and the Proactive Team Survey Process were pilot tested in 14 residential programs for the mentally retarded during July and August of 1979. The pilot test phase involved advance work in the waiver of state licenses, the survey team composition, selection of pilot facilities, and training of surveyors and facility staff.

State Licensure Waiver

One of the first areas to be explored for the pilot testing was waiver of state licensure for those facilities participating in the pilot. All along, grant-project activities were aimed at reducing the number of surveys and streamlining the licensure process. Therefore, it was considered critical that the pilot survey not add yet another layer to regulatory system by requiring an additional survey. The Attorney General's staff at both the Department of Health and Minnesota Department of Public Welfare were contacted to determine the legal implications for waivers.

The Department of Public Welfare decided to issue a one-year waiver of its Rule 34 state program license for the 14 pilot facilities. The Department reviewed the Model Standards and determined that they were substantially in accord with the Rule 34 regulations and could replace the Rule 34 licensing survey for the pilot test. Facilities found to be in compliance with the Rule 34 provisions contained in the Model Standards were issued a Rule 34 license.

The Minnesota Department of Health, however, elected not to waive its Supervised Living Facility (SLF) license for the pilot facilities.

Survey Team Composition

The model survey team of three members was defined as: Mental Retardation Program Specialist, Health Care Evaluator, and Sanitarian. Three options for actual survey staff were examined. Option 1. A team of three independent consultants who met the qualifications defined by the project, but not employed by the State of Minnesota for licensing.

The chief benefit of this option was that the team composition would meet the project findings for the model survey team and, as such, could provide expert, in-depth consultation to facilities. However, the Department of Public Welfare would not have been able to replace their state licensing survey with the model survey unless state licensing staff conducted the survey. In addition, the project's emphasis on streamlining the licensure system sought to combine existing licensing efforts between the Health and Welfare Departments. A team of independent consultants would not have provided a test for this combination.

Option 2. A team of three licensing staff from the Departments of Health and Welfare currently responsible for surveying residential programs for persons who are mentally retarded.

Although all team members did not meet the qualifications defined for the model survey team, Option 2 did provide an opportunity to use existing licensing staff in a cooperative venture. It was felt that utilization of department staff would result in a stronger commitment by both state departments to seriously consider pilot results and recommendations for future implementation.

Option 3. A third option was discussed in the event Option 2 was not possible. Option 3 consisted of a survey team comprised of state welfare licensing staff and federal Title XIX surveyors from Region V, Health, Education, and Welfare. It was hoped that this approach would lend greater visibility to the need for valid, reliable certification measures and simplification of certification procedures at the federal level.

The survey team that was finally selected to test the Model Standards and proactive approach consisted of Department of Public Welfare and Minnesota Health Department surveying staff, or Option 2. The Health Department loaned two health surveyors for the two months to conduct the pilot tests. These two health surveyors (a registered nurse and health sanitarian) participated in all 14 surveys. The Welfare licenser regularly assigned to the particular facility served as the team leader for the model survey. A total of six welfare licensers participated in the pilot test. In addition, a project staff member also participated in the surveys as an independent observer.

Selection of Pilot Facilities

The major factor for pilot site selection was representation of the residential service delivery in Minnesota. The following variables were considered: geographic distribution of pilot sites; age and

functional level of clients served; urban-rural location; staffing patterns (house parent or shift staff); number of clients served; and facility ownership (state-owned institutions and community-based non-profit and proprietary organizations).

Participation in the pilot test was voluntary. Seventeen facilities were initially contacted by telephone and later by letter to explain the project and invite their participation in the pilot test. Of the 17 original facilities contacted, one declined the request because they had recently opened and had never had the usual, required state surveys. Later, one of the welfare licensers was hospitalized, necessitating cancellation of surveys of two facilities. Fourteen facilities participated in the model survey.

Training of Surveyors and Facility Staff

Eight regional training sessions were held for facilities and licenser's participating in the pilot tests. The first workshop was held exclusively for surveying staff to detail the survey with its scoring and sampling procedures. Welfare licensers also attended the regional training for the facilities they would be surveying. In this way, mutual concerns were addressed and consistent information was presented to both facility and licensing staff. The following agenda was presented to both facility and licensing staff in the workshops:

I. Introduction and Overview to Minnesota Management Model for Deinstitutionalization
II. Minnesota Residential Facility Inventory
  A. Instrument
  B. Instructions
  C. Use of data
  D. Reports
III. Minnesota Model Standards
  A. Development
  B. Instrument
  C. Survey form and instructions
  D. Scoring
IV. Survey Process
  A. Team composition and team leader
  B. Decision rules for surveying
  C. Exit interview and compliance strategy form
  D. Time-line for survey and team validation
  E. Legal implications
V. Results
  A. How pilot phase is evaluated
  B. Facility and licenser input into revisions

A User Manual detailing instructions for completing the survey was also provided to facilities and survey teams.

THE PROACTIVE SURVEY

The proactive survey process consisted of four components: completion of the Minnesota Residential Facility Inventory; Facility Self Survey using the Minnesota Model Standards; On-site survey team validation using the model standards; and the Exit Interview.

Minnesota Residential Facility Inventory

The Minnesota Residential Facility Inventory was designed to collect information that described residents that the facilities served. Results of this inventory were intended to provide information to assist local social services agencies in making placements for persons who are mentally retarded in the facility that can best meet their needs. Additionally, these data were to provide the Minnesota Department of Public Welfare with the data base to assess the scope of current residential services, identify gaps in the service delivery system, and base responsible planning and policy development to meet the needs of persons who are mentally retarded.

Five types of information were completed by the 14 pilot sites from the Facility Inventory:

- **Facility Identifying Information** included name and address of the facility, state licenses currently held, ownership type, and number of buildings in the licensed facility.
- **Operating Information** included the facility's opening date, the total operating days during the past 12 months, and total client days during the past 12 months.
- **Client Information** included information on number of admissions and source of those admissions, number of discharges from the facility and subsequent placement, and admission criteria, including disability type, intellectual functioning, mobility, vision, and hearing.
- Admission-Discharge Criteria sought to collect data on the range of adaptive behaviors served by the residence. This section contained a set of behavioral skills in eight domains - gross motor, toileting, dressing/grooming, eating, language, reading/writing, quantitative, and independent living skills. Each domain consisted of two behavioral statements arranged in developmental sequence. The facility was asked to check the items describing behaviors clients must be able to perform before being admitted to the program; and that residents were expected to perform prior to discharge from the facility.

- **Staffing** requested information on staffing levels in administrative, direct care, and other (non-direct, e.g., dietary, laundry, house keeping, maintenance).

No analyses of these data are presented since aggregated management data of a non-random sample would be meaningless. Rather, it was the process that was tested for possible statewide implementation. The results suggested that such a management model could be implemented statewide and would provide the type of data base that would permit the planning and policy development the state needs.

Self-Survey

Seven of the 14 facilities completed a self-survey of their programs using the Minnesota Model Standards. The self survey was completed approximately two weeks prior to the on-site team survey. The purpose of the self survey was twofold:

- To test the benefit of self survey process with 50 percent of the facilities; and
- To test the reliability of the standards' pre- and post-test data.

The self survey process was proposed as a means of assisting program operators with assessing their program and correcting any deficits prior to the on-site team survey.

A portion of the training materials used are shown in Appendix B of this report.

On-Site Team Survey Using the Multidisciplinary Team Approach

The multidisciplinary survey team, comprised of the Welfare licenser, a registered nurse, and a health sanitarian reviewed the 14 pilot sites with the Minnesota Model Standards Survey Evaluation Form. The survey evaluation form was used to record the results of both the self survey and the on-site team survey. The survey form listed each standard, the surveyor responsible for assessing the standard, the required level for compliance, the relative importance value of the standard, and the results of compliance with the standard. The User Manual detailed an explanation of the survey form. Ten percent of the total facility population, but not fewer than four records, were reviewed to determine compliance with the standard. The surveys were generally completed within one full day each.

EXIT INTERVIEW - COMPLIANCE STRATEGY FORM

At the conclusion of the on-site survey, an exit interview was held with the facility administrator and other program staff to review the items of non-compliance and to define resources necessary to come into compliance. A Compliance Strategy Form was developed to facilitate this process. The Compliance Strategy Form contained information regarding the specific standards that were out of compliance, the corrective action to be taken by the facility, and any resources needed, e.g., staff positions, furnishing, equipment, remodeling. The facility administrator and survey team jointly completed the strategy form. This process assumed that survey team members were familiar with various resources needed to assist the facility in complying with the standards. This compliance strategy form also served as a "contract" of action to be taken and was signed by the facility administrator and survey team leader.

The pilot tests were completed August 31, 1979. Results of the survey and evaluation of the team process are presented in the following chapter.

CHAPTER 4
RESULTS OF THE SURVEY

Each of the 14 facilities was rated by the survey team on each of the 141 model standards according to whether it exceeded, met, or did not meet the standard. Results were collected and several analyses were performed. The first analysis computed category totals for each facility, corrected for item weight, and reported in percent of possible and relative standing (percentile) within the group. Figure 3 shows a sample facility profile.

The second analysis employed the GAS formula described previously, which produced the Compliance Index (CI), a T score with SD 10 and an X = 50. The range of performance in the sample extended from a high of 52.4 down to a low of of 47.5. In interpreting the CI, it is recommended that if a facility's CI exceeded 55 (1/2 SD above the X of 50), commendation is deserved. For a facility out of compliance (below 50), attention should be directed to the category scores for diagnostic purposes. If a facility scores below 45 on the Compliance Index, a more intensive review of the facility is warranted.

Figure 4 displays "compliance profiles" for two of the field trial facilities. These two facilities represented the extreme for the sample. The figure illustrates the usefulness of profile comparisons for identifying regulatory categories that either discriminate or fail to discriminate between facilities. For instance, both the strongest and weakest facilities in the sample exceeded the expected

Figure 3

INDIVIDUAL FACILITY PROFILE

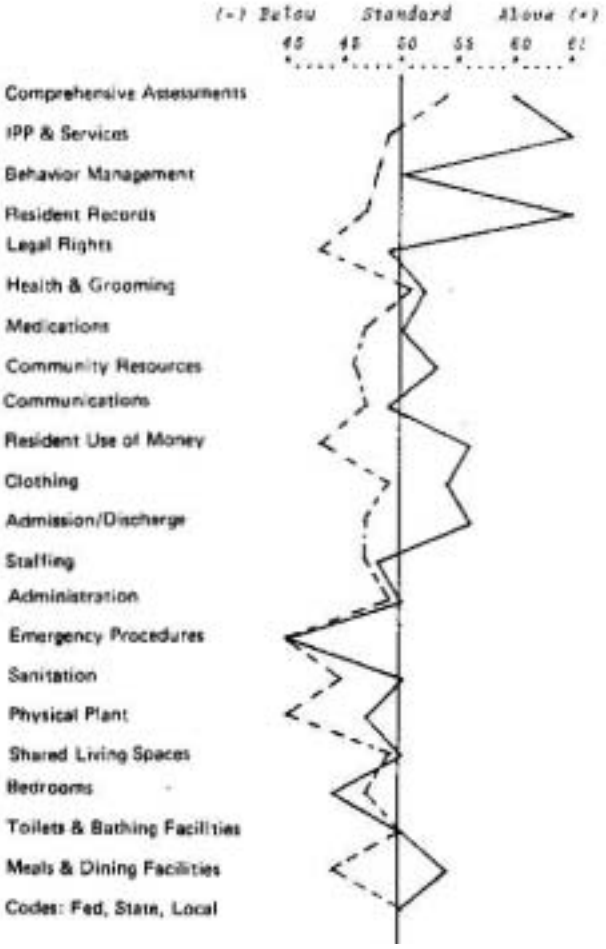
Percent of Maximum Possible by Category

	Percent of Maximum	Percentile*
1. Comp. Assessments	74.29	50
2. IPP and Services	84.05	79
3. Behavior Management	42.39	21
4. Resident Records	100	99
5. Legal Rights & Confidentiality	51.48	43
6. Health and Grooming	61.66	14
7. Medications	55.18	14
8. Community Resources	32.51	7
9. Communications	100	99
10. Possession & Use of Money	47.54	36
11. Clothing	55.09	21
12. Admission/Discharge	36.53	14
13. Staffing Patterns & Personnel	85.13	71
14. Administration	100	99
15. Emergency Procedures	39.28	14
16. Sanitation	33.36	7
17. Physical Plant	54.50	50
18. Shared Living Spaces	43.56	7
19. Bedrooms	36.19	7
20. Toilets & Bathing Facilities	72.00	14
21. Meals & Dining Facilities	66.82	71
22. Federal, State & Local Codes	100	99
TOTAL	69.22	21

*The Percentile score represents this facility's relative standing within the Pilot Group. Total N of facilities equals 14, thus each facility represents 7.1% of the total group.

