Office of the Ombudsman for Mental Health and Mental Retardation

"We Can Do Better for Minnesota's Vulnerable Citizens"

A Review of Conditions at South Center Manor an Intermediate Care Facility for Mental Retardation in Center City

An Ombudsman's Public Report
August 2003

Mission

. . . Promoting the highest attainable standards of treatment, competence, efficiency and justice for persons receiving services for mental health, developmental disabilities, chemical dependency, or emotional disturbance.

The Office of Ombudsman for Mental Health and Mental Retardation began this investigation in January, 2003. The initial review of South Center Manor revealed serious concerns. We contacted other agencies involved and began working cooperatively with the Minnesota Department of Health and the Department of Human Services regulatory divisions.

As a result of this cooperative effort, South Center Manor has entered into a voluntary closure agreement with the Department of Human Services, Disability Services Division and Chisago County. All residents will be transitioned to more suitable placements.

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Prepared under the authority of the
Ombudsman for Mental Health and Mental Retardation
under MN. Stat. 245.91-99

Acknowledgements

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Preface

The Office of the Ombudsman for Mental Health and Mental Retardation is charged under Minn. Stat.§ 245.94 with promoting the "highest attainable standards of treatment, competence, efficiency, and justice for persons receiving services for mental health, developmental disabilities, chemical dependency, or emotional disturbance." This review of services provided by South Center Manor was conducted under the powers granted to the Ombudsman's Office in Minn. Stat. § 245.91-97.

South Center Manor is licensed by the Minnesota Department of Health (MDH) and the Minnesota Department of Human Services (DHS) as an Intermediate Care Facility for persons with Mental Retardation (ICF/MR) in Center City, Minnesota. At the date of the initiation of this review there were eleven persons residing at this facility. At the time of the review there were four females, (ages 44, 51, 63 and 76) and seven males (ages 34, 54, 54, 63, 64, 70 and 84) residing in this facility.

Persons with developmental disabilities who must rely upon others for some or all of their basic daily needs are some of Minnesota's most vulnerable citizens. This is compounded by the fact that many of the clients at this facility are elderly with the associated conditions of the aging process. Everyone who works within this system has an obligation to see that reasonable quality care is provided. In late January of 2003, the Ombudsman's Office received complaints and concerns from several sources about South Center Manor. In addition, there was concern expressed that agencies with oversight responsibilities were not doing anything about this program. The complaints and concerns to the Ombudsman's Office included:

1. The condition of the approximately 80 year old structure;
2. General safety issues as related to the location of the facility and the condition of the physical plant itself;
3. An infestation of mice and bats within the facility;
4. The quality of medical care provided to the residents by the nurses employed by South Center Manor;
5. Programming and lack of choices provided to residents;
6. Possible inappropriate use of client funds;
7. Use of underage direct care staff, and
8. The lack of appropriate training for direct care staff.

The information and observations detailed in this report by Ombudsman staff are based on unannounced visits to South Center Manor on February 25 and 26, 2003, and May 28, 2003. In addition to the visits, the Ombudsman staff interviewed numerous persons who have direct contact with the residents of this facility, reviewed records from the Departments of Health and Human Services and spoke with various county social service staff.

The Regional Ombudsman staff conducting this review contacted DHS, MDH, the Attorney General's Office and the counties to request that they take appropriate action under their respective regulatory authorities.

A letter indicating concerns arising out of the Ombudsman's review was sent to the facility director along with recommendations. Written responses to the Ombudsman's recommendations from the director of South Center Manor are also included in this report.

After reviewing all of the documentation and reading the responses, The Ombudsman has concluded that there are substantial reasons to warrant concern about the quality of care and subsequent safety of the residents of this facility. If immediate and substantial steps are not taken to improve the physical plant and quality of care by the facility management state regulatory agencies should follow through with decertification of the facility, revocation of its various licenses to operate in Minnesota and the placement of this facility under state receivership until these resident clients can be transitioned to more suitable placements.

Questions regarding this report should be directed to the Ombudsman at 651-296-3848.

Roberta C. Opheim
Ombudsman for Mental Health and Mental Retardation

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“We Can Do Better”

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Background

South Center Manor (SCM) is paid with state and federal funds to provide care to vulnerable adults. In order to operate the facility must hold certain licenses and work with county social service agencies to admit a resident to their facility and receive authorized payment for services. They are required to provide certain services in accordance with state and federal laws and rules. Included are some of the most basic services of food and shelter. They also must ensure that resident's health care needs are met including visits to clinics and other providers, providing for medication management, other health care assistance and therapeutic programming on an individualized basis.

The facility must be licensed by the Minnesota Department of Human Services (DHS) as an Intermediate Care Facility for Mentally Retarded (ICF/MR), by the Minnesota Department of Health (MDH) as a Supervised Living Facility (SLF) and receive a Certification as a Medicaid Eligible Facility which is issued by MDH. Part of the certification process includes a Fire Safety Inspection conducted by the State Fire Marshal. There are provisions in law for these governmental regulatory agencies to perform periodic reviews of these types of facilities in order to maintain their licenses and certifications.

Once it has been licensed, certified and inspected, county social services may place clients in the facility, after an assessment of the client determines that this is an appropriate placement. SCM is located in Chisago County and if someone from another county is placed in this facility, Chisago County serves as the Host County and must provide Host County Concurrence authorizing the placement. The Host County would also be the place where concerned parties would file reports of possible maltreatment of a vulnerable adult under Minnesota's Vulnerable Adult Act. The Host County would then be responsible for forwarding those reports on to the appropriate lead investigative agency that would make the actual determination of abuse, neglect or financial exploitation.

Clients at this facility range in age from 34 to 84 with more than half of them over the age of 60. Accordingly this facility would need to provide an appropriate environment and associated services to accommodate that ageing process for persons with developmental disabilities.

In January and February of 2003, the Office of the Ombudsman received numerous complaints from more than one source regarding the services being provided at SMC. One source indicated that they tried to report issues to the county under the Vulnerable Adult Act. According to the reporter, the county refused to even take the report. At that time the Regional Ombudsman staff requested additional documentation from those sources to support some of the reported complaints. The documentation obtained by the Ombudsman staff indicated possible serious concerns involving individual rights, health care services and safety. Based on the preliminary information provided to the Office of the Ombudsman, it was determined that an on-site review of the facility was necessary to gather additional information.

The Ombudsman staff conducted an initial on-site review on February 25 and 26, 2003. Ombudsman staff reviewed the records for the eleven residents, interviewed some residents and staff, and observed interactions between SCM staff and residents. Ombudsman staff also conducted an inspection of the physical plant to observe any obvious conditions that may be considered a hazard to the residents' health and safety.

Following the February on-site review, the Ombudsman staff contacted MDH' Office of Health Facility Complaints; the Minnesota DHS' Services Division of Licensing; the Minnesota Attorney General's Office and others. Those agencies were notified of the Ombudsman review of this facility and were requested to take action under their regulatory and certification authority with regard to the problems identified during the on-site visit.

In a letter dated April 3, 2003 to the SCM management, the Ombudsman outlined specific concerns discovered in the review process of the facility and asked that they respond to the concerns raised.

Observations

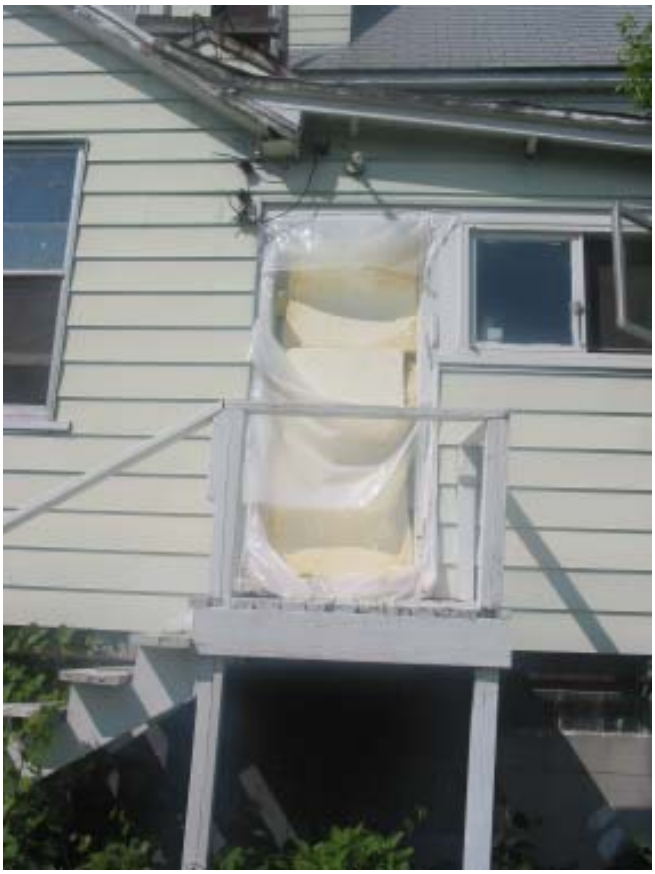
Following are areas of observation and concern that were identified:

