STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES
444 LAFAYETTE ROAD
ST. PAUL, MINNESOTA 55101

April 7, 1987

Ms. Elaine Timmer
Chief Executive Officer
Fergus Falls Regional Treatment Center
P.O. Box 179
Fergus Falls, MN 56537

CERTIFIED MAIL

Dear Ms. Timmer:

Pursuant to Minnesota Statutes, section 245.801, subdivisions 3, 4, and 5 (1984), the Commissioner of Human Services is issuing you a license and making it probationary until May 1, 1988. This notice of probation results from substantiated noncompliance with Minnesota Rules, parts 9525.0210 through 9525.0430 and parts 9555.8000 through 9555.8500.

On December 8 through 11, 1986, the Fergus Falls Regional Treatment Center was reviewed to determine compliance with the provisions of Minnesota Rules, parts 9525.0210 through 9525.0430 and parts 9555.8000 through 9555.8500, which govern the licensure of residential programs for persons with mental retardation. The licensed capacity of the program was 236. At the time of the review 179 persons were receiving services.

CORRECTION ORDER

The following violations) of state and/or federal laws and rules were observed. Corrective action for each violation is required by Minnesota Statutes, section 245.805, and is hereby ordered by the Commissioner of Human Services. Failure to correct the violations within the prescribed amount of time may result in fines and/or action against your license, as provided for in Minnesota Statutes, sections 245.801 and 245.803.

To assist you in complying with the correction orders, a "suggested method of correction" may be included for any or all of the violations cited. Please be advised that a "suggested method of correction" is only a suggestion and you are not required to follow the "suggested method of correction." Failure to follow the "suggested method of correction" will not result in a fine or an action against your license. However, regardless of the method used, you are required to correct the violation(s) within the prescribed amount of time.

April 7, 1987 1. Citation; Minnesota Rules, part 9555.8300, subparts 2. and 3., and Minnesota Statutes, section 626.557, subdivision 1.

Violation; The facility has not adequately protected vulnerable adults or provided a safe living environment. Review of resident records revealed that individual abuse prevention plans did not specify measures to be taken to minimize the risk of abuse for residents, other than a general statement that 24-hour supervision will be provided. That general statement is not adequate as an individual (or program) abuse prevention plan. Based on the numerous incidents involving these residents, "24-hour supervision" alone does not provide adequate protection to the residents. Further, the records revealed that the interdisciplinary team did not utilize the previous reports of abuse/neglect regarding the resident when annually reviewing the plan. For example:

a. A resident with severe medical conditions (D.W.) died as a result of those conditions (according to the physician's report). The facility did not have a plan to minimize the risk of abuse/neglect for this resident regarding her severe medical condition and her history of apnea (stopping breathing). A facility administrator stated an individually developed plan was not necessary, as this resident was adequately covered by the program's general abuse prevention plan.

b. A resident was placed in a locked seclusion room at approximately 9 p.m. and left there when staff went off duty at the end of the shift. At approximately 11 p.m., staff on the next shift discovered the resident when they noticed a pool of urine running out from under the door of the seclusion room. This instance of seclusion was used without a program plan. At least 21 other instances of seclusion or restraint were used without a program plan from January 30, 1987 to February 12, 1987.

c. For R. J., Achievement Center for Multihandicapped (ACMH) Cedar Unit, the assessment identified 28 areas of susceptibility to abuse but no prevention plans existed.

The record reveals a pattern of falls and stumbling that have not been identified as an area of susceptibility. The falls have resulted in injury. Must recently, the resident was found in the early morning with his head stuck between the bed and the guard rails after falling from bed. It is not known how long the resident's head was stuck, nor was the incident reported as possible neglect. The fall did result in several cuts, scrapes, and abrasions on the feet, head, and neck. Further, the resident's record indicates a visual impairment which could be an additional factor in the falls, but a physical exam report concludes that glasses are not appropriate currently. No rationale is given for the decision.