Figure 4

COMPLIANCE PROFILES:
TWO MR FACILITIES



standard on Comprehensive Assessments. Both were below standard in Emergency Procedures. Resident Records, Possession and Use of Money, and Meals and Dining Facilities were categories of strong discrepancies between the stronger and weaker facilities. The usefulness of the Compliance Profile for diagnostic purposes is further illustrated by the disclosure that even the "best" facility was in need of considerable improvement in the area of Emergency Procedures.

EVALUATION

Upon completion of the pilot survey process, each participating facility and survey team leader was asked to respond to a nineteen item questionnaire that solicited comments regarding the standards and survey.

Briefly, the results from the respondents showed that approximately 67 percent of the survey team members agreed that, overall, the MMS were well organized, easy to read, measurable, and valid indicators of program quality. The facilities responded with 75 percent agreement to these criteria. When questioned about the approach taken in the survey process, 92.5 percent of the survey team members responded positively. Facility responders were 80 percent in agreement with the process.

The third category of questions centered around the exit interview and use of the compliance strategy form. Over 83 percent of the surveyors felt the process was good. Of the facility staff who participated in the exit interview, 80 percent were in agreement with the process.

Finally, each respondent was asked whether the MMS should be implemented in lieu of DPW Rule 34, MDH SLF, and the Federal ICF/MR surveys. Seventy-three percent of the surveyors agreed that this should be investigated. Similarly, 75 percent of the facility directors agreed with the surveyors.

RESULTS- COMPLIANCE STRATEGIES

The Compliance Strategy Form was designed to collect information regarding those standards that were not met, what action was needed to correct the deficiency, and to identify possible resources needed to achieve compliance. This form was completed at the time of the exit interview by the survey team and facility staff. An analysis of these Compliance Strategy Forms showed that the largest number of deficiencies occurred in the following categories of the Model Standards: Emergency Procedures {58 deficiencies), Legal Rights and Confidentiality (38 deficiencies). Meals and Dining Facilities (35 deficiencies), Bedrooms (19 deficiencies), Medications (26 deficiencies}, and Behavior Management (25 deficiencies}.

Compliance strategies listed corresponded directly with the specific standards. Those strategies included actions in the areas of policy development, policy revision, hiring of consultants, remodeling and purchase of furniture. The primary resources necessary to achieve compliance were staff time for policy revision and development, financial resources for facility remodeling and purchase of furniture, and hiring of consultants. After reviewing and analyzing the data on the form, it was concluded that the more measurable and clear the standard, the more measurable and clear was the compliance strategy.

CHAPTER 5

SUMMARY AND CONCLUSIONS

Residential facilities for the MR may currently be over-regulated when considering the degree of duplication of existing regulations and rules. It has been demonstrated that not only can the number of regulations (or standards) be reduced dramatically without affecting state monitoring capabilities, but also that the standards can be improved in validity and reliability.

It was further demonstrated that the survey process(es) can be coordinated between agencies.

A "proactive" approach, which alters the traditional role of the surveyor by adding a consultative function, was seen as positive by the vast majority of those involved with this project. The use of standard scores on differentially weighted measures of performance was shown to be particularly useful in assisting programs in identifying and correcting those areas of weakness. Conversely, program excellence can be rewarded by recognizing those programs which surpass the minimal levels called for in standards.

The results of aggregation across facilities of non-compliance categories has clear implications for management action at both the facility and state levels. Resource allocation and staff development emphasis are two readily apparent categories of action.

Finally, it has been shown that the process of standards development, when carried out in a systematic and controlled manner, will produce a rational and useful product.

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APPENDIX A

THE MINNESOTA MODEL STANDARDS

ASSUMPTIONS:

These model standards are based on two major assumptions:

1. All services, equipment, furnishings, and buildings should be provided in accordance with the principles of normalization. The principle of normalization is defined as making available the patterns and conditions of daily life as close to the culturally normative as possible.
2. All services should be provided in accordance with the developmental model. The developmental model acknowledges each individual's capacity for learning, growing, and developing, regardless of the severity of the disability. In the context of these standards, each resident must be provided with training to assure his or her optimum level of independence.
3. The facility must comply with all applicable state, federal, and local laws, and must meet the requirements of all governmental agencies that have jurisdiction. Appendix C contains a partial compendium of applicable state and federal laws.
4. Full participation in all placement and significant program decisions must be accorded to: the resident, if over age 18, unless (and then only to the extent that) there is a court-appointed guardian or conservator; a court-appointed guardian; a conservator in those matters that have been ordered by a court; or parent(s) of a resident under age 18.
5. Any instance of the application of any policy or required procedure may be appealed to the Commissioner of Public Welfare, or to the corresponding officer of any other public agency promulgating the policy or requirement.

BASIC REQUIREMENTS OF THE MINNESOTA MODEL STANDARDS:

These are the basic provisions of the standards that apply to residential services for mentally retarded persons in Minnesota. The specific standards are derived from these requirements:

1. All facilities, furnishings, equipment, and services intended for resident use must be functionally appropriate and accessible to the residents.
2. Whenever there is an assessed deficit in the mental, physical or adaptive function of the resident, there must be:
   a. An individualized program plan of services to address that deficit;
   b. Actual provision of the services specified in that plan;
   c. Provision of such adaptive equipment and environmental modification as may be specified in the plan.

EXPECTED LEVEL OF COMPLIANCE:

Compliance determinations are based on the formula below. The sample size for the survey assessment with each standard is 10% of the total facility population, but not fewer than four records. The standard is considered MET according to the following formula. N = the sample record size.

Compliance Level		Sample Size
N-l	for	0-10 records
N-2	for	11-20 records
N-3	for	21-30 records
N-4	for	31-40 records
N-5	for	41-50 records
N-6	for	51-60 records

For example, if four records are drawn for review,

the standard is considered met if three records (N-1) are in compliance. In a larger facility, if 50 records are inspected, the standard is considered met if 45 records are in compliance.

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SURVEY EVALUATION FORM
MINNESOTA MODEL STANDARDS 1.0
COMPREHENSIVE ASSESSMENTS

Standard	Priority Weight	Surveyor*	Expected Level of Compliance**	Result
1.1 Each resident must receive a comprehensive behavioral assessment at least annually. The annual assessment must objectively describe the resident's specific performance/behavioral status and include the resident (if capable of participation), facility staff and data supplied by the legal guardian, if any.	7.78	MR	MCL	Met _____ Exceeded _____ Did Not Meet ___
1.2 The annual comprehensive behavioral assessment must be based, wherever appropriate and available, on a standardized assessment instrument and include the following areas: a. Self-care skills, to include toileting, grooming, bathing, eating, dressing and clothes selection; b. Economic and money skills; c. Language development; d. Number and time skills concepts; e. Domestic skills, to include food preparation and service; f. Vocational and prevocational skills; g. Maladaptive behavior and emotional disturbances, if any; h. Community orientation; i. Self-preservation skills or ability to meet emergency situations.	6.92	MR	MCL	Met _____ Exceeded _____ Did Not Meet ___
1.3 An initial comprehensive behavioral assessment must be completed for each resident covering the areas specified in 1.2, within one month after admission to the facility.	5.71	MR	MCL	Met _____ Exceeded _____ Did Not Meet ___
1.4 There must be a record of an annual medical assessment in each resident's record which includes, but is not limited to: a. Physical examination by a licensed physician; b. Hemoglobin count; c. Urinalysis; d. Determination of freedom from tuberculosis; e. Immunization status, using the recommendations of the U.S. Public Health Advisory Committee on Immunization Practices; and f. Any recommendations as a result of the medical assessment and statement of any restrictions on resident's activities due to functional limitations.	6.42	HCE	MCL	Met _____ Exceeded _____ Did Not Meet ___

*MR = Mental Retardation Program Specialist
HCE = Health Care Evaluator
S = Public Health Sanitarian
**MCL = Multiple Compliance Level

SURVEY EVALUATION FORM
MINNESOTA MODEL STANDARDS 1.0
COMPREHENSIVE ASSESSMENTS (Contd.)

Standard	Priority Weight	Surveyor	Expected Level of Compliance	Result
1.5 There must be a record of annual dental exam in the resident's record for residents from age three years and older, with documentation regarding any remedial or corrective action taken.	4.89	HCE	MCL	Met _____ Exceeded _____ Did Not Meet
1.6 Dietary assessment must be performed by a registered dietician or nutritionist within 30 days after each therapeutic diet has been prescribed. Thereafter, dietary assessments of therapeutic diets must be performed quarterly unless more frequent review is recommended by a physician, registered dietician or nutritionist, or the interdisciplinary team.	4.21	HCE	MCL	Met_____ Exceeded _____ Did Not Meet_ Not Applicable_
1.7 There must be a record of annual screening of residents in the following areas: a. Vision for residents ages 2-12 years, and as needed thereafter; b. Speech and language for residents ages 2-16 years; c. Hearing for residents ages 2-12 years, and thereafter when hearing change is suspected.	5.03	MR	MCL	Met _____ Exceeded _____ Did Not Meet_ Not Applicable___
1.8 There must be a record of the intellectual functioning of the resident as determined by a standardized psychological test conducted by a licensed psychologist performed at least every three years for residents under 16 years of age.	4.71	MR	MCL	Met_ Exceeded _____ Did Not Meet_____ Not Applicable____
1.9 If the annual screening indicates any deficits, there must be a comprehensive assessment and a plan for remedial or corrective action.	6.0	MR & HCE	MCL	Met _____ Exceeded _____ Did Not Meet____ Not Applicable___
1.10 All screening and assessments must be conducted by relevantly qualified, licensed, certified or registered personnel.	4.92	MR + HCE	100%	Met_ Did Not Meet____ Not Applicable___

MINNESOTA MODEL STANDARDS 2.0 INDIVIDUAL PROGRAM PLANS AND SERVICES

2.1 There must be an annual individualized program and treatment plan for each resident which is based on the needs identified in the annual comprehensive behavioral assessment and upon other appropriate information.	7.78	MR	MCL	Met_____ Exceeded_____ Did Not Meet

SURVEY EVALUATION FORM
MINNESOTA MODEL STANDARDS 2.0
INDIVIDUAL PROGRAM PLANS AND SERVICES (Contd.)

	Standard	Priority Weight	Surveyor	Expected Level of Compliance	Result
2.2	The individualized program plan (IPP) must be completed within one month of the most recent comprehensive behavioral assessment.	7.78	MR	MCL	Met__ Exceeded__ Did Not Meet__
2.3	The IPP of each resident must contain the following information: a. Goals for the residents developmental growth and for the normalization of his/her patterns of daily living; b. Behavioral objectives, stated in measurable terms, with targeted dates of attainment not more than one year into the future. Behavioral objectives must include specific performance/behavioral skills; c. Plans for the delivery of needed services which specify: 1) methods to be used; 2) frequency, amount, and duration of each planned service; 3) personnel responsible for the delivery of each service; and 4) measures to be used in evaluating the progress of each resident; d. A signed statement which documents resident and/or legal guardian participation in the development of the IPP, and agreement to its provisions; e. The name and affiliation of each person who assisted in the preparation of the IPP.	6.89	MR	MCL	Met__ Exceeded__ Did Not Meet__
2.4	The IPP must be prepared by an interdisciplinary team which includes: a. The resident, unless the resident is legally unable to communicate on own behalf; b. The resident's legal guardian (if any) must be invited; c. The chief executive officer and/or the program director of the facility or his/her delegate; d. Those persons who provide, or who are expected to provide, developmental services to the resident; e. The representative from the local social services agency; f. An accredited representative of the public school district must be invited to participate, if such a district is currently responsible for delivering or securing an educational program for the resident; g. The resident's advocate, if the advocate's participation has been authorized in writing by the resident or the legal guardian (if any).	6.75	MR	MCL	Met__ Exceeded__ Did Not Meet__

SURVEY EVALUATION FORM
MINNESOTA MODEL STANDARDS 2.0
INDIVIDUAL PROGRAM PLANS AND SERVICES (Contd.)