I. Physical Plant

SCM is located on a peninsula-like area of Center Lake in Center City, Minnesota. It is approximately 50 feet from waters edge on two sides of the building. There are no barriers or fences between the facility and the lake on either side of the building. The facility is also located approximately 50 yards from Highway 8, a paved road that has a steady traffic flow with posted speeds at 45 miles per hour. A review of records indicated that one of the current SCM residents sustained a closed head injury as a result of a car hitting him/her during an attempt to cross this highway on foot some years ago. The SCM building is a wood frame structure built in the 1920's, according to the fire inspection reports on file at the MDH. There is one primary entrance to the building, on the north side. One entrance on the south side of the building, in the kitchen has been blocked off and is not in use. Another entrance on the west side of the buiding leads up to the kitchen and steps down to the basement. The Ombudsman's staff did not observe any staff or residents using this west side door to enter or exit the facility.

The primary entrance on the north side of the building has a screened in porch. During the February visits, the screens were covered with heavy plastic. As you enter the facility through this porch there is a strong odor of cigarette smoke. It was observed that only one resident smoked, and he smokes a pipe. All other persons observed smoking in this porch were staff and management. There is a concern that residents with serious health problems (two residents require oxygen) must enter through this area where there is a strong cigarette smoke odor. On at least one occasion the Ombudsman staff observed staff smoking while residents were entering the facility.

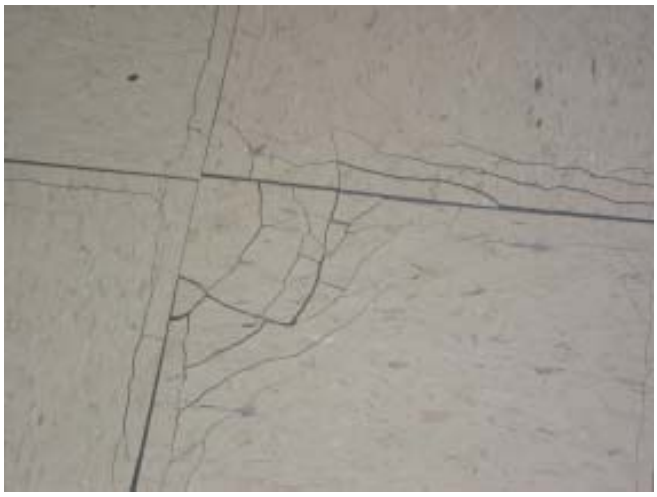
Beyond the screened porch, there is an entry foyer. To the right of the foyer is a large living room. The



furniture in this room was covered with blankets and throws. To the left of this foyer was one resident bedroom. There are three other resident bedrooms on this floor. The foyer also includes the stairway to the second floor and a hall way leading to the dining room. The dining room has numerous tables and is sparsely decorated. On the east wall of this room is a long, cafeteria style table. Under this table are many six and twelve packs of soda pop. During the visits the staff log was found on this table, as well as a coffee maker and other items. On the same wall, to the north, is a bulletin board that contains Polaroid pictures of all the residents and with their names written below their pictures. During the May 28, 2003 visit there was also a room chart that included the names of persons who resided in the first floor bedrooms. Across from the bulletin board are storage closets. Between the bulletin board and the cafeteria like table is the door to the offices. There are two adjoining offices for staff and management. Beyond the dining room is the kitchen. The floor on the first level was uneven in many areas raising concerns for persons with walking or mobility problems.

The kitchen contains a stainless steel food preparation center, a counter with an old ceramic sink, dishwasher, large refrigerator, and large commercial gas stove and ovens. The floor is old, with linoleum tile squares that are yellowing and cracked in many places.

Between the tiles are large gaps that are black and appeared to have dirt and other unknown particles imbedded in them. There is a sanitation concern



regarding this floor that is in disrepair. MDH records indicate that the facility was cited on the condition of the floor in 1995, however it appears that no correction has been made.

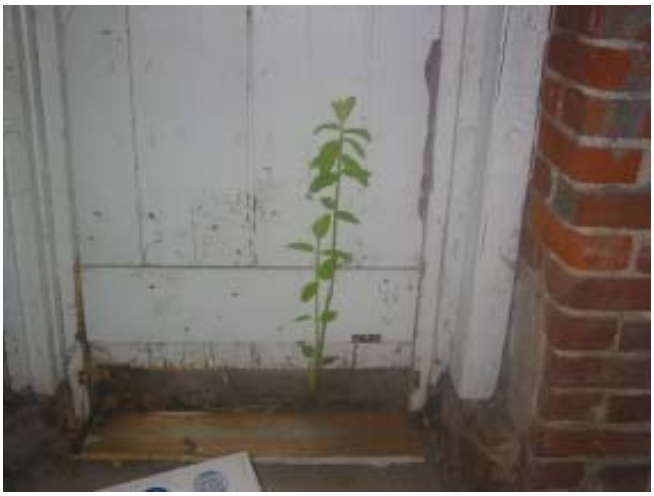
On the May 28, 2003 visit, the Ombudsman staff observed two large packages of ground beef in a bowl on the counter by the sink. Upon closer observation it was determined that the meat was thawed and slightly brown. The Ombudsman staff immediately notified direct care staff about this meat. After touching the meat with her finger, the staff person stated, "Oh, it is thawed. I thought it was frozen. I guess they took it out last night."

The basement is accessed through the kitchen. It is an extremely narrow and low-ceilinged staircase. It was difficult for the Ombudsman staff to get down to this space. The basement had a damp and musty odor. It contained a freezer which held frozen food, another freezer (unplugged) that contained some dry food, a washer and dryer. The cement floor was uneven, dirty and wet in some areas.

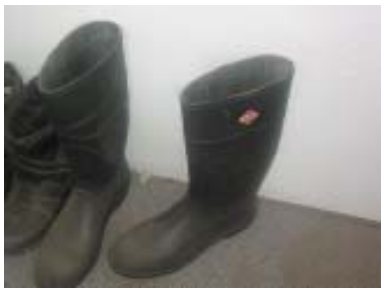
The Ombudsman staff was told by several direct care staff that whenever it rains the basement floods, and sometimes the water is knee-deep in places. There is one area against the south wall where you can see

the sunshine from the outside through the cracks in and around the floor and wall. On the May 28, 2003 visit the Ombudsman staff observed weeds growing

from the outside of the building into the basement. There is a concern regarding the possibility of mold and other contaminants in this space. There is also a concern regarding the use of this space by staff and residents during tornado and severe thunder storm warnings. SCM staff have reported that they put on



rubber boots and unplug appliances before taking residents down into the flooded basement Other staff indicated they did not unplug appliances in the basement in this situation. One former staff person stated that during weather warnings she would stay upstairs on the main floor in a closet with one resident who is unable to maneuver down the basement stairs. Another former staff stated that to keep the residents from becoming upset as they stood in the basement in the water, she would give them popsicles to eat.

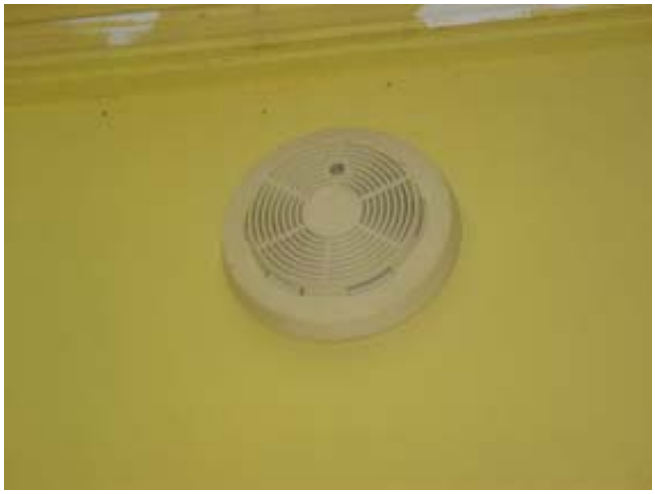


On the second floor of the facility there are seven occupied bedrooms and two bathrooms. There are also other empty bedrooms that contain storage of clothing, oxygen canisters and other items. During the February visits the Ombudsman staff observed holes in the ceiling in both bathrooms around the pipes.