d. For resident T. R., CTAC 4, the assessment identified 26 areas of susceptibility to abuse with no prevention plans developed. The record reveals a pattern of self-abuse and aggression towards others, and that the resident "is vulnerable, gets scratched but will not call out. [The resident has] Blindness . . . will not seek first aid."

e. For resident J. J., CTAC 3, the assessment identified 28 areas of susceptibility to abuse with no prevention plans developed. In addition, the record reveals a pattern of incidents that were not addressed in the individual abuse prevention plans. On February 13, 1986, the resident was found to have a scrape on the middle of the back; cause unknown. On May 13, 1986, the resident was found to have a human bite mark on the arm. On June 10, 1986, the resident was found to have a day old abrasion on the elbow; cause unknown. On two occasions, the resident choked on inedible items; July 8, 1986, a checker was lodged in the resident's throat and required the Heimlich Maneuver; also in 1986 the resident choked on a bead. On October 26, 1986, the resident was found to have a sore finger which was not identified for at least one full day as a broken bone; cause unknown. On December 9, 1986, the resident was poked in the eye by another resident.

Time Frame for Correction: By May 1, 1987, submit the individual abuse prevention plans for the above individuals including the measures being taken to minimize risk. Reevaluate all records to determine the need for individual abuse prevention plans, including day programs and submit the results of the evaluation by July 1, 1987. All identified revisions shall be completed and abuse prevention plans implemented by January 1, 1988.

2. Citation: Minnesota Rules, parts 9525.0280, subpart 14.

Violation: Aversive behavior programs are being developed or changed and implemented without the consent of parents and/or legal guardians. For example:

a. The record of resident R. J. of the Cedar Unit showed that the most recent parental consent for aversive programming was given in 1983 and that the most recent legal guardian consent was obtained in January of 1985. The program states that this consent would be in effect for one year only. Despite this fact, the human rights committee gave consent for continued aversive programming in February of 1986 without current consent from either parents or legal guardians.

b. Resident J. J. from CTAC 3 is under state guardianship. The social worker, as guardian, denied the use of aversive procedures in March of 1986. In August 1986 Kay Hendrikson, DHS Public

Guardianship Administrator, allowed the aversive procedure on the condition that data be reviewed monthly by the team and in 90 days by her. However, staff interviews and records indicated that aversive programming was implemented between March 1986 and August 1986 after consent had been denied by the social worker (acting as guardian) and prior to consent from Ms. Hendrikson.

Time Frame for Correction: By May 1, 1987, submit a copy of consent for aversive behavior programming or evidence that aversive behavior programming is not being used.

3. Citation; Minnesota Rules, part 9525.0280, subparts 2. and 3., and part 9525.0310, subpart 3.

   Violation: Staff did not consistently devote their attention to the care and development of the residents or maintain a warm, family, or home-like environment conducive to the achievement of optimal development by the resident. Further, living unit staff do not consistently train residents in activities of daily living and in the development of self-help and social skills, including dining skills on a regular basis. For example:

   a. On December 10, 1986, on CTAC 4, from approximately 4:30 to 5:30 p.m., 5 staff were present with 15 or 16 residents. During these peak programming hours, there was little or no interaction with residents conducive to development or training of residents. Interactions did not provide residents with training or guidance in appropriate behavior to replace inappropriate behavior. Observation revealed that no program plans were being implemented.

   b. On CTAC 3, between approximately 5:30 and 6:30 p.m., 3 staff were present with 15 residents. All residents were seated at the dining room table for the evening meal. Staff did not use this opportunity to provide training in eating or social skills. During this time, at least two residents were observed eating bananas with the peelings on. Staff did not intervene. Two other residents held their eating utensils in one hand and picked up their food and ate it with the other hand. Staff did not intervene to teach appropriate use of eating utensils.

   c. During the morning on December 10, 1986, for approximately 45 minutes, three staff in the "Sunshine Room did not interact with residents after they had placed them in the repositioning equipment.

   d. At 5:10 p.m., December 10, 1986, eight residents sat in the activity area of the "Heading Out" unit. A television was the only source of stimulation. Four staff persons were observed in a small room sitting around a table eating snacks and talking with each other. None of the staff present attended to the care and development of residents.