Standard	Priority Weight	Surveyor	Expected Level of Compliance	Result
2.5 The IPP must be updated by a member or members of the interdisciplinary team at least monthly to: a. Incorporate the findings of any recent assessments; b. Record the implementation of services; c. Record the resident's progress toward the objectives; d. Document any changes in behavioral objectives or plans for the delivery of needed services.	4.89	MR	MCL	Met _____ Exceeded _____ Did Not Meet ____
2.6 The IPP must be reviewed and revised annually interdisciplinary team. There must be more frequent review and revision within 30 days when the monthly updates of the IPP indicate that more than 50% of the resident's behavioral objectives have been achieved. This review shall include: a. A list of the objectives achieved; b. A list of the objectives modified; c. A list of new goals and objectives; d. Evaluation of the services provided; e. Consideration of the need for continued residence and alternate programs; f. Review of the resident's legal status and need for change of that status; g. Documentation of new IPP as specified in 2.2 and 2.3.	6.78 by the	MR	MCL	Met _____ Exceeded _____ Did Not Meet ___
2.7 The IPP document must be available to: resident, if a legally independent adult; b. The resident's legal guardian, if any; c. Representative of the local social services agency; d. The chief executive officer and program director of the facility; e. Facility living unit staff; f. Any provider of a service specifically identified in the IPP as a needed service, including service providers in other agencies whose services are specified in the IPP; and g. Members of the survey team implementing these standards.	5.35 a. The	MR	MCL	Met _____ Exceeded _____ Did Not Meet ___
2.8 Unless contraindicated by physician order, all residents must: a. Spend at least nine hours of their waking day out of bed; b. Spend at least six hours of their waking day out of their bedroom areas.	5.14	MR& HCE	100%	Met _____ Did Not Meet ___

SURVEY EVALUATION FORM
MINNESOTA MODEL STANDARDS 3.0
BEHAVIOR MANAGEMENT

Standard	Priority Weight	Surveyor	Exceeded Level of Compliance	Result
3.1 The facility must have written policy and procedures for the behavior management of residents that: a. Are directed to the goal of maximizing the growth and development of the residents, and 1) Provides that the least restrictive method which is effective must be used; 2) Provides that positive methods for controlling behavior must be given primary consideration; b. Are available to parents/guardians; c. Are available in each living unit to staff and residents; d. Provide for resident participation, as appropriate, in the formulation of such policies and procedures; e. Prohibit corporal punishment, verbal and physical abuse, and the withdrawal or use of food as punishment; f. Prohibit residents from disciplining other residents.	7.78	MR & HCE	100%	Met_____ Did Not Meet ___
3.2 Any use of mild aversive and deprivation procedures (as defined) for behavior modification must be reviewed as the resident's interdisciplinary team, and participation in design or review of the procedures by a behavior management expert must be documented.	5.82	MR	MCL	Met_ Exceeded _____ Did Not Meet ____ Not Applicable ___
3.3 If the facility uses any aversive or deprivation procedure other than those defined as mild, restraint and/or seclusion, it must have a facility human rights committee which reviews and approves these programs. The membership of the human rights committee must include the chief executive officer of the facility or his/her designee, direct service staff, a licensed physician, a behavior management expert not employed by the facility who serves in a consulting capacity on the committee, a behavior management expert employed by the facility, if the facility employs one, and a resident advocate, if requested by the resident. Programs utilizing behavior management procedures other than mild must be reviewed by the committee within 30 days of their initiation, and may not be continued unless approved by the committee.	5.82	MR	MCL	Met_ Exceeded _____ Did Not Meet ____ Not Applicable ___

SURVEY EVALUATION FORM
MINNESOTA MODEL STANDARDS 3.0
BEHAVIOR MANAGEMENT (Contd.)

Standards	Priority Weight	Surveyor	Expected Level of Compliance	Result
3.4 Each use of aversive or deprivation procedures, restraint and seclusion must be recorded in the resident's record. The record must include: a. A description of the precipitating behavior; b. Expected behavioral outcome; c. Possible side or secondary effects, if any; d. Date for review or termination; e. Description and schedule of procedures actually carried out; f. Actual behavioral outcome; g. Actual side or secondary effects; and h. Signature of person authorizing the procedure and signature of person reporting implementation and effects.	6.07	MR & HCE	MCL	Met_ Exceeded_____ Did Not Meet ___ Not Applicable __
3.5 Programs utilizing restraint or seclusion must be approved by the facility human rights committee for a specified and limited time and employed only when absolutely necessary to protect the resident from injury to self or to others and must not be employed as punishment, for the convenience of staff, as a substitute for programs, or as a behavior modification device.	5.87	MR & HCE	100%	Met_ Did Not Meet ____ Not Applicable ___
3.6 The facility must establish and follow written policies and procedures concerning the use of restraints and seclusion. These policies and procedures must clearly require the following: a. Orders indicate the specific reason for use of restraints and seclusion; b. Their use is temporary and limited to a specific period of time; c. Reorders are issued only after a review of the resident's condition by the facility human rights committee. d. Monitoring procedures must be described and must include identification by name and staff position those staff members permitted to monitor the use of restraints under supervision of the authorizing physician; e. The use of restraints are allowed only when a person cannot be otherwise subdued or controlled; f. Persons in physical restraints must be in constant view of staff; g. Mechanical restraints must avoid physical injury to the resident and provide a minimum of discomfort; h. No locked restraints may be used;	6.42	MR & HCE	100%	Met _____ Did Not Meet ____ Not Applicable ___

SURVEY EVALUATION FORM
MINNESOTA MODEL STANDARDS 3.0
BEHAVIOR MANAGEMENT (Contd.)

Standard	Priority Weight	Surveyor	Expected Level of Compliance	Result
i. Opportunity for motion and exercise is provided for a period of not less than 10 minutes during each two hours in which restraints are employed, except at night; j. The practice of locking residents alone in their room constitutes physical restraint and must be in conformance with the requirements of the Life Safety Code.				
3.7 Orders for restraints must not be enforced for longer than 12 hours, unless the resident's condition is documented to warrant a specified longer period.	6.42	MR	100%	Met _____ Did Not Meet ____ Not Applicable ___
3.8 A resident placed in physical restraints must be checked at least every 15 minutes by those staff members permitted to monitor their use, and an account of this surveillance and comments regarding the resident's behavior must be entered in the resident's record.	6.42	MR	MCL	Met_ Exceeded _____ Did Not Meet ____ Not Applicable ___
3.9 Unless the resident is a legally independent adult, the facility must provide monthly communication to the legal guardian regarding incidents in which restraints and/or seclusion were used, with the explanation of the emergency circumstances which necessitated their use.	6.42	MR	MCL	Met _____ Exceeded _____ Did Not Meet ____ Not Applicable ___
3.10 There must be an individualized treatment plan developed and/or by the facility human rights committee for residents under restraint which is directed toward reducing the necessity for restraints and eventual replacement of restraints with a positive reinforcement plan.	6.42	MR & HCE	MCL	Met_ Exceeded _____ Did Not Meet ____ Not Applicable ___

MINNESOTA MODEL STANDARDS 4.0
RESIDENT RECORDS

4.1 The following information must be on written record in the resident's record upon admission to the facility, except that in cases of emergency placement, the information must be recorded within three days after admission: a. Resident's name, previous address, and birth date; b. Name, address, and phone number of legal guardian (if any) and person to contact in an emergency;	5.35	HCE	MCL	Met_ Exceeded _____ Did Not Meet____

Standard	Priority Weight	Surveyor	Expected Level of Compliance	Result
c. Medications taken by prescription; d. Special diet needs and food allergies, if any; e. Name of local social services agency representative.				
4.2 Within one month of the resident's admission to the facility, the facility must request in writing the following information from the referring agency: a. The results of comprehensive behavioral and physical assessments conducted within the last two years; b. Records of professional service delivery within the last two years, including a summary of day program services; c. All program plans developed within the last two years; d. Record of prescriptions and administration of medications within the past two years; e. Dates and descriptions of illnesses, accidents, treatments thereof, and immunizations for the past two years; f. Summary of hospitalizations, to include recommendations for follow-up and treatment for the past two years.	5.03	MR & HCE	MCL	Met__ Exceeded__ Did Not Meet__
4.3 The facility must maintain a record for each resident, which contains the following information: a. The resident's name, date of birth, previous address, date of admission to and discharge from the facility, and person to contact in an emergency; b. The results of comprehensive behavioral and physical assessments conducted within the last two years; c. Records of professional service delivery within the last two years, including a summary of day program services; d. All individualized program plans developed within the last two years; e. The name and address of the resident's physician; f. The name and address of the resident's dentist; g. The name and address of the resident's case manager; h. Adverse reactions to drugs, if any, and prominently post a notice as a precaution;	6.53	MR & HCE	MCL	Met__ Exceeded__ Did Not Meet__

SURVEY EVALUATION FORM
MINNESOTA MODEL STANDARDS 4.0
RESIDENT RECORDS (Contd.)

Standard	Priority Weight	Surveyor	Expected Level of Compliance	Result
i. Record of prescriptions and administration of medications within the past two years; j. Quarterly review of medication regime for past two years; k. Dates and descriptions of illnesses, accidents, treatments thereof, and immunizations for the past two years; l. Summary of hospitalizations, to include recommendations for follow-up and treatment for the past two years; m. Written orders by physician prescribing therapeutic diets, if one is in effect, a copy of the diet, and the dates of review of the diet; n. All physicians' orders within the past two years; o. A complete record of the use of the resident's funds, if such use is supervised by the facility; p. Height and weight records for past two years; q. Date, time, and circumstances of resident's death, if the resident dies while residing in the facility.				
4.4 All entries in the resident's record must be legible, dated, and authenticated by the signature and title of the individual making the entry.	4.28	MR	MCL	Met__ Exceeded__ Did Not Meet__
4.5 There must be a permanent record of all admissions, discharges, deaths, and transfers of residents.	3.75	MR	MCL	Met__ Did Not Meet__
4.6 The following information must be maintained in the living unit in which the resident resides and available to living unit staff: a. Current IPP; b. Results of most recent behavioral and physical assessments; c. Copy of any therapeutic diets, list of food allergies, and any special dietary needs; d. Medications taken; e. Adverse reactions to drugs; f. Name, address, and phone number of parent and/or legal guardian (if resident is not a legally independent adult) and person to contact in an emergency.	5.96	MR & HCE	90%	Met__ Exceeded__ Did Not Meet__