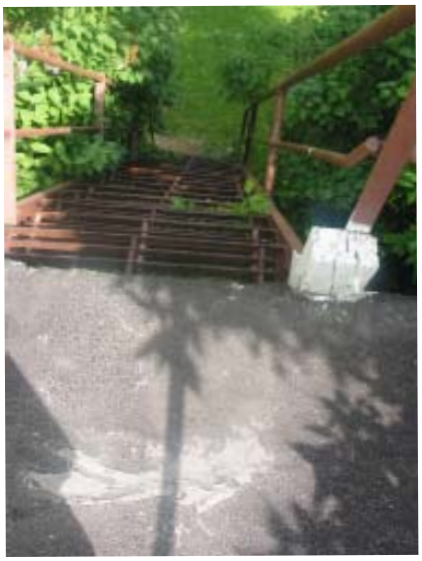
One bedroom on the second floor is occupied by a resident who is profoundly deaf. In the event of a fire emergency, this resident would not be able to hear the fire alarm or see the flashing light alarm (specifically designed for hearing impaired persons)

from their room. The flashing light alarm is located in the hall on the same wall as the bedroom door. It is mounted near the ceiling and if the light were flashing, it would not be visible from the bedroom if the door was closed. During the February visits no fire alarms were observed to be in this resident's room. The director was made aware of this and when the Ombudsman staff returned in May it was observed that only a sound smoke alarm had been placed inside this resident's bedroom. Again, this woman is profoundly deaf and unable to hear an audio alarm.

The fire exit door on the south side of the second floor leads to the roof of the building. There is metal



pipe railing leading to the fire escape steps on the east side of the building. This railing did not appear to be anchored solidly and moved easily when grasped by the Ombudsman staff. The roof surface felt soft under their feet in areas. The Ombudsman staff learned later that rotted flooring was replaced in the bathroom that is located next to this roof area. The fire escape steps from the roof are narrow, metal steps which are extremely steep and overgrown with weeds on all sides. The Ombudsman staff did not climb down these stairs as it appeared too risky and dangerous. There are numerous concerns about this fire exit. First, there is no alarm on the door leading out to the roof to alert staff if a resident should wander out this exit. Second, the roof may not hold the weight of seven residents attempting to escape in an emergency. Third, the unsteady iron pipe railing may not be anchored securely enough to provide steady, strong support for the seven persons who may have to exit this way in an emergency. Fourth, the steps leading down from the roof are so steep and possibly slippery from the weeds that are growing in and around them, that the Ombudsman staff question if all the residents, especially the older and less agile residents, would be able to maneuver these steps. And fifth, would the hearing impaired resident be able to follow instructions on how to evacuate the building and descend the stairs?



The third floor of this facility is not used for living purposes. The door to this floor was unlocked, open and accessible to anyone at the time of the February visit. A resident would be free to wander up there should they decide to do so. In the hallways there are empty cardboard boxes and wood planks. In the many rooms the Ombudsman staff found mattresses, open boxes of papers and files, clothing, suitcases, furniture and other items. There were also old paint cans and painting rags. There are two toilets that do not have water in the bowls and are covered with black and rusty substances. Some of the floors on this level were carpeted with old, dirty carpet. The floors and some furniture throughout this level were strewn with bird droppings, rodent droppings and bat droppings. There were holes in the floor around

the pipes leading to the second floor bathrooms In the northeast corner of this floor there was a large pile of what appeared to be bat droppings. The pile of droppings was considerably larger in May than during the February visit

All interviewed current and former staff, recounted the problems with bats and mice in this house. They stated that the residents often run screaming from their rooms at night because the bats are flying around their beds. One former staff stated that on at least one occasion, she had to run from the bats that followed her and two of the residents down to the first floor. Another former staff person stated that often at night she would see the bats hanging from the clothing poles in the residents' closets. During the May visit the Ombudsman staff stood in the northeast area of the third floor and heard a constant, audible wing-fluttering sound which appeared to come from the walls in this area. This rodent and bat infestation raises many health and safety concerns for the residents of this facility.

In general, the Ombudsman staff found many concerns regarding the physical plant that may affect the health and safety of those persons who reside at the facility.

II. Staff/Resident Interaction

Direct care staff interaction with residents observed during the visits to SCM was generally positive and respectful. There were two incidents that did raise concerns for the Ombudsman staff. Both incidents occurred during the visit in February, 2003. The first incident involved a conversation between the LPN (licensed practical nurse), and the QMRP (qualified mental retardation professional). The Ombudsman staff members were sitting at a table in the SCM dining room; the LPN and QMRP were sitting at another table in the same room. Two residents, a male and a female were also sitting with them at this table. The LPN began a conversation discussing detailed medical and behavioral issues regarding the male resident. The conversation did not include an acknowledgement that this resident was sitting next to the LPN. They spoke about him as if he were not present in the room. The staff also did not make any effort to keep this private information from the female resident sitting at the table. The male resident began to look at the Ombudsman staff and then down at the table top as if he were uncomfortable or embarrassed by the staff's conversation about him in the presence of another resident and the Ombudsman staff.

The second incident occurred during the same visit. It involved the LPN. She was sitting in

the office area, speaking loudly enough for the Ombudsman staff, SCM staff and residents to hear her. She was speaking to the QMRP, who was also in the office area. Her voice was raised as she stated over and over again that she did not care what people said about her, she was a good person. The Ombudsman staff felt this behavior, by a professional, was inappropriate and may cause emotional discomfort for the residents who may have heard her and rely upon her for their care.

The Ombudsman staff concerns in this area are specifically about interactions with and about residents by the management and medical personnel without regard or sensitivity to the client and without caution for client data privacy.

III. Individual Resident Concerns

Detailed below are some of the more serious individual resident concerns that appear to demonstrate, in addition to other issues documented in this report, a lack of concern for the health and safety of individuals who reside at South Center Manor.

- **Resident number one**, who resides at SCM, is profoundly deaf. There is a concern regarding staff ability to effectively communicate with this resident who is deaf, to ascertain her/his needs and wants. The Ombudsman staff did not observe any use of sign language during the initial two day visit at the facility. In the SCM director's initial response to the Ombudsman letter he stated that some staff had been trained in sign language. The Ombudsman requested documentation of this training from the director. In the second response from the SCM director, he provided a certificate from 1980 that he had completed a "beginning sign language" class through Chisago Community Education Department. He also provided a "Certificate of Achievement" for another staff person who attended a "sign language I" class in 1990. A third document he provided to the Ombudsman's Office was for a staff person who was no longer employed by SCM (Please see document attachments A, B and C). The resident has a bedroom on the second floor of this building. As outlined earlier in this report, there is a serious concern regarding her/his safety in the event of a fire because she/he is unable to hear the fire alarm or see the flashing light alarm in the hall way outside her/his bedroom. Following the Ombudsman staff initial visit, after a letter detailing this issue as a concern, a smoke detector was installed inside her/his bedroom. This smoke detector is a sound alarm, not a light-flashing alarm, which would be ineffective in alerting this individual to a fire emergency. Interviews with SCM staff, former staff and day program staff indicate that this same individual is terrified of bats as they frequently fly around her/his bedroom and hang from the pole in the closet on the second floor of SCM during the summer months.

- **Resident number two** who resides at SCM is diagnosed with insulin dependent diabetes. Concerns were raised by several persons who currently work with this individual or have worked with her/him in the past that she/he may not be getting appropriate and necessary medical care and diet to help control the diabetes. Following a review of records and interviews with staff at the day program and staff from SCM, three serious concerns were brought to the attention of the Ombudsman staff. The first concern is whether this individual is being provided with appropriate food choices for meals and snacks. For example on at least one occasion the lunch brought from SCM included a rather large (4 cups) container of pasta. According to staff, her/his diet only allows one half to one cup of pasta per meal. According to MayoClinic.com web site, the portion per meal of pasta should be one half cup.