Time Frame for Correction: Immediately and on a continuing basis staff shall devote their time to the care and development of the residents as their primary activity. Staff breaks should be scheduled so that some of the staff on duty are attending to the care and development of the residents at all times. By June 1, 1987, submit an evaluation of the programs and environment of each household and day program. Include plans to increase active learning opportunities and optimum learning potential at each site.

4. Citation; Minnesota Rules, part 9525.0340, subpart 1.

Violation; There is evidence that facility staff are not implementing programs developed by the interdisciplinary team. For example:

a. Resident J. J. from CTAC 3 is on an aversive program and receives behavior-controlling medications. Five other program objectives were found in the record but data were collected on only two of the objectives. There were no data recorded after November 30, 1986, relating to any of the program objectives. A direct care staff person could not produce any current programs and said that the behavior analyst may have them (his office was locked). Another direct care staff person said that he was new on the unit and had not been trained to carry out the programs or to take data.

b. For resident T. R. from CTAC 4, the program plan showed objectives in at least six areas. During the evening shift on December 10, 1986, a direct care staff person stated he did not have access to programs or program data because they were not on the computer yet. He stated that he was not that familiar with T. R.'s program because he was not assigned to T. R. Neither of the people named in the program plan as being responsible for carrying out the program was on duty.

c. One of the night shift staff stated that they do not follow written program plans because they have their own "informal" procedures.

Time Frame for Correction: By May 1, 1987, submit evidence that all unit staff have been trained and are implementing the above programs. Further, submit evidence that staff are trained and supervised in the implementation of all formal programs.

5. Citation: Minnesota Rules, part 9525.0260, subpart 2.

Violation; The facility did not provide free use of all living space; exterior and interior doors were locked. For example: The household of CTAC 1, 2, 3, 7 and ACMH keep unit doors locked. Individual wardrobes on CTAC unit 3 and 7 were locked. Television sets, VCRs, tape

decks, and stereos on CTAC 7 were locked in cabinets. Bathrooms between CTAC units and in the administration building require a key for entrance. In CTAC 3 the refrigerator is locked. On CTAC 6 toothbrushes are kept in a locked wall cabinet. There was no evidence in resident records that the interdisciplinary team considered the need for or developed corresponding positive behavioral programs to eliminate the need for locking doors and cabinets.

Time Frame for Correction; Identify where locks are being used and evaluate the current need for these locks. If locks are not necessary to protect residents from clear and present danger remove the locks or develop individual program plans to address the behaviors that make the continued use of locked doors necessary. Submit the results of the evaluation by June 1, 1987. New individual programs must be incorpora-. ted into each resident's individual program plan by September 1, 1987, or the interdisciplinary team tust document that such programs have been considered and given a low priority in light of each resident's other needs for training.

Citation; Minnesota Rules, parts 9555.8200, subpart 5., and part 9555.8400, subpart 7.

Violation; Records lack evidence that an orientation to the program abuse prevention plans and the reporting system was provided for residents or their representatives. This orientation is essential if residents or their representatives are to understand existing risk factors, plans to minimize risks, and how to report incidents of abuse or neglect.

Time Frame for Correction; By May 1, 1987, submit evidence that all current residents or their representatives have received orientation to the reporting system and that any newly admitted residents or their representatives will receive training within the required timelines.

Citation; Minnesota Rules, part 9525.0260, subpart 2.

Violation: One household unit, CTAC 6, exceeded the licensed capacity by one person. Seventeen (17) people temporarily lived there while unit moves were taking place. There were other units with 14 or 15 people which could have been used to house this person.

Time Frame for Correction; By May 1, 1987, submit evidence that no more than 16 clients reside in each household.

Citation; Minnesota Rules, part 9525.0340, subpart 1.B.

Violation; In the records reviewed there was no documentation to indicate that the interdisciplinary team had considered the proper exercise of the residents' civil and legal rights including the right to adequate service.