SURVEY EVALUATION FORM
MINNESOTA MODEL STANDARDS 5.0
LEGAL RIGHTS AND CONFIDENTIALITY

Standard	Priority Weight	Surveyor	Expected Level of Compliance	Result
5.1 The facility must specify in writing its grievance procedures and due process rights, to include: a. The names and phone numbers of persons to contact in order to register a complaint; b. The time schedules established for registration of complaints and appeals; c. The time limits required and/or allowed for decisions to be made by the facility and adjudicators; and d. Procedures and locations for appeal of decisions.	5.35	MR	100%	Met_ Did Not Meet ____
5.2 The facility must provide to residents and/or their legal guardians a written copy of the grievance procedures and due process rights followed by the facility.	5.35	MR	MCL	Met_ Exceeded_____ Did Not Meet ____
5.3 The facility must have a written policy indicating the methods used to elicit residents' views regarding the policies and procedures that affect them.	4.92	MR	100%	Met_ Did Not Meet ____
5.4 The facility must have a written policy concerning the exercise and protection of individual rights in accordance with Chapter 144.651, Minnesota Statutes, Patients and Residents of Health Care Facilities; Bill of Rights.	6.0	MR	100%	Met_ Did Not Meet ____
5.5 Information in the resident's record must be made available by the CEO or governing body to: a. The resident, if a legally independent adult; or b. The resident's legal guardian, if any; c. Others who are specifically so authorized in these regulations.	4.92	MR	100%	Met_ Did Not Meet ____
5.6 Persons other than the resident, or his/her legal guardian (if any) may gain access to information in the resident's record only with written permission from the chief executive officer. Such permission can be granted only with the signed release of information from the resident or his/ her legal guardian. The signed release of information shall include: a. The date for release of information; b. Information to be released; c. Purpose for which information is being released; d. Person or agency to whom the information is released;	4.78	MR	100%	Met_ Did Not Meet ____

SURVEY EVALUATION FORM
MINNESOTA MODEL STANDARDS 5.0
LEGAL RIGHTS AND CONFIDENTIALITY (Contd)

Standard	Priority Weight	Surveyor	Expected Level of Compliance	Result
e. Signature of resident or parent and/or legal guardian; f. Expiration date for release of information.				
5.7 All records specifically required by these standards shall be made available by the chief executive officer or governing body to the survey team responsible for implementing the standards.	3.82	MR	100%	Met _____ Did Not Meet ____
5.8 Facility personnel who participated in the determination of the **IPP** or who are designated as responsible for the implementation of the IPP, and personnel of other agencies who similarly participated or who are designed in the IPP to be expected to implement the plan, may examine the IPP document.	4.96	MR	100%	Met__ Did Not Meet_

MINNESOTA MODEL STANDARDS 6.0
HEALTH AND GROOMING

1 There must be: a. Monthly weighing of residents; b. Quarterly measurement of height, until the age of 18 years; c. Maintenance of height and weight records.	2.85	HCE	MCL	Met_ Exceeded_____ Did Not Meet ___
2 Orders prescribing total bed rest must be prescribed by a physician and must be self-terminating in three days unless renewed by a physician's order.	4.17	HCE	MCL	Met _____ Did Not Meet ___ Not Applicable __
3 Any occurrence of sickness or communicable disease listed in Appendix A, incurred by staff or residents, must be promptly reported to a physician.	4.92	HCE	100%	Met__ Did Not Meet ___ Not Applicable __
4 Residents who are members of an organized religious group opposed to any health practices shall be excused from regulations applying to personal health upon prior written request by the resident or his/her legal guardian, if any. However, all residents shall be subject to requirements for control of outbreaks of infectious disease.	3.71	HCE	100%	Met Did Not Meet_ Not Applicable __

SURVEY EVALUATION FORM
MINNESOTA MODEL STANDARDS 6.0
HEALTH AND GROOMING (Contd.)

Standard	Priority Weight	Surveyor	Expected Level of Compliance	Result
6.5 Every resident who is not toilet trained must be engaged in a toilet training program, unless contraindicated by the IPP.	5.75	MR	100%	Met _____ Did Not Meet____ Not Applicable___
6.6 Residents who are incontinent must be immediately bathed or cleansed upon voiding or soiling, unless specifically contraindicated by a plan for toilet training; and all soiled clothing must be changed.	5.75	HCE	100%	Met _____ Did Not Meet____ Not Applicable___

MINNESOTA MODEL STANDARDS 7.0
MEDICATIONS

7.1 The facility must develop and follow a written medication control plan acceptable to the State Department of Health. The plan must be on file and available for inspection and reviewed annually. The plan must contain at least the following provisions: a. A statement of whether staff will administer medications, how staff will supervise self-administration of medications, whether medications will be self-administered, or a combination of the above systems; b. Qualifications of staff to administer medications; c. Procedures for distribution and storage of medications, including description of locked storage facilities and refrigeration; d. Procedures for recording medications that residents are taking; e. Procedures for recording resident refusal to take medications; f. Procedures for reporting medication errors to physician; g. Procedures for sending medications with the resident to day programs, vacation, home, etc.; h. Procedures for notification and involvement of legal guardians when psychotropic medications are administered to the resident.	6.03	HCE	100%	Met _____ Did Not Meet____
7.2 Medications must be administered to residents only upon the written order of a licensed physician or dentist, except that orders may be given by telephone or verbally provided that such orders are authorized by the physician or dentist, recorded by the person so authorized, and signed by the physician or dentist within 72 hours.	6.50	HCE	100%	Met_ Did Not Meet____

SURVEY EVALUATION FORM
MINNESOTA MODEL STANDARDS 7.0
MEDICATIONS (Contd.)

Standard	Priority Weight	Surveyor	Expected Level of Compliance	Result
3 There must be quarterly examination and review of medication regimes by an R.N., unless more frequent review is ordered by a physician.	6.03	HCE	100%	Met_ Did Not Meet ____
4 Stock supplies of prescription medications must not be maintained in the living unit unless it is a licensed pharmacy. In no case shall medications be maintained, distributed, or administered from containers other than individual prescription containers bearing appropriate labels, except on the case of a unit dose dispensing system approved by the State Board of Pharmacy. Prescription medications may only be distributed or administered to the person for whom prescribed.	4.0	HCE	100%	Met_ Did Not Meet ____
5 Except in the case of a unit dose dispensing system approved by the State Board of Pharmacy, all prescription medications must be kept in their original container bearing the original label with legible information stating the prescription number, name of prescriber, name of drug, strength and quantity of drug, expiration dates of all time-dated drugs, directions for use, resident's name, original date of issue, or in case of a refill the most recent date thereof, and name and address of the licensed pharmacy which issued the medications. No medication shall be accepted into the facility unless the above criteria for labeling are met. a. Any drug container having detached, excessively soiled, or damaged labels must be returned to the issuing pharmacy for re-labeling. b. The contents of any drug container having no label or with an illegible label must be destroyed immediately. c. Medications having a specific expiration date must not be used after the date of expiration.	5.21			Met_ Did Not Meet____
5 If authorized by the resident's physician, medications belonging to residents must be given to them or the legal guardian when the resident is discharged or transferred. This must be recorded in the resident's record.	3.75	HCE	100%	Met_ Did Not Meet ____ Not Applicable ___

SURVEY EVALUATION FORM
MINNESOTA MODEL STANDARDS 7.0
MEDICATIONS (Contd.)

	Standard	Priority Weight	Surveyor	Expected Level of Compliance	Result
7.7	Unused portions of controlled substances must be handled by contacting the State Board of Pharmacy, which will furnish the necessary instructions and appropriate forms, a copy which must be kept on file in the facility for two years. Any other unused portions of prescription drugs remaining in the facility after the death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently must be destroyed by the facility or designee by flushing them into the sewer system and removing and destroying the labels from the containers. A notation of such destruction must be recorded in the resident's record with the following information: date, quantity, name of medication and prescription number, signature of the person who destroyed the medication and signature of a witness to that destruction.	3.75	HCE	100%	Met__ Did Not Meet__ Not Applicable__
7.8	For any resident who is prescribed a psychotropic drug, the facility must maintain a description of the resident's behavior prior to use of the the drug if observed, and the resident's behavior while on the drug, the effects of the drug, and a description of the resident's behavior if the use of the drug is omitted or discontinued.	6.28	HCE & MR	MCL	Met__ Exceeded__ Did Not Meet__ Not Applicable__

MINNESOTA MODEL STANDARDS 8.0
COMMUNITY RESOURCES

8.1	All daytime developmental and remedial services, called for by individual assessment and program plan, must be rendered outside the facility, unless contraindicated by a physician or unless the service does not exist in the community.	6.14	MR	100%	Met__ Did Not Meet__
8.2	If daytime developmental and remedial services are provided in the facility because of lack of such services in the community, the facility must maintain documentation of its efforts to obtain the services in the community.	4.28	MR	100%	Met__ Did Not Meet__ Not Applicable__
8.3	All therapeutic and health services utilized by residents must be provided by persons or facilities licensed or certified to provide these services.	4.92	HCE	100%	Met__ Did Not Meet__

SURVEY EVALUATION FORM
MINNESOTA MODEL STANDARDS 8.0
COMMUNITY RESOURCES (Contd.)

Standard	Priority Weight	Surveyor	Expected Level of Compliance	Result
8.4 The facility must directly provide, or must establish formal arrangements to assure the provision of, generic services to those residents who are unable to secure such services in the community. In particular, the facility must establish formal arrangements with licensed dentists and physicians to provide: a. Annual physician and dental examinations, for each resident who is unable to utilize community settings for the receipt of such services; b. General medical and dental services, as needed; c. Medical services for emergencies.	4.92	HCE	100%	Met _____ Did Not Meet ___
8.5 The facility must document that assistance has been provided to each resident to select and secure services in the community. In particular, the facility must document its efforts to assure that each resident is provided the assistance required to enable independent use, as defined in the IPP, of the following community resources: a. Recreation resources; b. Cultural/entertainment resources; c. Stores and restaurants; d. Places of worship; and e. Sites where general medical and dental services are delivered.	5.0	MR	MCL	Met _____ Exceeded _____ Did Not Meet ___

MINNESOTA MODEL STANDARDS 9.0
COMMUNICATIONS

9.1 The facility must specify in writing its policy on family visitation and other means of communication with the resident and staff.	4.42	MR	100%	Met _____ Did Not Meet __
9.2 Mail and packages addressed to residents must be delivered to the addressee unopened, and outgoing mail must not be censored or read.	5.46	MR	100%	Met__ Did Not Meet __
9.3 The facility must have at least one telephone in a shared living area for incoming calls and local outgoing calls. The facility must provide access by the resident to a telephone for making long distance calls.	5.28	S	100%	Met _____ Did Not Meet __

SURVEY EVALUATION FORM
MINNESOTA MODEL STANDARDS 10.0
POSSESSION AND USE OF MONEY

Standard	Priority Weight	Surveyor	Expected Level of Compliance	Result
10.1 The facility must establish and follow written policies and procedures with respect to the possession and use of money by residents. These policies and procedures shall: a. Allow residents to have their own money in their possession for use in community commercial, professional, or recreational establishments, unless contraindicated in the IPP; b. Allow residents to maintain savings and checking accounts in community financial institutions. c. Provide financial counseling to all residents, unless contraindicated in the IPP.	6.42	MR	100%	Met_ Did Not Meet ___
10.2 The facility must maintain a complete record of the use of the resident's funds, if such use is supervised by the facility, and reconcile the account at least quarterly.	5.82	MR	MCL	Met _____ Exceeded_____ Did Not Meet ___

MINNESOTA MODEL STANDARDS 11.0
CLOTHING

11.1 The wardrobe of each resident must include clothing and outerwear that is season-appropriate.	4.96	MR	100%	Met_ Did Not Meet ___
11.2 Clothing that is marked must be inconspicuously marked with the resident's name.	3.46	HCE	100%	Met_ Did Not Meet ___
11.3 Clean clothing must be available daily to all residents.	4.71	HCE	100%	Met _____ Did Not Meet____
11.4 The facility must document that training and assistance have been provided to each resident in the following areas, unless specifically contraindicated in the IPP or unless the facility documents the resident's attainment of functional adult independence in the activity: a. Selection and purchase of their own clothing as independently as possible, utilizing community stores; b. Selection of their daily clothing; c. Dressing; d. Changing their clothes to suit the activities in which they engage; e. Maintain (launder, mend, and clean) their clothing as independently as possible.	5.35	MR	MCL	Met__ Exceeded _____ Did Not Meet ___