  The second issue stems from an ongoing concern regarding this individual's high blood sugar levels. According to interviews and documents from his work program, she/he would run very high blood sugar levels (between 300 and 600). The MayoClinic.com website states that normal blood sugar levels should be between 70 and 110. The staff at the work program observed symptoms in this person that caused them con-

cern and believed it was necessary for them to get a doctor's order to test her/his blood sugar during the day to ensure her/his health and safety. The staff at the work program stated that if her/his blood sugar was running high they could then call staff at SCM to provide any necessary medical attention.

According to staff at the day program, when they began getting very high blood sugar levels and they contacted SCM about these health concerns, the SCM LPN contacted this individual's physician and obtained an order that stated blood sugar testing was <u>not necessary</u> at the day program. The LPN then removed the resident from the day program without consulting or informing the person's case manager or the day program. She/he was out of the day program for approximately four months. It took the intervention of the client's case manager to get the resident returned to this work program.

- **Resident number three** has a diagnosis of a severe seizure disorder. A review of records from SCM (submitted by the director) did not include several seizure reports. The seizure reports for May 21, 2002, August 2, 2002 and October 21, 2002 were not provided to the Ombudsman. Evidence of those seizures having occurred are indicated elsewhere in this individual's record, however were not documented on a seizure report and not included with other seizure reports submitted by the SCM director.

  This same resident (number three), receives medication for "aggressive" behavior. A review of incident reports indicates that on several occasions in the past year the nursing staff for SCM approved Ativan PRN (as needed) for behavior that included, "scowl on face," "crabbiness," and verbal complaints to staff or refusal to complete morning and afternoon tasks. Documentation in the incident reports lists the criteria for the necessity of the drug intervention as <u>*a possibility*</u> she/he <u>*may*</u> become "more angry" or "out of control." A Functional Analysis Interview completed by Region 7E Crisis Services in May and June of 2002 for this individual recommends the following:

  "1. Continue to utilize the services of a psychiatrist. …needs to see a medical professional specific to psychiatric care. In addition to this service, coordination of the psychiatric, neurologic, and general services is of the utmost importance. By coordinating the psychiatric and neurological care, …'s team will decrease the likelihood of serious behavioral and epileptic situations." ***This person's records do not indicate that this coordination has been initiated by SCM.***

  "2. Don't hastily encourage medication changes

  "3. Attempt to make …'s communication more functional. When (she/he) refuses, (she/he) is communicating. Communicating is not a bad thing, and …. needs to learn that communicating (her/his) wants/needs are more functional than displaying more aggressive behavior." ***There is no documentation in her/ his record to indicate recognition that facial expressions such as a scowl and crabbiness are forms of communication or that any changes in assisting this individual to communicate more effectively have been made.***

  "4. Positive behavioral programming. While …. has a well written program for staff to follow and implement, it lacks any form of reinforcement. While …. seemingly can't make the connection between (her/his) actions and a reward, it does start conditioning …. to get attention in a more positive way. Continue to train and evaluate staff's interactions with …. as written in the program. ***There is no documentation to indicate this recommendation has been implemented and that this individual is receiving reinforcement for positive behavior. Her/His records only indicate that staff has initially ignored her/his negative behavior.***

  "5. Adapt to …'s physical and mental decline. As …'s skills lessen, expectations should lessen

as well." ***There is no indication that this recommendation has been considered or included in regards to this individual's programming.***

There is a serious concern regarding the method SCM uses to maintain pertinent medical data. Data on clients appears to be kept in as many as nine different places with no one place containing all relevant information on a client. This may affect services provided by their physicians, other medical personnel, case managers and facility staff if they do not know about or have access to information to provide a complete picture of the client's history and needs. There is also a concern regarding the general medical care and the criteria for the use of psychotropic medications provided by the nurses at SCM.

- Two residents have a DNR/DNI order in their records (ages 51 and 84). Both residents' records do not indicate any life threatening disorder at this time. The LPN at the facility stated he/she was unaware of the DNR order for one of these individuals. The LPN also stated that the other individual expressed that he/she wanted the DNR order placed in his or her record (the 84 year old resident). There is a concern regarding the ability of this person to make an informed decision regarding this matter. His/her records indicate an over all IQ score of 35 and during an interview with him/her, it was unclear that he/she would understand the gravity of this kind of decision. This person's record also included a note that states the LPN contacted this person's doctor to discuss ordering a DNR for this person. There is a concern regarding the appropriateness of a DNR/DNI orders for these individuals.

IV. Individual Resident Choice

All programming for residents is supposed to be based on individual needs and personal preferences.

Approximately once per month members of a local church come to SCM to conduct a bible study and sing hymns. It is highly commendable that they would be willing to volunteer their time and efforts for the residents of SCM. The concern here is not whether any of the residents at SCM like or enjoy this monthly event as it is documented that some of the residents do enjoy the activity. However, since only one religious denomination provides this service, questions arise over religious freedom and opportunities for resident choice of activities. Specifically are concerns of:

a) whether individuals actually have a choice to refuse to participate in this monthly in-home service, and

b) whether individuals are provided an opportunity to attend outside services in their individual religious denominations or have them come into this facility.

The first concern rises from documentation in individual records regarding their willingness to attend and willingness to participate in the bible study and singing. It is noted in each individual's record when they have refused to attend and when they have refused to participate in this monthly event. The use of the word "refused" implies a negative judgment on the part of staff and appears as if it is a behavior management issue rather than a resident choice issue. In regards to the second concern (b), a former staff person who continues to have contact with the residents of SCM indicated that while she was employed at SCM she would regularly take some of the individuals who are of her own religion to her church each Sunday. She stated that when she quit working at SCM those same individuals no longer were taken to church. At least one resident told staff that she/he would like to attend Christmas services. Individual records indicated no one attended services on Christmas of 2002.

There is also a concern that residents of SCM are not always provided a choice in regards to the community activities they attend. During the February 2003 visit it was noted that resident leisure assessments were not up to date and had not been done for

some clients. Following the initial letter from the Ombudsman's Office where this concern was noted, leisure assessments for the residents at SCM were completed or update in May, 2003. Prior to this date, only seven of the eleven residents had been assessed in the area of leisure activities. Those assessments were completed 15 years ago, in 1988. Four of the residents had never been assessed prior to May, 2003 to determine what kinds of leisure activities they enjoyed doing in the community. A review of activities in the past year indicated that many of the community activities involved shopping or going to a movie. Below are just two examples of individual's chosen or preferred activities, and what actual activities they attended in the community.

One resident was assessed to be "very interested in doing often" the following activities: "checkers, card playing, puzzles, picnics, music, movies, TV, radio, flea markets, garage sales, singing, bird watching and traveling." In the previous five months (all that was recorded in her/his record), the individual had attended four movies (all within a one month period and one of the movies was seen twice with two different staff), shopped once, ate out once, went to an "award ceremony", and the "Pumpkin Patch."

Another resident was assessed to be "very interested in doing often" the following activities: "puzzles, picnics, bowling, music, concerts, movies, TV, radio, swimming, garage sales, cooking, painting, singing, fishing, dancing, traveling, and camping." In the previous six months this individual went shopping five times, attended three movies, went for two "rides", attended an "awards program", a high school football game, a peewee hockey game, the "Pumpkin Patch", and went out to eat once.

There continues to be a serious concern that residents of SCM are not provided an opportunity to choose and attend personalized religious or leisure activities.

V. Financial Concerns

The first issue of concern in the financial area is the use of individual's personal needs money to purchase medical supplies and equipment. Minnesota service providers have an obligation to assist clients in budgeting and spending these funds in an appropriate manner and pursing payment from legitimate other funding sources such as Medicare or Medicaid for covered services and equipment.

- **Resident number four** has difficulty ambulating without the use of a walker or wheel chair. Records indicate that on September 13, 2002, management of SCM purchased a used wheel chair for $200.00 using this individual's personal money (please see document attachment D). When the Ombudsman staff initially raised the question of why this purchase was not paid for by medical assistance, the director stated he just did not put in the request for a reimbursement. In the first written response to the Ombudsman's Office the director then stated it was the individual's "choice" to make this wheel chair purchase with their own funds and that the guardian had agreed to this. The Ombudsman's Office requested documentation the guardian's. Several weeks later the director provided an undated, hand written note that states "I —— guardian of ——— grant permission for ——to buy a new wheelchair out of her own funds." The note from the guardian was not dated. The person's record did not include documentation indicating the need for the wheel chair purchase at the time of the purchase. This documentation would have been needed for Medicaid reimbursement.

- **Resident number five** is diagnosed with diabetes. Records indicate that this individual regularly pays for syringes and other medical supplies at Gordy's Pharmacy from his personal funds (please see document attachment E). There was no explanation offered by the SCM director why the individual's personal funds had been used to purchase medical supplies that could be paid through Medical Assistance.