Time Frame for Correction: By May 1, 1987, submit a copy of the policy and procedure to be followed to document that the interdisciplinary teams have reviewed the residents' and parents' civil and legal rights.

Suggested Method of Correction; This review should include, but is not limited to, how the use of any aversive behavior programs, restrictions on use of funds, restrictions on freedom of movement, locked wardrobes or drawers may impact on limitations of freedoms due to programming.

Citation: Minnesota Rules, parts 9525.0280, subpart 4.

Violation: Day programs in the CTAC building provided services that were neither functional nor age appropriate and did not resemble the cultural norms for nonhandicapped peers. For example:

a. On December 8, 1986, about 2:30 p.m. approximately 45 adults (staff and residents) were in one room where the only activity was a children's cartoon on television (VCR). The television screen was too small for appropriate viewing by all residents. During this time, many residents engaged in maladaptive behavior; there was no alternative activity available to help reduce those maladaptive behaviors.

b. Activities provided to adults in the day programs included children's peg boards and puzzles, rhythm band instruments, and sand and water tables. Some adults were presented work sheets with number tracing, dot-to-dot, bead stringing, and coloring.

   These teaching methods and materials are not chronologically age-appropriate for use with adults. The skills that were being taught with these materials are largely irrelevant to the functional living skills needed by adults.

c. In interviews, staff stated that some residents were sorting **blocks** to "keep them busy." This activity was not related to any purposeful outcome stated in the residents' individual program plans.

Time Frame for Correction: By May 1, 1987, submit a plan to provide functional and age appropriate day services to all residents.

Citation; Minnesota Rules, part 9555.8500, subparts 1 and 2.-

Vioiation: Orientation and training related to vulnerable adults consists only of training in the facility's internal policies and procedures but does not include.a review of Minnesota Statutes, section 626.557, and Minnesota Rules, parts 9555.8000 to 9555.8500, in their entirety. This training is essential if mandated reporters are to fully understand and act on their responsibilities under Minnesota law.

Time Frame for Correction: By May 1, 1987, submit evidence that training for all personnel, for all required parts, has been completed. Complete the training on an annual basis thereafter.

Citation: Minnesota Rules, part 9555.8400, subpart 4.

Violation: Policies and procedures regarding internal investigation are inadequate. For example:

a. Neither the written policies and procedures nor the actual investigation records include persons and authorities notified;

b. One 1986 investigation also lacked a record of persons involved in the incident.

Time Frame for Correction: By May 1, 1987, submit revised policies, procedures and reporting forms.

Citation: Minnesota Rules, part 9525.0270, subparts 1. and 4., and part 9525.0280, subpart 5.

Violation: The interior design (arrangement) of the living areas did not simulate the functional arrangements of a home to encourage a personalized atmosphere. For example:

a. On CTAC 6 and 7 furniture is arranged in an institutional manner **with** furniture lined up along the walls of large rooms. CTAC 6 policies require that the furniture be arranged in this **way. A staff** interview revealed that sometimes the residents attempt to **rearrange** their furniture, but policies require the staff to return it to the institutional arrangement. CTAC 6 has plants, lamps, and other decorative items hung from a high ceiling out of the normal range of vision. CTAC 7 lacked personal and decorative i terns.

b. On CTAC 3 there is a strong urine odor in the living room area.

Time Frame for Correction: By July 1, 1987, evaluate each living unit and submit a plan to improve the home-like quality for any areas identified as needing improvement. Corrective action must be accomplished by September,1, 1988.

13. Citation; Minnesota Rules, part 9525.0260, subpart 2.

Violation: The facility did not have adequate provisions for privacy. For example: On CTAC 7 one bedroom window (room 323) opens to the household porch which residents do use in the summer, but the window has no curtains or privacy shades. On CTAC 3, rooms 45 and 46 are at ground level opening on campus grounds, but there are no curtains or privacy shades. On CTAC 4, curtains are hung at windows, but the curtains do not cover the full width of the window. CTAC 1, room 12 is on the ground level and has no curtains or privacy shades on the window. One curtain is missing from the toilet stall on the "Heading Out" unit facing the ACMH urit. CTAC 7 has a door missing from the second stall in the women's bathroom.