SURVEY EVALUATION FORM
MINNESOTA MODEL STANDARDS 12.0
ADMISSION/DISCHARGE

Standard	Priority Weight	Surveyor	Expected Level of Compliance	Result
12.1 The facility must specify in writing the following information: a. Preadmission and admission procedures; b. Admission criteria to include age, and type or degree of handicap; c. Developmental and remedial services provided by facility staff; d. Developmental and remedial services provided by other agencies or persons through agreement; e. Means for individual program planning for residents; f. Plan for grouping residents into living units (if applicable); and g. Discharge procedures.	4.78	MR	100%	Met__ Did Not Meet____
12.2 The facility must specify in writing its admissions policy and procedures to include: a. Nondiscrimination statement with regard to race, creed, or national origin; b. Provisions for applicants and parents/ guardians to visit prior to admission of the facility and the living unit in which the applicant is likely to be placed; c. Provisions that permit direct application for admission to the facility by applicants and their parents/guardians; d. Provisions that information specified in 12.1 is available to applicants, their parents/ guardians, and referring agencies; e. Nonacceptance of persons who have a communicable disease or a disease endangering the health of other residents; f. Procedures for appeal of admission and discharge decisions.	4.57	MR	100%	Met__ Did Not Meet ___
12.3 Upon determination of the possible inadmissability of a resident, the facility must consult with the referring agency, the applicant and/or the legal guardian and provide written documentation stating reasons for inadmissability, if requested.	4.14	MR	MCL	Met_ Exceeded _____ Did Not Meet_____ Not Applicable ____
12.4 When admission is not an optimal measure, but must nevertheless be implemented, the facility must inform the resident, legal guardian, and the referring agency why the admission is judged non-optimal. The inappropriateness of the admission must be documented in the resident's record.	4.60	MR	MCL	Met_ Exceeded_____ Did Not Meet ____ Not Applicable ___

SURVEY EVALUATION FORM
MINNESOTA MODEL STANDARDS 12.0
ADMISSION/DISCHARGE (Contd.)

Standard	Priority Weight	Surveyor	Expected Level of Compliance	Result
12.5 Upon acceptance of a school-age child, the facility must notify the local school district within seven calendar days prior to starting school.	4.64	MR	MCL	Met_ Exceeded _____ Did Not Meet___
12.6 Upon admission, each resident must have a medical evaluation conducted by a physician within 60 days preceding admission or within three working days following admission.	4.78	HCE	MCL	Met_ Exceeded _____ Did Not Meet___
12.7 The facility must provide counseling about the advantages and disadvantages of discharge to parents/guardians who request the release of a resident.	3.85	MR	MCL	Met_ Exceeded_____ Did Not Meet ___ Not Applicable __
12.8 Except in an emergency, planning for discharge shall be made only with the prior involvement and written notification of the referring agency, facility staff, the resident, and the legal guardian, if any.	5.28	MR	100%	Met_ Did Not Meet ___ Not Applicable __
12.9 At the time of discharge, a copy of the resident's record as specified in 9.2 must be transmitted to the receiving residential facility, if that facility is covered by these regulations.	4.53	MR	100%	Met _____ Did Not Meet ___ Not Applicable __

MINNESOTA MODEL STANDARDS 13.0
STAFFING PATTERNS AND PERSONNEL

13.1 At all times that residents are up and about in the facility, there must be at least one staff person awake, dressed, and up and about in the facility. This person must be accessible to all residents in the facility and must be the person to whom residents can report injuries, symptoms of illness, and emergency situations.	6.14	MR	100%	Met _____ Did Not Meet____
13.2 The facility must prepare a job description and must establish minimum qualifications for each staff position. These qualifications must address the following factors: a. Educational requirements, if any required; b. Relevant work experience, which is required or desired; c. Required professional certifications, licensures, or registrations; and d. Skills required to perform job.	4.89	MR	MCL	Met _____ Exceeded _____ Did Not Meet____

SURVEY EVALUATION FORM
MINNESOTA MODEL STANDARDS 13.0
STAFFING PATTERNS AND PERSONNEL (Contd.)

Standard	Priority Weight	Surveyor	Expected Level of Compliance	Result
13.3 There must be staff on duty so that provision of facility services are not dependent upon the use of unpaid residents or volunteers.	5.67	MR	100%	Met_ Did Not Meet
13.4 Residents who perform staff duties must receive pay and privileges comparable to those of the staff who perform the same or equivalent duties.	4.57	MR	100%	Met_ Did Not Meet Not Applicable
13.5 The facility must have written personnel policies which are available to each staff member. Personnel policies shall include: a. Application and hiring procedures; b. Nondiscrimination statement; c. Statement of probation period and procedure for annual performance evaluation; d. Procedure for suspension and/or dismissal of employees; e. Benefits, e.g., health insurance, social security, worker's compensation, unemployment compensation, sick leave, and vacation; f. Grievance and appeals procedure.	4.75	MR	100%	Met__ Did Not Meet
13.6 The facility must require that: a. All staff must, within one year of employment and annually thereafter, show freedom from tuberculosis by a report of a standardized tuberculin test or a chest X-ray. If the test is positive or contraindicated, a chest X-ray must be taken. The results of these tests must be on file in the facility. b. Any staff member with a communicable disease must not be permitted to work in the facility until a physician certifies that the staff member's condition will permit return to work without endangering the health of other staff and residents.	4.67	HCE	100%	Met_ Did Not Meet
13.7 The facility must have an annual written plan for staff training and orientation that includes: a. Orientation for all new employees which includes the philosophy, organization, program, policies and practices, goals of the facility, and emergency procedures; b. In-service training for full and part-time staff.	5.75	MR	100%	Met_ Did Not Meet
13.8 Twenty (20) hours of in-service training or outside workshops each year to update and improve skills and competencies must be provided to each full-time staff person directly involved in the developmental training of residents.	5.75	MR	MCL	Met_ Exceeded Did Not Meet

SURVEY EVALUATION FORM
MINNESOTA MODEL STANDARDS 13.0
STAFFING PATTERNS AND PERSONNEL (Contd.)

Standard	Priority Weight	Surveyor	Expected Level of Compliance	Result
13.9 Ten (10) hours of in-service training or outside workshops each year must be provided to each part-time staff person and volunteers directly involved in the developmental training of residents.	5.75	MR	MCL	Met_ Exceeded Did Not Meet__

MINNESOTA MODEL STANDARDS 14.0
ADMINISTRATION

14.1 The facility must have a written statement or organizational chart defining its administrative and organization structure and likes of communication.	4.17	MR	100%	Met_____ Did Not Meet __
14.2 The governing body must appoint a chief executive officer of the facility with the authority and responsibility for management of the facility.	4.17	MR	100%	Met_ Did Not Meet __
14.3 The facility must have a written statement clearly defining its philosophy, purpose and goals which: a. Is consistent with the principle of normalization; b. Includes representative facility goals stated in terms of expected resident outcomes which the facility strives to achieve.	5.67	MR	100%	Met_ Did Not Meet __
14.4 The facility must provide for consumer representation and public participation in its operation through one of the following means: a. The governing body shall include consumer representatives, interested citizens, and relevantly qualified professionals; or b. If consumer representatives, interested citizens, and relevantly qualified professionals are not represented on the governing body, an advisory body composed of such representation shall be appointed by the governing body. The advisory body shall sit ad hoc to the governing body and to the chief executive officer and provide consultation and assistance.	4.17	MR	100%	Met_____ Did Not Meet __

SURVEY EVALUATION FORM
MINNESOTA MODEL STANDARDS 15.0
EMERGENCY PROCEDURES

Standard	Priority Weight	Surveyor	Expected Level of Compliance	Result
15.1 The facility must have a written emergency plan and procedures for fire, serious illness, severe weather, and missing persons. Plan shall include: a. Assignment of staff and residents to specific tasks and responsibilities; b. Written instructions relating to the use of alarm systems and signals; c. Information on methods of fire containment; d. Plans for the overnight or short-term resettlement or relocation of residents; e. Systems for notification of appropriate persons in emergencies.	6.17	S	100%	Met_ Did Not Meet ___
15.2 The written emergency plan must be developed with the assistance and advice of the local fire and/or rescue authority.	3.25	S	100%	Met_____ Did Not Meet_
15.3 A visible and central routing, of emergency procedures and a floor plan with exit routes and location of fire-fighting equipment clearly marked, must be posted.	6.17	S	100%	Met_ Did Not Meet ___
15.4 The facility must have documentation that training and orientation in emergency procedures has been provided for each new staff member and each newly admitted resident capable of self-preservation. Training shall occur within one month of employment or admission to the facility.	6.17	S	MCL	Met_ Exceeded _____ Did Not Meet ___
15.5 There must be documentation of quarterly review of emergency plan and procedures with staff on each shift and with those residents who are capable of self-preservation.	6.17	S	100%	Met _____ Did Not Meet____
15.6 The facility must conduct building evacuation drills at least quarterly. At least one drill shall be conducted during normal sleeping hours and at least one drill during normal waking hours each year.	4.96	S	100%	Met_ Did Not Meet ___
15.7 First-aid equipment, approved by a physician, must be maintained on the premises in a readily available location and staff must be instructed In its use.	5.03	HCE	100%	Met_____ Did Not Meet ____
15.8 There must be at least one noncoin-operated telephone which is accessible to staff, residents, and visitors at all times for use in emergency. A	5.32	S	100%	Met _____ Did Not Meet____

SURVEY EVALUATION FORM
MINNESOTA MODEL STANDARDS 15.0
EMERGENCY PROCEDURES (Contd.)

Standard	Priority Weight	Surveyor	Expected Level of Compliance	Result
list of the following telephone numbers must be posted at this telephone: police, fire, ambulance, hospital, and emergency physician.				
15.9 In the event of an emergency, the resident's legal guardian and the local county welfare department must be notified. The wishes of the resident and the legal guardian about religious matters must be determined and followed as closely as possible.	5.28	HCE	100%	Met__ Did Not Meet__
15.10 An incident report must be made for use by the facility and, in case of injury, all relevant legal requirements must be complied with, including state reporting requirements for abuse or neglect (see Appendix C). The incident report must include any remedial action taken.	4.96	HCE	100%	Met__ Did Not Meet__

MINNESOTA MODEL STANDARDS 16.0
SANITATION

16.1 The water supply system must be located, constructed and operated in accordance with the standards of the State Health Department.	4.35	S	100%	Met_ Did Not Meet ____
16.2 Every facility must be constructed or equipped to prevent the entrance, harborage or breeding of insects or vermin.	3.92	S	100%	Met_ Did Not Meet_
16.3 All liquid waste must be disposed of in an approved public sewage system or in a sewage system which is designed, constructed, installed, and operated in accordance with the standards of the State Health Department and the State Pollution Control Agency.	4.14	S	100%	Met _____ Did Not Meet ____

MINNESOTA MODEL STANDARDS 17.0
PHYSICAL PLANT

17.1 All buildings, structures, furnishings, and equipment must be kept in good repair and maintained to protect the health, comfort, and safety of the residents.	5.82	S	100%	Met_____ Did Not Meet __

SURVEY EVALUATION FORM
MINNESOTA MODEL STANDARDS 17.0
PHYSICAL PLANT (Contd.)