- In early December of 2002 at least seven gift cards from local discount stores (Kohls and Walmart) varying from $25 to $40 were purchased using residents personal funds. Individual

records do not indicate what happened to the gift cards. However, in the director's response letter he indicates the cards went to various family members of the residents. The lack of adequate documentation raises questions regarding possible financial exploitation of a vulnerable adult. There is a concern about purchasing gift cards for large amounts with resident's personal funds as the majority of the residents do not have a very large monthly income. There is also a concern that the cards may be used by anyone as easily as cash. While a resident could request that type of gift card be purchased as a holiday gift, the facility should have clear documentation of the request, along with information on the gift card's intended use. Without adequate documentation it raises questions and the possibility that staff or anyone else could take these cards and use them without any way to trace where the money went. If it were to be used in that way, it could be considered financial exploitation of a vulnerable adult.

The Ombudsman believes that a complete audit needs to be conducted of this facility to ensure that federal and state funds are being spent in accordance with appropriate rules and laws.

- Facilities that are certified as ICF/MRs have certain requirements regarding appropriate financial procedures and limits on operating expenses. The Ombudsman staff has been provided with documents from a resource person for this report. These documents are handwritten by the SCM director and show that he provided cash advances to himself and the LPN, beginning in June of 1999 for a total of $17,599.68. The Ombudsman has been advised that the SCM director and the LPN are engaged to be married. Two of those notes indicate an $8,725.27 "advance for property" on 10/1/01 and on 11/15/01, $5,000.00 "P...M…. advance for car." (Please see document attachments F and G) The director of SCM stated in a written response that he "disagreed with your (Ombudsman) assertion" of this matter.

- The Ombudsman staff has been provided with receipts from grocery stores that appear to indicate the director and/or the LPN charged personal groceries to an account listed as South Center Manor. According to staff and charge statements from Marketplace Foods in St. Croix Falls, Wisconsin, staff purchase groceries approximately once per week. Statements from Marketplace Foods indicate that additional charges were made on the same day or within a couple of days and those purchases. Staff stated that those purchases were not brought to SCM. One receipt from Marketplace Foods lists some of the purchases. Examples from these additional charges outside of the regular facility shopping trips include: one CF Pizza, one package of LF Hash browns, one can of green beans, one can of tomato soup, one can of pineapple, two pounds of boneless, skinless chicken breasts, one package of Dole coleslaw vegetables, etc.; none of which would be used at SCM nor be of a sufficient quantity to feed 11 persons. Staff at SCM indicated that most of the other items listed on this receipt would not be used at SCM for the residents. The Ombudsman staff requested an explanation of these records to explain these purchases. The SCM director responded to this request by stating he "disagreed with" the assertion of this matter.

There is a reasonable cause for concern about the possible misuse of Federal funds being paid to this facility. The Ombudsman believes that a complete audit needs to be conducted of this facility to insure that federal and state funds are being spent in accordance with appropriate rules and laws.

Initial Recommendation

After the initial visit to the facility and review of the documents and circumstances surrounding the original series of complaints, the Ombudsman office outlined its concerns in a letter to the facility. The letter outlined the following recommendations:

1. That the concerns regarding the condition of the physical plant be addressed immediately to ensure the safety of the eleven residents at South Center Manor.

2. That the facility review and make appropriate changes regarding the following practices:

   a. Programming for the residents that allows for individual choice and promotes independence.

   b. Training and devises that provide adequate communication methods for all residents.

   c. Documentation and training of staff on documentation. Documentation on residents should be kept in one location where staff may have easy access at any time of the day.

   d. Facility and individual risk management plans be reviewed for accuracy, taking into consideration the condition of the physical plant and the individual needs and vulnerabilities of the residents.

3. Review appropriate laws and rules governing the use of resident funds and public financial resources.

Facility Responses

I. February 25 and 26, 2003 Visit to SCM

On February 25, 2003, the Ombudsman staff arrived at SCM at approximately 7:30 a.m. Most of the residents of SCM were either in the dining room eating breakfast or in the living room watching television and waiting for van rides to their day program. Within several minutes of the Ombudsman staff arrival the facility director came into the room. His face was red and his voice was loud and angry as he told the Ombudsman staff (in the presence of SCM staff and residents) that they were "violating peoples' rights" and "privacy" by coming unannounced and so early in the morning.[1] He continued to raise his voice at the Ombudsman staff. Ombudsman staff encouraged the director to call the Ombudsman Central Office and speak to the Ombudsman or the Director of Client Services if he had questions about their visit. They provided the phone number to the director if wished to do this.

On February 25 and 26, 2003, the facility director was reluctant to provide information and documentation requested by the Ombudsman staff. When asked to provide specific financial information and records for the eleven residents, the facility director refused to do so. The authority of the Ombudsman's Office was explained to the director; however, he continued to state that he was not going to provide the information to the Ombudsman staff. After approximately 30 minutes the facility director called out very loudly from his office that he wanted the Ombudsman staff to talk with his accountant. The Ombudsman staff explained to this accountant the authority of the Office to have access to these financial records and offered to fax him a copy of the Ombudsman Statute. He stated that was not necessary and would suggest to the facility director that he provide the requested documentation.

II. SCM Written Response, Received April 22, 2003

The Office of the Ombudsman sent a letter dated April 3, 2003 to the SCM director, outlining concerns about the facility and services provided there (please see document attachment H). The SCM written response was received on April 22, 2003 (please

[1] MN Stat. 245.94 Sub 1 (g) allows the Ombudsman to enter and inspect the facility. Ombudsman staff were careful to ensure that no clients were in their bedrooms before entering those rooms.

see attachment I). The response included attachments that provided an explanation for two of the financial concerns noted in the April 3rd letter from the Ombudsman. The SCM response did little to explain or diminish the concerns regarding the care, safety and programming provided by SCM. The first recommendation made by the Ombudsman Office was that the concerns regarding the condition of the physical plant be addressed immediately to ensure the safety of the residents. The written response from the director of SCM, received on April 22, 2003, stated that "Administrator will make sure that the third floor is cleaned of all debris." He also stated that "the third floor will be cleaned along with the two toilets mentioned" and "Cleaning has begun and will be completed by May 9th, 2003." ***When the Ombudsman staff returned to the facility on May 28, 2003, they found the third floor in much the same condition as it was on February 26, 2003. There were also additional boxes, clutter and much more bat dung present on this floor. The only recognizable change to this floor was the removal of some material that had been hanging down from the ceiling in one of the rooms. No other concerns detailed in the Ombudsman April 3rd letter regarding the physical plant had not been dealt with.***

The Ombudsman recommended that programming for the residents allow for individual choice and promote independence. In the SCM April 22nd response, the director denied that this was an issue or concern. ***In the response of 4/22/03, no documentation or evidence was provided to the Ombudsman to indicate that individuals were provided the opportunity to choose activities or provided programming that promotes and fosters their independence.***

The Ombudsman recommended that training and devices used for communication between staff and the residents with hearing loss be reviewed and changes made to facilitate more effective communication between staff and residents. The written response from SCM stated, "Staff have been trained in sign language in the past and initially. All new staff will be trained during orientation. One of our staff is trained as a sign language interpreter and is available to those residents that need assistance." ***The Ombudsman was not provided documentation of any training completed by staff in the area of sign language with this initial response from SCM. In a follow up letter to the facility, SCM was asked to provide documentation on this training. There are continued concerns regarding the quality of sign language training that can be provided in the new staff orientation because there are no certified sign language teachers employed at SCM. There are also concerns regarding the lack of training of current staff in this method of communication.***

The Ombudsman recommended that staff be trained in how to document in resident records and that the facility maintain those records in one location for easy access by staff. The written response to this concern by SCM stated: "All resident information is kept in the office area. For each resident there is a medical book, a program book. These are available for staff if needed. There is also a chart note book, a book for nursing notes, and a data book for monitoring goals and objectives. The last three are the most used books for staff. All staff are aware of these and where to find these. When state survey was here they liked the way it was set up. A staff log is kept and information for staff to follow is kept there as well as pertinent medical notes. All information is communicated verbally and in all the appropriate places listed above." ***The written response by SCM further emphasizes the continued concern that pertinent documentation and information may not be received by direct care staff. As noted above, pertinent information on residents could be located in five to six locations or files. In an emergency, it would be difficult to gather all relevant information quickly for medical professionals. There also remains a concern that some pertinent information regarding residents is provided only verbally to staff and not written down for future reference by staff or others.***

The Ombudsman recommended that SCM review and revise the facility and individual risk management plans taking into consideration the conditions of the physical plant and the individual needs and vulnerabilities of the residents. ***The written response***

from SCM did not address this issue. In addition, the facility was cited for this in 2001 by the Department of Human Services (see attachment L). This was supposed to have been done as a result of those citations.