Time Frame for Correction: By June 1, 1987, submit a plan to provide privacy in each of the identified areas. This plan must result in the correction of all violations by August 1, 1987.

14. Citation: Minnesota Rules, part 9555.8200, subpart 2.A.

Violation: The assessments of factors that might contribute to abuse or neglect of vulnerable adults and program abuse prevention plans did not address each site where services are delivered.

Time Frame for Correction: By May 1, 1987, submit assessments of the physical plant, population, and environments that are specific to each building or living unit.

15. Citation: Minnesota Rules, part 9555.8200, subpart 3.

Violation: The program abuse prevention plan assessment fails to describe the mental functioning, physical and emotional health, or behavior of the population. It also fails to identify the need for specialized programs of care for residents and does not include knowl edge of previous abuse situations.

Time Frame for Correction: By May 1, 1987 submit a program abuse prevention plan for each building, with the above information included.

16. Citation: Minnesota Rules, part 9555.8200, subpart 6., and part 9555.8400, subpart 8.

Violation: Community Training Achievement Center (CTAC) 1, 2, and 5 did not have a posted copy of the plan and the reporting procedures. In CTAC 3 the posted plan was dated April 1983; this is not the current plan.

Time Frame for Correction: By May 1, 1987, submit evidence that copies of the program abuse prevention plan and reporting procedures have been posted prominently on all residential and day units and that staff have been informed of. the location.

17. Citation: Minnesota Rules, part 9525.0340, subpart 1.F.

Violation; In the records reviewed, the annual interdisciplinary team summary identifies the guardianship status of the residents, but does not document consideration of the need for (continued) guardianship or conservatorship or restoration to capacity and the accompanying rationale for the team's decision.

Time Frame for Correction: By January 1, 1988, the interdisciplinary team must review each resident and document the need and recommendations for guardianship or continued guardianship and the rationale for the decision.

18. Citation: Minnesota Rules, part .9525.0340, subpart I.E.

Violation: In the records reviewed, the interdisciplinary team had identified and summarized the resident's community placement needs. However there was no documentation of the rationale for the team's decision.

Time Frame for Correction: By May 1, 1987, submit copies of three annual reviews which document the rationale for that decision.

19. Citation: Minnesota Rules, part 9525.0370, subpart 5.

Violation: Consumers did not participate in the facility's human rights committee, contrary to existing policies of the facility and to the requirement to have consumer representation when consumers are not a part of the governing body.

Time Frame for Correction: By July 1, 1987, submit a list of consumers who have agreed to serve on the human rights committee.

It is recommended that the current organizational structure of the facility be changed for the purpose of improving the coordination and communication in implementation of residents' program plans. The facility director of mental retardation services could be given the responsibility for supervision of all direct care staff, including the night staff. This structure could alleviate the issue of night staff persons not implementing the program plans.

PENALTY FOR FAILURE TO CORRECT VIOLATIONS

Failure to correct the above violations within the prescribed time frame will result in revocation of your license.

RIGHT TO APPEAL

The decision to issue a probationary license may be.appealed by notifying the Commissioner of Human Services in writing, within ten days of receipt of this letter. Upon receipt of a timely, written appeal, Fergus Falls Regional Treatment Center shall have the opportunity for a prompt hearing before an impartial hearing examiner.

Provide a copy of this letter to each local social service agency that has clients placed at your facility.

If you have any questions concerning this Correction Order, contact Suzanne Dotson, 612/297-1876, immediately.

Sincerely,

Charles C. Schultz
Deputy Commissioner

CSD/43

cc: Sandra S. Gardebring, Commissioner
Maria Gomez, Assistant Commissioner
Al Hanzel, Assistant Commissioner
Margaret Sandberg, Assistant Commissioner
Beverly Heydinger, Assistant Attorney General
Julie 3runner, Welsch Compliance Unit
Mary Stanislav, Special Assistant Attorney General