Standard	Priority Weight	Surveyor	Expected Level of Compliance	Result
17.2 Lighting levels, measured 30 inches above the floor, must not be less than 10 foot-candles for all resident use areas and not less than five foot-candles for exit stairways, mechanical equipment, and storage areas. There must be a minimum of 20 foot-candles for reading or work surfaces.	2.96	S	100%	Met _____ Did Not Meet ___
17.3 Air replacement vents must be designed to permit the entrance of an equal volume of displaced air and to prevent the entrance of insects, dust or other contaminating materials.	3.03	S	100%	Met _____ Did Not Meet ___
17.4 Toilet rooms must be well ventilated by natural or mechanical methods. Interior toilet rooms, central toilets serving more than four persons, and utility rooms must be provided with mechanical exhaust ventilation.	4.17	S	100%	Met__ Did Not Meet____
17.5 Make-up air must be tempered during seasons when weather conditions require tempering of make-up air.	3.32	S	100%	Met_ Did Not Meet____

MINNESOTA MODEL STANDARDS 18.0
SHARED LIVING SPACES

18.1 The number of residents in a living unit must not exceed 16.	5.46	S	100%	Met _____ Did Not Meet ___
18.2 The living area must be physically and functionally differentiated from areas for developmental and remedial services, except that training in self-care and independent living skills may be carried out in appropriate living areas.	5.21	MR	100%	Met__ Did Not Meet ___
18.3 The living unit must be physically self-contained. Walls defining the living unit must extend from floor to ceiling. a. The living unit must contain bedroom, living room and bathroom. b. There must be a recreation area, which may serve more than one living unit within the facility.	4.89	S	100%	Met_ Did Not Meet ___
18.4 Shared living spaces must be free from bolted-down furniture, mesh-protected ceiling lights and similar furnishings.	4.42	S	100%	Met_ Did Not Meet ___

SURVEY EVALUATION FORM
MINNESOTA MODEL STANDARDS 18.0
SHARED LIVING SPACES (Contd.)

Standard	Priority Weight	Surveyor	Expected Level of Compliance	Result
18.5 Minimum areas for resident dining and living areas must be 10 and 20 square feet, respectively, per resident, or 30 square feet total per resident when the area is used for a combination thereof. Common use areas for use by nonambulatory mobile residents require an increase of 50%.	3.75	S	100%	Met_ Did Not Meet __
18.6 In no case may locked doors be a substitute for program or for staff interaction with residents.	5.82	S& MR	100%	Met_ Did Not Meet __
18.7 Residents must be allowed free use of all space within the living unit, with due regard for privacy, personal possessions, and safety.	6.10	S& MR	100%	Met Did Not Meet __

MINNESOTA MODEL STANDARDS 19.0
BEDROOMS

19.1 The number of persons sleeping in any bedroom must not exceed four. Walls defining bedrooms must extend from floor to ceiling.	5.60	S	100%	Met_ Did Not Meet ____
19.2 Single bedrooms for ambulatory residents must be at least 80 square feet in size; multi-person bedrooms must have at least 60 square feet per person,	4.21	S	100%	Met_ Did Not Meet _____ Not Applicable ____
19.3 Single and multiple bedrooms for nonambulatory residents must provide at least 100 square feet of usable floor area with a side dimension of not less than nine feet. Mobility space must be not less than four feet at the side of each bed and not less than three feet at end of beds.	4.14	S	100%	Met_ Did Not Meet _____ Not Applicable ____
19.4 Bedrooms for nonambulatory, mobile residents must have accessible space for storage of wheelchairs and other prosthetic or adaptive equipment for daily out-of-bed activity or similar storage space must be provided outside of the bedroom readily accessible to the resident.	4.64	S	100%	Met_ Did Not Meet _____ Not Applicable ____
19.5 Doors to bedrooms must not have vision panels.	3.96	S	100%	Met_ Did Not Meet____
19.6 Each bedroom must be an outside room in which the window area is not less than nine square feet for each resident using the room. The windowsill must not be more than three feet	4.17	S	100%	Met_ Did Not Meet____

SURVEY EVALUATION FORM
MINNESOTA MODEL STANDARDS 19.0
BEDROOMS (Contd.)

Standard	Priority Weight	Surveyor	Expected Level of Compliance	Result
above the floor. Bedrooms with floor level located below the grade at the outside wall must have floors and walls adequately sealed to prevent leakage or dampness from underground and surface runoff water.				
19.7 Level ceilings in sleeping rooms must not be less than seven feet in height. In sleeping rooms with sloped ceiling, only the areas with vertical wall heights of five feet or more shall be included in the required usable floor. At least one-half of the usable floor area must have a ceiling height of seven feet or more.	3.64	S	100%	Met_ Did Not Meet ____
19.8 Each resident must have an individual standard-size bed. Beds for adults must be at least 36 inches wide. Each bed must have springs and a clean, firm mattress. Provisions must be made for people with unique, cultural sleeping requirements and married couples.	4.32	S	100%	Met_ Did Not Meet ____
19.9 Each resident must be provided with the following bedroom furnishings: a. A bed with a mattress and pillow. Bedding must be seasonably appropriate and include mattress pads, blankets, and bed linen. Bed and bath linen which is worn out or unfit for further use must not be used. Pillowcases, sheets and bath linen must be washed before they are used by another resident. Clean bed linen must be furnished at least once each week; b. A closet or locker for personal use, which includes shelves, a rack and hangers for storing clothes and small personal possessions. Such space must be accessible for use by each resident; c. Drawers for personal use; d. A bedside table or desk in each bedroom; and e. A mirror accessible to the residents in each bedroom.	5.07	S	100%	Met_ Did Not Meet_
19.10 A clean washcloth and towel or appropriate paper service must be available to each resident. Drying space for washcloths and towels must be available either in the bedroom or bathroom area.	4.92	S	100%	Met_ Did Not Meet_

SURVEY EVALUATION FORM
MINNESOTA MODEL STANDARDS 19.0
BEDROOMS (Contd.)

Standard	Priority Weight	Surveyor	Expected Level of Compliance	Result
19.11 There must be a provision for residents to mount pictures and other personal *items* on bedroom walls.	4.50	S	100%	Met Did Not Meet ___
19.12 Unless there is threat to the health and/or safety of residents, residents must be permitted personal possessions. Storage areas must be provided for the safekeeping of resident possessions.	6.21	S	100%	Met__ Did (Mot Meet ___

MINNESOTA MODEL STANDARDS 20.0
TOILETS AND BATHING FACILITIES

20.1 There must be at least one toilet and hand-washing facility for each six ambulatory residents. In facilities serving nonambulatory residents, there must be at least one toilet and one handwashing facility for each four residents.	4.85	S	100%	Met _____ Did Not Meet ___
20.2 Multiple toilets must be in separate stalls, with partitions extending to at least six feet above floor level, and with a door lockable from the inside only. Each stall must be equipped with toilet paper.	4.89	S	100%	Met _____ Did Not Meet____
20.3 Handwashing facilities must include soap, hot and cold water, and towels or a drying mechanism.	4.60	S	100%	Met _____ Did Not Meet ___
20.4 There must be at least one tub or shower for each six residents. If showers are provided in a central area, each shower unit must be divided by partitions *or* curtains extending from floor level to a height at least six feet above the floor.	4.75	S	100%	Met _____ Did Not Meet ___
20.5 Toilet and bathing facilities for residents must be located on each resident living unit when not provided for in each individual bedroom.	4.57	S	100%	Met _____ Did Not Meet ___
20.6 Toilet and bathing facilities must be accessible to the residents who reside there. Facilities used by nonambulatory persons must be in accordance with ANSI (American National Standards Institute) standards.	5.07	S	100%	Met_ Did Not Meet____
20.7 Equipment must be provided for those residents involved in a toilet training program, including equipment for use by multiple-handicapped residents.	5.17	MR	100%	Met _____ Did Not Meet_____ Not Applicable____

SURVEY EVALUATION FORM
MINNESOTA MODEL STANDARDS 21.0
MEALS AND DINING FACILITIES

Standard	Priority Weight	Surveyor	Expected Level of Compliance	Result
21.1 Any food service provided in the facility must be in accordance with the provisions of the State Health Department governing food and beverage service establishments.	4.32	S	100%	Met_ Did Not Meet ___
21.2 There must not be more than 14 hours between a substantial evening meal and breakfast. Three meals must be provided daily, at hours in accordance with local custom, when residents are not routinely absent from the facility for work, school or other purposes. If only breakfast and dinner are served, these two meals must together provide at least two-thirds of the total daily nutritional allowances of each resident.	5.35	S	100%	Met_ Did Not Meet ___
21.3 The food and nutritional needs of residents must be met in accordance with their needs and must meet the dietary allowances as stated in the recommended dietary allowances. National Academy of Sciences, 7th Edition, 1973. Providing each resident the specified servings per day from each of the following five food groups will satisfy this requirement: a. Meat or Protein Group. Two or more servings per day of protein food to provide 5 ounces (150 grams) daily for each person. Each of the following is considered as one ounce (30 grams): 1 ounce of cooked meat such as: beef, veal, pork, lamb, poultry or variety meats, such as: liver, heart or kidney. 1 ounce of processed cheese or 1/4 cup (60 cc) of cottage cheese. If counted as a milk substitute, cheese may not be counted as a meat equivalent. If counted as a meat equivalent, cheese shall not exceed 4 ounces (120 grams) weekly. 1 1/2 ounces (45 grams) of prepared luncheon meat 2 ounce frankfurter — 8 per pound. 1 egg (medium size). 1 ounce of fresh, frozen or cooked fish or shellfish or 1/4 cup (60 cc) of canned fish. ½ cup (120 cc) cooked navy beans or soybean product, or 2 tablespoons peanut butter when served with 1 ounce of meat or 1 egg. The combination	4.21	S	100%	Met_ Did Not Meet ___

SURVEY EVALUATION FORM
MINNESOTA MODEL STANDARDS 21.0
MEALS AND DINING FACILITIES (Contd.)

Standard	Priority Weight	Surveyor	Expected Level of Compliance	Result
equals 2 ounces (60 grams) of protein of high biological value, only when served at the same meal. b. Milk. Two 8 ounce glasses (480 cc) of milk or the equivalent are required for each resident. This amount may be served in a cooked form, such as cream soups, desserts, etc. Cheese and ice cream may replace part of the milk; the amount is calculated on the basis of calcium content. 1 ounce of cheese = 3/4 cup milk. 1/2 cup cottage cheese = 1/3 cup milk. 1/2 cup ice cream = 1/4 cup milk. If cheese is counted as a meat equivalent, it may not be counted as a milk equivalent. c. Juices, Fruits and/or Vegetables. Four or more servings daily; a minimum of 2 cups (480 cc) daily shall include: A citrus fruit or other fruit or vegetable high in Vitamin C daily. A dark green or deep yellow vegetable high in Vitamin A at least every other day. Other fruits or vegetables. Potatoes may be included only once daily as a vegetable. A raw fruit or vegetable at least three times weekly. Only 100% juices will be accepted as a fruit or vegetable serving. d. Cereal and Bread. Three or more servings of whole grain or enriched cereal or bread shall be served daily. 1 slice of bread — 1 serving. 1/2 cup cooked cereal — 1 serving. 3/4 cup of prepared dry cereal - 1 serving. e. In addition to daily food groups and quantities, snacks shall be available daily to all residents unless contraindicated by special dietary needs.				
21.4 Menus must vary daily and must be adjusted for seasonal changes and holidays. Foods must not be repeated on the same day of each week.	4.10	S	100%	Met_ Did Not Meet ___
21.5 All menus, including special diets, must be planned, dated, and available for review for a minimum of one week in advance. Notations must be made of any substitutions in the meal actually served and these must be of equal nutritional value.	3.35	S	MCL	Met_ Exceeded_____ Did Not Meet ___

SURVEY EVALUATION FORM
MINNESOTA MODEL STANDARDS 21.0
MEALS AND DINING FACILITIES (Contd.)