The Ombudsman recommended that the facility review appropriate laws and rules governing the use of resident funds and public financial resources***. The SCM facility director denied any problems in regards to the use of resident funds and public financial resources. The written response from SCM did not address this issue.***

In general, the April 22nd written response from SCM provided very little additional information or documentation to address the Ombudsman's concerns and recommendations. Based on the SCM written response, there continues to be a concern that the issues detailed in the Ombudsman letter of April 3, 2003 are not being seriously addressed by the director and management of SCM.

Based the April 22nd response from the facility the Ombudsman sent a follow up letter dated May 9, 2003 requesting specific documentation on some of the issues raised. (See attachment J)

III. May 28, 2003 Visit to SCM

The Ombudsman staff did an unannounced follow up visit to the SCM facility on this date. The facility director was not present at the time of this visit. The Ombudsman staff requested direct care staff contact the director to notify him of this visit. The direct care staff reached the director by phone and told the Ombudsman staff that the director wished to speak with them. After Ombudsman staff identified themselves over the phone, the director immediately stated, "What the *h*—- are you doing there?" The Ombudsman staff stated that they were at the facility to determine if the changes had been made as indicated in the director's April 22nd letter to the Ombudsman. The director asked for the specific things the Ombudsman staff would be looking at during the visit. It was explained to him that the Ombudsman staff would be looking at all the physical plant concerns to determine if he had made the changes and cleaned up areas as he stated in his April 22nd written response. The director attempted to argue with the Ombudsman staff, stating, "If you don't know exactly what you are looking for, how the *h*—- can you do your job?" The Ombudsman staff repeatedly told the director that they would not argue with him and if he would like to discuss this matter he could come to the facility and he would be provided with a copy of the letter he sent to the Ombudsman. The Ombudsman staff also asked the director if he had sent in the requested documentation outlined in the May 9, 2003 letter to him. He stated that he had not done this. The Ombudsman staff reminded him that this information had been due in the Ombudsman office on May 22, 2003, six days prior to this visit. The facility director suggested that the Ombudsman get the information we wanted from the Department of Health investigator. It was explained to him that the Ombudsman's review is conducted in a different manner than the Department of Health. The SCM again insisted that the Ombudsman obtain any information we wanted from the Department of Health investigator.[2] The Ombudsman staff explained again that they were not going to argue with him about this issue. The Ombudsman staff asked when he would be submitting the requested information and documentation. He stated that he wasn't going to do it that day because "clients come first and I have to take one to the doctor." The Ombudsman staff then asked him when his written response could be expected to arrive at the Ombudsman Office. The SCM director then said *"f—- you"* and hung up on the Ombudsman staff.

The Ombudsman received a phone message that same day from the SCM director following the visit to the facility by Ombudsman staff. The SCM director stated that he would be sending in the requested information, but provided no reason for the delay of his submissions.

[2] Because of the nature of this review, the Ombudsman wanted the director to supply the specific information directly in order to allow for comparison with the documents and information supplied to MDH in order to check for consistency.

IV. SCM Written Response, Received on May 30, 2003

On May 9, 2003, the Ombudsman sent a second letter requesting additional information and documentation regarding the concerns found at SCM (please see attachment J). The written response from SCM received on May 30, 2003 (please see attachment K) included some but not all the requested documentation and information.

In the May 9th letter from the Ombudsman, it was noted that none of the records of the eleven residents included any kind of leisure assessment to determine what individual choices for activities. The Ombudsman requested copies of those assessments. The May 30th response from SCM did include completed leisure assessments for all eleven residents as requested by the Ombudsman. All of the assessments were completed during the month of May, 2003. Some of the residents had been assessed in this area in the past and those assessments were included in the submissions. Those previous assessments were dated in 1988, fifteen years ago. ***There remains a concern that individuals are not always provided a choice and opportunity to do the activities they are interested in and enjoy. This continued concern is based on a comparison of the residents chosen list of activities and the activities they actually were given an opportunity to participate in during the previous year.***

The Ombudsman requested documentation that individuals were given a choice and opportunity to attend outside religious services. The SCM response indicated the religion of each individual resident as noted in their records. According to the submitted documentation, each individual was asked if they would like to attend services outside the facility. Some of those individuals who expressed a desire to attend outside services had not been given an opportunity to do so in the past year. ***The concern continues to be whether the residents are provided a choice and opportunity to attend outside religious services.***

The Ombudsman requested documentation that staff had received training in sign language. The SCM response included three certificates, one that belonged to a staff person who no longer works for the facility. The other two certificates were for introductory classes completed 13 and 23 years ago. The Ombudsman requested a copy of the communication book for one resident. That was not included in the submitted materials. ***There continues to be a concern regarding the staff's ability to communicate effectively with those residents who are deaf or hard of hearing.***

The Ombudsman requested documentation regarding a serious injury to one resident that occurred on November 15, 2002. The SCM response included the requested information.

The Ombudsman requested information and documentation for another resident that is prescribed psychotropic medication. The documentation requested for the past year included: medication administration records, behavioral incident reports, seizure records, documentation of the last neurological exam and assessment, documentation of neurologist and psychiatric visits in the past year. The SCM response did not provide all the requested information. Only four to six months of requested documentation were included in the response. No documentation of the last psychiatric visit was provided with this written response. ***Due to the information provided by SCM, as well as the information not provided, there continue to be concerns regarding the medical care and use of psychotropic medication for this resident.***

The Ombudsman requested documentation from SCM regarding the consent of one resident's conservator to purchase a wheel chair using personal funds, rather than seek reimbursement through Medical Assistance. The Ombudsman also requested documentation from this resident's physician stating the need for the use of this wheelchair. The SCM director provided two items: an undated, handwritten note signed by this resident's conservator, stating that it was okay to use personal funds to purchase the wheel chair; and a typed note, dated April 15, 2003, from the SCM LPN to the resident's primary physician which included a

statement checked by the physician that stated "OK to use wheelchair until foot/ankle are repaired and healed." No documentation was provided to indicate that the conservator had been informed about Medical Assistance as a source to purchase the wheelchair. The note faxed to the physician requesting an order for the wheelchair appears to have been returned to SCM on April 29, 2003, seven and one half months after the purchase of the wheelchair on September 13, 2002. ***It appears that this documentation was created after the Ombudsman began its review of the facility. The Ombudsman continues to have concerns about the use of personal funds for this medical device.***

The Ombudsman informed SCM that the Minnesota Department of Human Services Consolidated Standards states that "Staff under 18 years of age may not perform overnight duties or administer medication." The SCM response stated, "Now that SCM is aware of this, no staff under 18 are or will be scheduled for overnight duties."

In the May 9, 2003 letter to SCM, the Ombudsman requested documentation regarding several issues related to the physical plant and safety of the residents. The SCM response did include the most recent fire marshal report, but did not include proof that flashing light alarms had been installed in the rooms of the persons who are deaf or hard of hearing.

The SCM response provided the following information regarding a safe place for individuals during a weather emergency: "In the event of Severe Weather residents will seek shelter in one of two places; first being the bathroom off the medication room and second being the dining room area in front of the clothing closet as this is a windowless area on the lowest possible floor in a central location of the building." The SCM response to a request for documentation regarding the hiring of building contractors to fix the various unsafe conditions with the facility were stated, "SCM is not able to respond to this as we are unaware of what unsafe conditions are being referred to in this concern." In regards to a request for documentation of the installation of an alarm system for the second floor exit, SCM responded, "SCM is in the process of putting this in. We are currently waiting for parts from the hardware store that are on order." ***The Ombudsman continues to be very concerned about the safety of the eleven residents who must live in this old building that appears to have had minimal upkeep in recent years.***

The SCM response to the Ombudsman request for additional financial documents included some, but not all of the requested information. SCM did include some legible deposit statements for one resident as requested. The SCM response did not include documentation from Gordy's Pharmacy for the purchases made in the past year for one resident. The SCM response simply stated that the items purchased "were insulin syringes." The SCM response did provide the names of individuals the director indicates received the gift cards purchased with individual resident funds. ***The Ombudsman remains concerned that resident funds and SCM funds are not being used in an appropriate manner.***

Involvement of Other Agencies Responsible for Care and/or Regulatory Oversight

The Office of Ombudsman for Mental Health and Mental Retardation contacted agencies with a role and responsibility in the provision of services or with a regulatory role as soon as possible after becoming aware of the conditions at SCM. The Ombudsman did not want to duplicate the work of those agencies or interfere with any efforts they may currently be undertaking. Each agency was responsive and cooperative with the Ombudsman. The Department of Health Office of Health Facility Complaints immediately initiated an investigation under its legislative authority. The Minnesota Department of Human Services Licensing Division has undertaken an investigation under it's authority under the Minnesota Vulnerable Adult Act and the Consolidated Standards. The Ombudsman was satisfied that once informed, most of the agencies have taken appropriate action to investigate identified problems. However, the Ombudsman is concerned that counties have placed two new clients in this facility despite knowledge of the problems.