Standard	Priority Weight	Surveyor	Expected Level of Compliance	Result
21.6 Records of menus must be filed for six months.	3.35	S	MCL	Met_ Exceeded _____ Did Not Meet ____
21.7 When food services are not directed by a registered dietician or nutritionist, quarterly consultation with a registered dietician or nutritionist must be utilized. Written records of consultations and recommendations must be maintained by the facility.	3.78	S	MCL	Met _____ Exceeded_____ Did Not Meet ___
21.8 Modified diets must be: a. Prescribed by a physician, registered dietician or nutritionist, with a record of the prescription kept on file; b. Reviewed quarterly by the physician, registered dietician or nutritionist and adjusted as needed.	4.78	S	MCL	Met_ Exceeded _____ Did Not Meet____
21.9 For persons age five years and older, dining arrangements must provide for more than one type of eating experience per year (e.g., cafeteria, family style, restaurant).	4.0	S	MCL	Met_ Exceeded _____ Did Not Meet____
21.10 All residents must eat in dining areas, except when contraindicated by the IPP.	5.0	S	100%	Met_____ Did Not Meet ____
21.11 For residents not able to get to dining areas, food service practices must permit maximum self-help and must promote social interaction.	5.03	S	100%	Met_ Did Not Meet ____ Not Applicable
21.12 In facilities serving more than 15 residents, tables used for dining must accommodate no more than eight persons.	3.28	S	100%	Met_ Did Not Meet ____ Not Applicable ___
21.13 Residents requiring assistance in development of eating skills or social skills during dining must have staff assistance during meals. Those residents who have semi-independent or independent eating skills must have opportunity to eat with staff.	5.96	MR	MCL	Met_ Exceeded _____ Did Not Meet____

SURVEY EVALUATION FORM
MINNESOTA MODEL STANDARDS 22.0
FEDERAL, STATE AND LOCAL CODES

Standard	Priority Weight	Surveyor	Expected Level of Compliance	Result
22.1 Facilities housing 15 residents or less who are ambulatory or mobile, nonambulatory, and who are able to act for their own self-preservation in emergency situations must meet the Lodging or Rooming Houses Section (Chapter 11) of the Residential Occupancy Requirements of the Life Safety Code of the National Fire Protection Association and the State Uniform Fire Code.	5.03	S	100%	Met_____ Did Not Meet_____ Not Applicable____
22.2 Facilities to which standard 22.1 does not apply must meet the requirements of the Institutional Occupancy Section (Chapter 10) of the National Fire Protection Association Life Safety Code and the State Uniform Fire Code.	4.57	S	100%	Met Did Not Meet_____ Not Applicable____

APPENDIX B DEFINITIONS

AMBULATORY: Able to walk independently and negotiate architectural features such as ramps, stairs, corridors, doors, etc., without the assistance of other persons.

BEHAVIOR MODIFICATION: The systematic application of teaching/training methods derived from operant learning theory with the intent of altering observable behaviors.

CHIEF EXECUTIVE OFFICER: The individual appointed by the governing body to act in its behalf in overall management of the facility.

DEPRIVATION: Procedures which involve withdrawal or delay of goods or activities and/or services; to which the client would ordinarily be entitled. Facilities retain the right to specify items of personal property which can be brought into the residential or treatment areas. However, once an item is approved and brought into the living area, it cannot then be taken from the client and sold or traded back to the client without being considered deprivation.

DIETICIAN: A person who: 1) is eligible for registration by the American Dietetic Association under its requirements in effect on January 17, 1974; or 2) has a baccalaureate degree with major studies in food and nutrition, dietetics, or food service management, has one year of supervisory experience in the dietetic service of a health care institution, and participates annually in continuing dietetic education.

FACILITY: An organization, including its physician plant, services and administrative components which provides room and board and certain other developmental services to persons who are mentally retarded as required herein,

FINANCIAL GUARDIAN (GUARDIAN OF THE ESTATE): An appointee by the court to see that the financial affairs of the resident are handled in their best interest.

GENERIC SERVICES: Services that are available within the community for anyone to use without regard to being handicapped {e.g., schools, shops and stores, health services, theaters, etc.).

GOVERNING BODY: The policy-making authority, whether an individual or a group, that exercises general direction over the affairs of the organization and establishes policies about its operation and the welfare of the individuals that it serves.

INDIVIDUALIZED PROGRAM PLAN: A detailed plan of the service provider setting forth both short-term and long-term goals for the resident with detailed methods for achieving movement toward these goals.

INTERDISCIPLINARY TEAM: A team consisting of the resident and any persons representing professions, disciplines, or service areas as are relevant in each particular case, and including the legal guardian and representative from the local social services agency. The interdisciplinary team assesses the resident's needs, develops an individualized program to meet identified needs, and reviews the resident's response to the program.

LEGAL GUARDIAN: A person appointed by the court to discharge the trust and interests as guardian of the person or estate or both of any person who is a minor or who has been legally judged to be incompetent to manage his/her person or estate. The court may appoint the Commissioner of Public Welfare as guardian, if it determines that a guardian is needed to supervise and protect the mentally retarded person.

LOCAL SOCIAL SERVICES AGENCY (LSSA): Local agency under the authority of the board of county commissioners or human service board which is responsible for social services.

LIVING UNIT: A unit of living area which is defined in physical terms and which houses 15 or

fewer individuals. The living unit must contain a bedroom, living room, and bathroom.

MENTALLY RETARDED PERSON: A mentally retarded person refers to any person who has been diagnosed as having significantly sub-average intellectual functioning existing concurrently and demonstrated deficits in adaptive behavior and manifested during the developmental period.

MILD AVERSIVE AND DEPRIVATION PROCEDURES: Procedures intended to alter resident behavior considered to be mild in level including:

a) contingent access to, or deprivation of, activities, goods and services (except food, drink and all life and health support substances);
b) time-out from positive reinforcement by removal from view or the room for no more than 15 minutes per day;
c) delay or removal of goods and services other than those to which one is entitled.

MOBILE: Able to move independently from place to place with the use of devices such as walkers, crutches, wheelchairs, wheeled platforms, etc.

MUST: Indicates that the requirement is mandatory; essentially equivalent to "shall".

NON-AMBULATORY: Unable to walk independently or without assistance.

NON-MOBILE: Unable to move independently from place to place.

NORMALIZATION PRINCIPLE: The principle of letting the person who is mentally retarded obtain an existence as close to the normal as possible, making available to their patterns and conditions of everyday life that are as close as possible to the norms and patterns of the mainstream of society.

NUTRITIONIST: A specialist in human nutrition with a master's degree, which includes advanced study in the science of nutrition, public health, the behavioral sciences, and education theory and practice.

PSYCHOTROPIC DRUG: Any chemical whose purpose is to serve as to alter mood.

RESIDENT: Any individual who, on partial grounds of being mentally retarded, resides in and receives services from a residential facility.

RESTRAINT: Any physical device or chemical agency which limits the normal movement of body or limbs.

SECLUSION: Involuntary removal from social contact with others and confinement in a separate room from which access is blocked from the outside.

STANDARDIZED ASSESSMENT INSTRUMENT: An installment whose validity and reliability have been established through repeated administrations on a large number of individuals {i.e., 1,000 persons) over an extended period of time (i.e., three years).

TIME-OUT: Exclusion, for a brief period of time, of a resident from ongoing activities and sources of reinforcement. Whenever possible, time-out is implemented eliminating sources of reinforcement without removing the individual from the area in which the problem behavior occurred.

APPENDIX C

REPORTABLE DISEASES

MINNESOTA STATE HEALTH REGULATIONS

When called to a case, suspected case, or death from any one of the following diseases, the attending physician, within 24 hours, shall provide the local health officer with the information on the reporting postcard. In areas where there is no local health officer, the information shall be reported directly to the Division of Personal Health Services, Minnesota Department of Health, Minneapolis, MN 55440. Diseases preceded by an asterisk shall be reported immediately to the Minnesota Department of Health either by the local health officer or by the attending physician.

Amebic Dysentery *
Anthrax *Botulism
Brucellosis
Chancroid
Chickenpox (only patients over 16)
*Cholera *Diptheria
Encephalitis
Foodborne Illness
Gonorrhea
Hepatitis - A
Hepatitis - B
Lead Poisoning
Leprosy
Leptospirosis
Malaria
Measles
Meningitis (all infectious types)
Menigococcemia
Mumps
Occupationally Related Diseases
Ophthalmia Neonatorum
*Plague
*Poliomyelitis
Psittacosis
*Rabies (animal and human cases and exposed persons)
Rheumatic Fever
Rubella and Congenital Rubella Syndrome
Rocky Mountain Spotted Fever
Salmonellosis (including typhoid)
Shigellosis
*Smallpox
Syphilis
*Tetanus
Trichinosis
Tuberculosis
Tularemia
Typhus Fever
Whooping Cough
Yellow Fever

APPENDIX D

COMPENDIUM OF STATE AND FEDERAL LAWS AND REGULATIONS

1. Minnesota Public Welfare Licensing Act, Minnesota Statute 245.781.

2. Minnesota Department of Public Welfare Rule 185: Community Mental Health Board and County Welfare or Human Service Board Responsibilities to Individuals Who Are Mentally Retarded.

3. Proposed Minnesota Department of Public Welfare Rule 39: Conditions for Use of Aversive and Deprivation Procedures.

4. Proposed Minnesota Department of Public Welfare Rule 40: Location of Residences for the Mentally Retarded.

5. Minnesota Statutes 462.357, Subd. 7 and 8 - Relating to Zoning for Residences for Mentally Retarded or Physically Handicapped Persons.

6. Minnesota Statutes, Section 626.554 - Relating to Reporting of Possible Child Abuse or Neglect.

7. Minnesota Statutes, Section 626.555 - Relating to Abuse or Neglect of Residents of Facilities Licensed Pursuant to Sections 144.50-144.58.

8. Minnesota Statutes, Section 245.813 - Relating to Abuse or Neglect of Residents of Facilities Licensed Pursuant to Sections 245.781-245.813.

9. Minnesota Data Privacy Law, Minnesota Statutes 15.162-15.1671.

10. National Fire Protection Association Life Safety Code, Lodging or Rooming Houses Section, Chapter 11, 1967.

11. National Fire Protection Association Life Safety Code, Institutional Occupancy Section, Chapter 10, 1967.

12. 1973 Minnesota Uniform Fire Code.

13. 1973 National Fire Protection Life Safety Code.

14. Minnesota State Building Code,

15. Requirements for Food and Beverage Establishments, MHD 146-151.

16. Minnesota Plumbing Code, MHD 120-135.

17. Construction Code for Water Wells, MHD 169-178.

18. Standards for Design of Soil Absorption Type Sewage Disposal Systems for Public Establishments, 1962, Chapters Seven and Eight.

19. Section 504, Rehabilitation Act of 1973, Public Law 93-112, 87 Statute 394.

20. American National Standards Institute (ANSI) Standard No. A117.1 (1961), American Standard Specifications for Making Buildings and Facilities Accessible to, and Usable, by, the Physically Handicapped.

21. Minnesota Statutes 390.11 - Relating to Reports of the Coroner.

22. Administrative Procedure Act, Minnesota Statutes 15.0411 to 15.052.

23. Minnesota Statutes 252.28, Mental Retardation Licensing Act including determination of need, location and program.

APPENDIX E

MODEL FOR STAFF DEVELOPMENT

REPORT ON MINNESOTA MODEL STANDARDS AND RATIONALE FOR TRAINING

Introduction

This report specifies three major components relating to the implementation of standards which are entailed in the Minnesota Management Model. These three major components are:

1. A rationale for personnel training units.
2. Groupings of standards by task analysis for training purposes.
3. A schema for training for each training cluster and the standards contained therein.

The Minnesota Model Standards are based on procedures that operationalize fundamental rights of disabled persons. They include these areas:

MMS 1.0 Comprehensive Assessments
MMS 2.0 Individual Program Plans and Services
MMS 3.0 Resident Records
MMS 4.0 Health and Grooming
MMS 5.0 Legal Rights and Confidentiality
MMS 6.0 Medications
MMS 7.0 Staffing Patterns and Personnel
MMS 8.0 Community Resources
MMS 9.0 Possession and Use of Money
MMS 10.0 Clothing
MMS 11.0 Admission/Discharge
MMS 12.0 Emergency Procedures
MMS 13.0 Administration
MMS 14.0 Behavior Management
MMS 15.0 Communications
MMS 16.0 Sanitation
MMS 17.0 Physical Plant
MMS 18.0 Shared Living Spaces
MMS 19.0 Bedrooms
MMS 20.0 Toilets and Bathing Facilities
MMS 21.0 Meals and Dining Facilities
MMS 22.0 Federal, State, and Local Codes

The standards are derived from two major principles — that of: (1) normalization, which is defined as optimizing the handicapped person's conditions by altering his/her daily living environment to approximate as closely as possible that which would be considered "normal", and (2) that all services be sequential and developmental in nature. This implies that all personnel in an organization serving developmentally disabled persons know how to determine the point at which a developmentally disabled person is functioning and the skills that a resident needs to acquire to move to a higher level of functioning.

These two principles essentially state that the task of human service agencies that care for developmentally disabled persons is to reduce dependency through the operationalization of the above two principles, Consequently, the implementation of these principles can only be successfully accomplished when staff members charged with responsibility for carrying them out understand specifically how they are to be accomplished.

This report does not address the specifics of how each component is to be accomplished, but focuses on an overall outline for managing, in a consistent way, staff development within an institution that is charged with care for developmentally disabled persons.

The determination of the point at which an institution decides to engage in personnel training is determined by the self-evaluation and Minnesota State Department evaluator's assessment of the facility's competency in each standard area. This suggests that the strengths and weaknesses of programs will be evaluated in ways which are highly variable and is the most optimum mode for the delivery of staff training. For instance, a workshop approach in one facility may be best accomplished in another facility by individualized training.

This report cannot prescribe for each facility what is the most feasible methodology for staff development. However, the level of confidence needed by each staff for each standard is addressed.

RATIONALE

The training components contained in this report are clustered into two major groupings. The first is those that require information and application skill and second, those that require information only. The operational definitions used for information is that the staff person be able to demonstrate his/her acquisition of an acceptable criterion level of information regarding a specific standard. The operational definition for application is that the person not only be able to demonstrate he/she has the information regarding the standard, but can, in an applied setting, perform the required functions explicit in the given standard.

Some standards are such that there is little discretionary judgment to apply as they pertain to clients and residents; i.e., those that specify life safety code, sanitation, etc. The degrees of variance are minimal. For those standards which address human development and the priorities for developing skills of independence, the degrees of staff judgment as to the appropriate action(s) are very great These latter standards are seen as those which require application competencies while the former are viewed as requiring informational competence only.

To cluster these standards into the dichotomous categories relating to training, a panel of experts in the area of developmental disabilities was convened. Each member of this panel was asked to sort the standards by the descriptions found in the Minnesota Model Standards report according to the above two categories. The mean ranking of a standard from the panel was then used to assign it to one of the two training categories.

MODEL STANDARD CLUSTERS

The following list is of those standards which were sorted into the Information/Application Category:

Comprehensive Assessment
Individual Program Plan and Services
Resident Records
Legal Rights and Confidentiality
Medications
Staffing Patterns and Personnel
Community Resources
Possession and Use of Money
Clothing
Admissions/Discharge
Emergency Procedures
Administration
Behavior Management
Meals and Dining Facility

It should be noted that these standards comprise the bulk of all those listed and apply to all facilities regardless of size and/or location. Because facilities in Minnesota vary greatly in their composition, in relation to standards and other factors, the mode for training staff to reach the information/ application level is not described, but rather an array of training delivery models is described (Table 1).

The shorter list, which follows, contains those standards which were determined to require only informational level of competence by facility staff, as noted previously:

Health and Grooming
Communications
Sanitation
Physical Plant
Shared Living Space
Bedrooms
Toilets and Bathing Facilities
Federal, State and Local Code

These standards are non-discretionary and are concerned more directly with overt environmental hazards and health-related factors. These standards also are derived from State or Federal codes which have general application to all persons in our society.

The training function of staff for the above cluster of Standards is seen as essential, but not complex. It is suggested that this can be efficiently carried out utilizing any of the procedures for staff development described. The governing rule for which procedures to employ, is to choose that which is most parsimonious to a particular facility. Table 1 displays six training models for staff development. Each model has utility for the purpose of training staff to meet the model standards. The characteristics of each model are as follows:

Self-Study. A set of curricular materials which are self-pacing and do not require an onsite instructor for a student. Students can enter these materials on their own time and the materials are entirely self-contained and require no additional resources. The advantages are that they allow a large number of individuals to enter the training sequence at variable time points, proceed at their own rate of learning and do not require onsite physical plant facilities, instructors, or other such accommodations. The disadvantages are that group motivation, dialogues, and group interactions, which aid understanding of complex topics, are missing.

Consultation. A process by which an individual who has a wider array of experiences than the trainee in a prescribed area shares perceptions regarding a particular structure problem. The advantages of this technique are

Table 1
TRAINING MODELS FOR IMPLEMENTATION OF MODEL STANDARDS

Methodology	Physical Plant Requirements	Time Constraints	Number of Trainees Needed	Instructional Staff Needed	Number of Instructional Hours Needed
Consultation					
a. peer	access to clinical setting	can only be accomplished by trainee working directly with client	no more than 8	peer who is competent in standard	variable
b. State Dept.	access to facility	scheduled	practical limit of 30	consultants with expertise in standard content	practical limits of 1 day of staff development time
c. outside	access to facility	scheduled	practical limit of 30	consultants with expertise in standard content	practical limits of 1 day of staff development time
Self-Study	flexible	none	—	none	variable
Self-Study and Consultation	meeting room only	prescribed or regular basis	no more than 5-7 per group	1 facilitator/ 5 staff	4 hours/ month
Informational Presentation	large meeting room	no more than 2 hours per session	no more than 50	at least 3	variable
Workshop	large meeting room plus one or more break-out rooms or space responsibility	must be held at time when many personnel can be freed of work	up to 50	2-4	1-2 days
Institute	large auditorium several meeting rooms	scheduled to accommodate calendar of large audience	50-2,000	variable	1-2 days

that it is highly personalized and detailed explanations can be given regarding an approach to problem solving. The disadvantages are that the consultant may misperceive the case involved, may omit important training elements, oversimplify complex issues, or may present an idiosyncratic approach to a problem that has a variety of alternative solutions.

Self-Study and Consultation. Utilizes both methods in staff development.

Informational Presentations. Those in which the presentor represents the prime source of information regarding a topic. The advantages of this model are that it allows for highly organized and articulated transference of information from a knowledgeable person to a large group of trainees. The disadvantages of this lecture focused model are well known. Unless the speaker can hold the attention of the audience through both content and delivery, the audience participation is diminished.

Workshop. The advantages are that each participant can, without risk, decide an approach to a solution of a problem and at the same time share their rationales for solution with colleagues. The simulation of real-life experience is believed to be a more transferable technique to real job situations. The disadvantages of the workshop model is the subtle pressure exerted on all participants to accept the modal solution as the "best." Second, the quality of the instruction is dependent upon the composition of the participant group.

institute. A series of informational presentations and workshop-like experiences. It shares the advantages and disadvantages of the two. Its major advantage is that it does allow for persons from a large geographic area representing a variety of facilities and locations to attend. The primary disadvantage is the difficulty in managing the logistics needed to organize an institute.

IMPLEMENTATION

The implementation of the standards both discretionary and nondiscretionary requires an analysis of the content necessary for meeting each standard. Table 2 discusses areas of information and application which are logically included in each standard. These areas do not delineate the specific task or skill level required of each standard. This is yet to be determined and is beyond the scope of this report. What is reported here is a first draft of identifying the categories which represent the general training objectives for each model standard. It is to be understood that the specific training package, which coincides with each model standard, is yet to be developed.

In summary, Table 2 depicts the results of the cluster analysis by the panel of experts and a further breakdown by competence (information or information/application level) and, for each standard, the general areas for which training packages need to be developed.

Table 2

MATRIX OF MINNESOTA DPW CLUSTERED STANDARDS FOR PERSONNEL TRAINING BY COMPETENCE LEVEL

Standard	Information	Application
CLUSTER I		
1.1 Comprehensive Assessment	Knowledge of available assessment systems, Minnesota adopted systems and client behavioral areas required	1. Ability to apply Minnesota adopted assessment scales (tools) to assess a client 2. Write report 3. Write a record of all assessments
1.2 Individual Program Plan and Services	Knowledge of standard and detailed components required under Minnesota statutes and Federal law	1. Ability to write individual client goals and objectives 2. Ability to write plan for service delivery 3. Ability to participate in team process 4. Ability to evaluate, review, and when necessary, revise client's plan for service delivery
1.3 Resident Records	Knowledge of required components for individual client's record	1. Apply adopted record keeping system 2. Interpret reports, records, etc., and summarize for records
1.4 Legal Rights and Confidentiality	Knowledge of mandated legal rights of clients, i.e., due process and grievance	1. Ability to write legal rights and confidentiality procedures 2. Development of legal rights and confidentiality procedural forms for assurance record keeping
1.5 Medications	Information on procedures for distribution, administration and control of drugs	1. Ability to develop a unit medication system 2. Ability to write observable description of client's behavior pre/post administration of a specific drug
1.6 Staffing Patterns and Personnel	Information on required staffing patterns, job descriptions and personnel policies	1. Ability to task analyze a job 2. Ability to write job description from task analysis 3. Ability to develop personnel policies based on No. 1 and No. 2 above and other mediated job stipulations 4. Development and implement a written plan for staff training and orientation
1.7 Community Resources	Knowledge of resources for clients, i.e., health, developmental, recreational and religious	1. Develop descriptive directory of community resources 2. Ability to develop record keeping system which allows for tracking of client requests and match to community resource
1.8 Possession and Use of Money	Knowledge of policies and procedures, accounting system and financial counseling for clients	1. Ability to write policies and procedures for client possession and use of money 2. Establish and know components of acceptable accounting system for individual 3. client's money Provide financial money management counseling to clients

Table 2 (Contd.)

Standard	Information	Application
1.9 Clothing	Knowledge of wardrobe procedures for each client, i.e., purchasing, laundry, ID of garments	1. Document training and assistance in wardrobe maintenance for staff and clients
1.10 Admissions/ Discharge	Knowledge of admission/discharge procedures for specific facility, client and Minnesota mandated policies	1. Write informational documents stipulating admission/discharge criteria for clients for specific institution conforming to Minnesota mandated policies and procedures 2. Ability to counsel parents, clients, guardians regarding admission/discharge
1.11 Emergency Procedures	Knowledge of adopted emergency procedures of the facility, i.e., medical, psychiatric, fire, police	1. Write an emergency procedure for: a. fire b. severe weather c. severe illness d. missing person 2. Implement training program to inform all personnel of above procedures 3. Develop accident and other forms for above contingencies
1.12 Administration	Knowledge of administrative organizational structure and administrative procedure	Ability to develop administrative handbook which contains the: (a) facility's philosophy, purpose and goals, (b) vehicle for consumer representation and public participation, and (c) schedule of rates and charge policies
1.13 Behavior Management	Knowledge of procedures and policies relating to client behavioral management	1. Ability to write policies and procedures for use of behavior management techniques directed to goals of maximizing client growth and development, which are available as indicated in the standards and which do not violate rights of clients as stipulated in standards 2. Ability to formulate client behavioral management plans through a team process 3. Ability to develop a system for describing client behavior and intervention techniques employed 4. Implement a staff training program for behavior modification
1.14 Meals and Dining Facilities	Knowledge of State Department of Health provisions on nutrition, food, preparation and cleanliness	Ability to keep accurate records regarding client diets
CLUSTER II		
2.1 Health and Grooming	Knowledge of requirements for appropriate health maintenance and grooming, i.e., physicians orders, exclusions or basis of religion, etc.	

Table 2 (Contd.)

Standard	Information	Application
2.2 Communications	Knowledge of written policies regarding clients interaction with family or legal guardian and mail and/or telephone communication	
2.3 Sanitation	Knowledge of standards of Minnesota State Health Department regarding safe water, approved public sewage systems and vermin control	
2.4 Physical Plant	Knowledge of health, comfort and safety codes for facilities	
2.5 Shared Living Space	Knowledge of resident living unit capacities, usage of space, and architectural requirements	
2.6 Bedrooms	Knowledge of appropriate living space, furnishing and privacy constraints	
2.7 Toilets and Bathing Facilities	Knowledge of requirements for bathroom facilities, accessibility, and related training	
2.8 Federal, State and Local Codes	Knowledge of codes applicable to facility, building, life safety code and state fire codes	