- Minnesota Department of Human Services, Licensing Division.

  The DHS, Licensing Division is currently responsible for a portion of the ICF/MR licensure, including the monitoring of the provider's use of psychotropic medications being prescribed to residents, the requirements governing the maltreatment of vulnerable adults and other items contained in the Consolidated Standards. According to DHS licensors, there are currently only six staff licensing facilities that serve persons with developmental disabilities throughout the state. The licensors reported that their caseloads are currently over 200. The DHS licensing public file indicates the most recent visit to South Center Manor occurred in June of 2001. Correction orders were sent to SCM following this licensing investigation visit. (See attachment L)

  The DHS, Licensing Division is the lead investigative agency regarding allegations of maltreatment in this type of facility (ICF/MR). The Ombudsman staff who conducted the on site review of SCM contacted DHS after their visit, with their list of concerns. DHS indicated which issues would appropriate for them to look into and which would be more appropriate for the MDH to investigate.

  On August 4th, DHS issued to SCM an "ORDER TO FORFEIT A FINE AND ORDER OF CONDITIONAL LICENSE". These orders were for failure to do background checks on three staff hired back in 2001, problems related to the administration of psychotropic medications, problem with the facility abuse prevention plan, failure to properly follow up after the use of a controlled procedure (manual restraint), failure to conduct an internal investigation following a vulnerable adult report, problems with the physical plant, use of underage staff, lack of required training for staff, problems with use of client funds, failure to implement polices and procedures regarding mandatory reporting and failure to notify client's legal representatives.

  The orders show a history of repeated findings with citations having been issued in the past. This report demonstrates a lack of responsiveness of the facility management. Of specific concern to the Ombudsman was that fact that the repeated violations were not minor issues but things that involve serious health and safety concerns for residents such as criminal background checks of employees, administration of powerful drugs that can have serious and potentially life threatening side effects, underage staff (minors) being used to cover alone overnight as well as others.

  The repeated nature of these citations speaks to a lack of responsiveness by the facility that is consistent with the experience of Regional Ombudsman staff. The Ombudsman does not believe that SCM management takes seriously the role of the regulatory agencies. Given that the facility has demonstrated unwillingness to correct things that have been cited in the past, why would DHS continue to give them more chances to correct the problem?

- Minnesota Department of Human Services, Disability Services Division.

  The Licensing Division notified the Disability Services Division of the Ombudsman's concerns. After reviewing conditions at the facility they began to work with South Center Manor on a voluntary closure agreement.

- Minnesota Department of Health; Facility and Provider Compliance Division.

  The MDH currently has the majority of licensure responsibilities for ICF/MR facilities. Two separate sections within this division are responsible for licensing, certification and complaint investigation. Those are the Office of Health Facility Complaints (OHFC) and the section that deals with Licensing and Certification

  Licensing and Certification surveys ICF/MR facilities to ensure compliance to Federal regulations and Minnesota Rules and Statutes govern-

ing Supervised Living Facilities (SLF). The public file for South Center Manor includes licensing and certification information, citations and correspondence dating back to 1995. Some of the current concerns and complaints are noted in citations dating back to 1995. According to this record, following surveyors' visits on January 14 and February 10, 2003, all citations and deficiencies issued from a November 11 to 14, 2002 visit were noted to be corrected. The Ombudsman has concern that many of the conditions found during the February 2003 visit by the Ombudsman staff are the result of years of neglect and deterioration of this facility and yet were not corrected as a result of the MDH licensing reports. While licensing can only issue citations relative to the minimum requirements, the Ombudsman does not believe that many of the conditions outlined by the Ombudsman meet anyone's standard of minimum requirements.

The OHFC recently completed an investigation based on complaints received from the Office of the Ombudsman Staff after their February visit. OHFC informed this office that this is the only report on record for South Center Manor. The OHFC investigation substantiated most of the complaints forwarded by the Ombudsman's Office. Accordingly new citations have been issued and SCM has been requested to submit an acceptable plan of correction. (See attachment M) A failure to correct these deficiencies could result in loss of their license and Certification as a Medicaid Eligible Facility.

A question has been raised as to why MDH is demanding action now based on the OHFC investigation when the facility has been operating this way for the past 15-20 years. The Ombudsman agrees that this is a good question that needs to be addressed. How could this facility have had certification and licensing visits over the years and not have been required to address the issues or have their license to operate revoked? The Minnesota Department of Health will need to assess and answer that question. The Ombudsman staffs' review of SCM records at MDH revealed what appears to be different areas of examination based on who the surveyor was and what their background was.

How could this facility had certification and licensing visits over the years and not have been required to address the issues or have their license revoked?

- County Case Management

At the time of the Office of Ombudsman review, eleven persons resided at South Center Manor. Those eleven persons are receiving Case Management services from the following Minnesota Counties: Chisago, Washington, Hubbard, Kanabec, Ramsey and Hennepin. Four of the residents are under State Guardianship, with the responsibilities for those services being delegated by the Commissioner of Human Services to the counties. Guardianship services were being provided by the following counties: Hubbard, Washington, Chisago, Kanabec and Ramsey. One case manager did suggest that their client be moved to a more appropriate facility but the guardian did not want the resident moved.

Chapter 256B.092 of the Minnesota Statutes outlines the duties of case managers in regards to the persons they serve. Of the discussion about whether or not county case managers found the conditions at SCM to be appropriate for their client's, the Ombudsman staff were told that many case managers visit their clients at their Day Activity Center and may not have been to the actual residential facility. In addition the Ombudsman has been told that often it is difficult to find a placement for their clients, and workloads prevent a lot of time being spent on these activities.

- Host County

Chisago County is the host county for this ICF/MR facility. Chisago County Human Services does have a Common Entry Point (CEP) for reports of suspected maltreatment of vulnerable adults. It was reported to the Ombudsman Office that at least two individuals attempted to file vulnerable adult reports with the Chisago County CEP and were unsuccessful in those attempts. One person stated that he/she was told their report would not be accepted because it appeared to the CEP that the report was being made by "a disgruntled employee" trying to get back at their employer. Ombudsman staff contacted the Chisago County CEP and was informed that the person interviewed did not remember receiving any calls regarding SCM but he/she said that they had been there for about a year. He/she said they would check with former staff as to whether or not complaints had been received. The Ombudsman staff received a voice mail message from someone in the Chisago County developmental disabilities section of county social services. A return call was made and the party was not in so a voice mail message was left for that person. No further calls were received regarding CEP reports.

Staff members at the DAC were observant and concerned about care provided to clients at SCM.

Minnesota's Vulnerable Adult Act clearly outlines the role of the CEP who is required to take the report and has a clear requirement to forward allegations of abuse, neglect and financial exploitation of a vulnerable adult to the appropriate lead investigative agency, in this case the Department of Human Services. It then is the lead investigative agency's responsibility to determine whether or not a report would be investigated.

Since the Vulnerable Adult Act was amended in 1995 to require each county to have a Central Entry Point for receiving VA reports, the Ombudsman has received numerous complaints from citizens about the refusal of some CEPs to accept reports based on the county staff's personal opinions. The law specifies that the county only has the ability to triage out calls when the caller has clearly contacted the wrong place (i.e. to complain about a barking dog or to ask where to pay the phone bill) but not where there is an allegation of abuse, neglect or financial exploitation.

- Day Activity Center (DAC)

Day Activity Centers provide services, treatment and activities to clients during the day. They also provide another point of observation of what may be going on with their clients' care. Staff members at the DAC were observant and concerned about care provided to the clients at South Center Manor. In at least one case they were concerned about a client's diabetes. When they attempted to monitor and address the problem, South Center Manor responded by having the doctor rescind an order authorizing the DAC to monitor glucose levels and then removed the client from that DAC. The client was later returned to this DAC with the assistance of the county case manager. The Ombudsman has documentation of contact by DAC staff with the Department of Health outlining their concerns regarding SCM. According to DAC staff this was faxed to the Department of Health two years ago.

It is the observation of the Ombudsman that because of the different roles each agency has in the process, sometimes those agencies look only at their piece of the regulatory role. When done in isolation of the other agencies, issues and problems can fall through the gaps. The Ombudsman hopes that all agencies involved will notify the others when they observe problems that others should address.

Findings

Based on a review of South Center Manor which included observations, a review of documentation, and interviews, the Ombudsman Office has made the following findings:

- Residents are exposed to multiple, negative environmental factors that may pose a risk to their physical and emotional health and safety.
- The physical structure has not been adequately maintained.
- This neglect of maintenance has been going on for years.
- The management and medical staff of SCM do not promote or provide the residents of SCM the rights entitled to them under the law, including privacy of personal data, freedom of religion and personal choice of activities.
- Most of the residents' daily activities, including religious and recreational or leisure, are chosen by staff, not the individual residents, providing little or no choice.
- Proper care is not always taken in the planning and preparation of food.
- The facility has a rodent infestation problem that has been ongoing for years, a problem which the facility has failed to properly address.
- The basement is not easily accessible and due to flooding is not an appropriate emergency shelter.
- Financial practices are not appropriate and may not be in compliance with state and federal law including such practices as the salary "advances" from SCM funds to the manager and LPN of SCM and grocery store purchases for personal use of the facility management.
- The quality of health care provided by the nursing staff is questionable and possibly dangerous to the clients.
- The facility management displays a lack of understanding of the importance of following rules and laws written to protect our vulnerable citizens and for responding to citations issued.
- When the Day Activity Center tried to monitor the blood sugar levels for a client, and when they notified the facility of a concern, the facility took steps to prevent the center from tracking the health of the client and the quality of health care provided to the client.
- The facility lacks the ability (without technical assistance) and the desire to bring this program into compliance.
- The Health Department's Licensing and Certification unit failed to aggressively address these serious issues during its visits over the years which led the facility to believe that these were acceptable conditions and practices.
- Despite serious and repeated citations issued by both MDH and DHS, no one seems to be aggressively pursing closure of this facility.
- County case managers failed their clients by not knowing or addressing the conditions under which their clients were living and receiving care.

Recommendations

South Center Manor

- The conditions identified by the Ombudsman and the Minnesota Department of Health regarding the physical plant immediately be addressed to ensure the safety of the residents at South Center Manor.

- An animal/rodent control specialist be brought in to rid the premises of mice and bats, and contracted with to inspect for rodent control regularly in the future.

- The bat and mice excrement be thoroughly cleaned and the affected areas sanitized to get rid of any potential health hazards associated with these rodents.

- Ensure that staff is knowledgeable in the programming for each client including their personal choices for leisure activities and that those programs are followed and allow for client choices and preferences.

- Establish new procedures to allow for clients to practice their individual religious beliefs.

- Assess each client who is deaf of hard of hearing for their ability to communicate using sign language or alternative communication devices and train all staff on those methods of communications.

- Improve the documentation system to include all information be kept in one place to ensure that those who must serve the clients have access to the information they need to provide the highest quality of service to each client without having to check multiple logs or files. All staff should be trained on proper documentation.

- Develop a system of clear, dated approvals from guardians/conservators including the date of the request, the specific approval you are requesting and a dated response from the guardian/conservator.

- The facility and client individual risk management plans be reviewed and updated taking into consideration the condition of the physical plant and individual needs and vulnerabilities of each resident.

- Facility management ensures that client funds are not used to pay for supplies and equipment that are covered by Medicaid and that facility staff aggressively pursue reimbursement when available.

- Facility management and staff do detailed documentation on funds expended out of client personal funds and that documentation be done in a timely manner to include the date, amount spent, purpose of the expenditure/items purchased, justification, and documented approval of the guardian, and if it is a gift, who the gift was for.

- The facility review and revise policies and training for staff on individual client nutritional needs accounting for such factors as diabetes or other diet affected diseases.

- All staff be trained on safe food preparation including thawing of food slowly in a refrigerated environment instead of being left out at room temperature

- The facility hire an outside firm to audit the financial records for both the facility and individual client personal needs funds. That audit should include recommendations to the facility on development of appropriate financial controls to protect against improper use of facility funds for personal use for such things as food, property or personal vehicles as well as to protect residents from unauthorized or inappropriate use of their personal funds.

- The facility review all appropriate laws and rules that govern the operations of an ICF/MR; hire outside professional assistance; review and re-

vise facility policies to ensure compliance with those laws and rules; and provide training to staff on implementation of those policies.

Other Agencies

Minnesota Department of Health

- The Ombudsman recommends that the department review its policies and practices regarding the periodic review of facilities to ensure comprehensive reviews with consistency and continuity from year to year.

- The department aggressively monitor this facility to ensure that all items identified are corrected within the time allotted under rule, without any extensions and if not to decertify this facility and revoke the appropriate licenses to operate

Minnesota Department of Human Services

- Undertake a comprehensive review of all client records regarding areas of psychotropic medication monitoring, client and facility abuse prevention/risk management plans, and individual programming issues and if found not to be in compliance, initiate appropriate regulatory action with aggressive follow up on the Orders dated August 4, 2003, to ensure corrections with in the time allotted.

- Conduct a comprehensive review of the training and understanding of county workers who receive complaints as the Central Entry Point under Minnesota's Vulnerable Adult Act to ensure that reports are taken and forwarded as required by law.

- Conduct a financial audit of facility records and if irregularities are found to provide for appropriate sanctions.

County Case Managers

- Review the appropriateness of this placement for their client with consideration to environmental safety and quality of programming.

- Review county practices to ensure that routine visits are made and meetings held alternatively in the facility where clients live as well as at their day activity programs.

- Ensure that case managers make reports to appropriate regulatory agencies when they have concerns about a facility or a program.

- Train all case managers on the requirements of the role of the guardian when done in conjunction with their case management role.

Chisago County

- Review and amend policies, practices and training surrounding their role as a Central Entry Point for vulnerable adult reports,

- Review the county's role as a Host County and initiate action to improve its knowledge of facilities that are receiving client from other counties and establish communication with placing counties, when the county has concerns about a facility.

In Summary

The Office of the Ombudsman for Mental Health and Mental Retardation has many concerns regarding the health, safety and quality of care provided to the residents of South Center Manor.

Based on the findings of the Ombudsman, MDH and DHS, the Ombudsman believes that South Center Manor management lacks the ability or desire to make the necessary changes. If immediate and substantial changes are not made, DHS should act quickly to place this facility under DHS receivership and run the program until such time as these clients can be safely and sensitively transitioned to a new and more suitable placement.

The Ombudsman does not make this recommendation lightly and acknowledges that many of these clients have lived at SCM for a long time. Any move could be disruptive and unsettling for them. However, the Ombudsman believes that there is an ongoing threat to the health, welfare and safety of these clients and that at some point, if no action is taken, there will be serious consequences to one or more of these residents that justifies these extreme recommendations.

It is the hope of the Ombudsman that should such a move be necessary, that all parties will work together to minimize any distress to these vulnerable adults.

Addendum

After this report was finished and submitted to the Department of Health and the Department of Human Services for review, the Ombudsman had contact with both agencies.

The Minnesota Department of Health indicated that they acknowledged the issues the Ombudsman raised in this report and have embarked on a process to examine how they can make improvements to their survey systems.

The Department of Human Services, Disability Services Division, has informed the Ombudsman that SCM has entered into a voluntary closure agreement with DHS and the county. The closure date is not finalized but is expected to be complete by November of this year. Planning for alternative placements for residents is currently taking place. The Regional Ombudsman for that area will monitor and assist with the transition of the residents of South Center Manor.

Equal Opportunity Statement

The Ombudsman Office does not discriminate on the basis of race, religion, creed, color, age, national origin, sex, sexualorientation, membership in a local commission, status in regard to public assistance, disability, marital status, or political affiliation.

This information will be made available in an alternative format upon request. Please give the Ombudsman Office advance notice if you need reasonable accommodations for a disability.

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