UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

James and Lorie Jensen, as parents, guardians and next friends of Bradley J. Jensen, *et al.*,

Plaintiffs,

v. Civil Action No. 09-1775

Minnesota Department of Human Services, an agency of the State of Minnesota, *et al.,*

Defendants.

Behavioral Intervention Devices & Practices: Achieving Compliance in Community Programs

David Ferleger
Court Monitor
Archways Professional Building
413 Johnson Street
Jenkintown, PA 19046
Phone: (215) 887-0123
david@ferleger.com

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I. INTRODUCTION

Summary

Both as a matter of policy, and under the Court's orders, the Department of Human Services is committed to forbidding mechanical, behavioral and other restraints and aversive practices, with regard to *all individuals* with developmental disabilities, regardless of where they are served. The issues raised in this report are not new; they raise anew circumstances which fall short of fulfilling the commitment.

A[redacted] L. and K[redacted] H. have been clients of DHS and their counties for many years. The particulars of their current situations have been known to their counties and to DHS' Community Support Services (CSS) for years. A[redacted] L.'s inadequate "transition" was found in non-compliance in 2013 by the Court Monitor and in non-compliance early 2014 by DHS' independent reviewer. K[redacted] H. has been in a community program for years, with the provider carrying forward DHS' institutional use of a restraint chair for her; the provider regularly detailed to DHS the extensive restraint chair use (on about 15 days per month, and up to 8 ½ hours daily), and shared the information often with the assigned CSS professional. DHS did not stop the use of the chair.

In K[redacted] H.'s case, the restraint chair was used not when she was aggressive but when she exhibited symptoms including "eye rolling," "eye fluttering" and "racing thoughts" in all but a few instances. For A[redacted] L., whose aggressive outbursts are rare but serious, the paucity of his environment and the restraining walls

are ever-present. (It is fair to say that DHS top management was appalled in September, 2014 when it learned at a meeting with the Court Monitor the extent of restraint chair use for K[redacted] H, and details of A[redacted] L.'s situation).

DHS has received 12,121 Behavior Intervention Report Forms (BIRF) between July 1, 2013 and September 19, 2014, from 398 providers; the reports document that 40 persons were mechanically restrained, and 70 persons put into seclusion during that period.

Unfortunately, the thousands of BIRF reports received little but aggregate review before the Court Monitor began this investigation. No action for A[redacted] L. is known to have occurred after the Court Monitor's 2013 finding except that DHS obtained the April 2014 concurring outside report. However, that report was not provided to either the program director or Mr. L's CSS behavior analyst until the day of the Court Monitor's site visit, September 15, 2014. Similarly, it was the DHS Licensing Division's happenstance discovery of the restraint chair which prompted outside attention (Licensing came in to examine a peach pit ingestion reported by the provider agency).

There is nobody, and no agency or office, which has acted with accountability for the continued restraint of A[redacted] L. or for the restraint chair use for K[redacted] H. As the Court Monitor observed in the community compliance review, there are "disconnects" among the agencies and departments which provide services and supports to clients, including CSS, Licensing, other DHS units, the counties and the community providers.

There appears to be a level of complacency among the state, counties and providers with respect to the importance of knowing

exactly what is going on for clients on a day to day basis and the need to provide necessary assistance to service providers for particular clients, as well as, on occasion, for the state to mandate others to take effective action. The Monitor's *Community Compliance Review's* conclusions corroborate this concern. The findings in this report raise a question about the extent that the department is indeed "one" department with a unifying vision and mission with each component carefully aligned with each other.

Significantly, the Court Monitor finds that the aversive devices and techniques described in this report are being implemented by well meaning people, many of whom are uncomfortable about doing so but do not know what else to do or who to talk to. CSS staff may have concerns but are not empowered to enforce or to ensure outside professional expertise. Provider agencies, as K[redacted]H.'s stated, are "caught in the cross-fire."

The extent to which restraints and other aversive practices and devices are employed in the community is a useful "window" into overall quality of services. Like the canary in the coalmine, this service component needs to be monitored continuously. Any use of mechanical restraints should be considered a "problem" to be addressed quickly. Complacency is to be avoided strenuously. At this point in the litigation, as the Court has indicated, urgency is to be embraced.

The introduction below is followed by three substantive sections (on A[redacted] L., K[redacted] H., and one on DHS' information on behavioral intervention devices and practices. Each of those sections has a highlighted "summary" to which the reader is referred. The Court

Monitor's recommendations to the parties and the Court conclude this report.

The Settlement Agreement in this litigation forbids the use of restraints and other aversive practices on people with developmental disabilities (with the exception of manual restraint) at the MSHS-Cambridge and all its successor facilities. In addition, the settlement requires an expansion of such restrictions through modernization of Rule 40 to comport with "best practices." DHS accepted the Rule 40 Advisory Committee report with a commitment to extend the facility-based restrictions state-wide. The Comprehensive Plan of Action adopted by the Court this year establishes that the new rule will forbid mechanical, behavioral and other restraints and aversive practices, with regard to *all individuals* with developmental disabilities, regardless of where they are served.[1] The Department has committed that "DHS will prohibit procedures that cause pain, whether physical, emotional or psychological, and establish a plan to prohibit use of seclusion and restraints for programs and services licensed or certified by the department."[2]

This report brings to the Court three situations representing current aversive practices in the community which have been known to DHS and counties but which have not been effectively addressed by either. First, in July and August of this year, the parties brought before the Court a disagreement regarding the restraint and

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[1] *Comprehensive Plan of Action* (CPA) (Dkt. 283) (March 22, 2014). The *Olmstead* Plan also addresses this issue in some respects.

[2] DHS Commissioner July 2013 statement quoted in CPA at 31.

segregation of a young man being served under the Settlement Agreement. Second, in early September, a community provider was cited for maltreatment on account of use of a "restraint chair" for many days and hours every month over years. Third, data provided at the Court Monitor's request this past month verified extensive state-wide use in the community of mechanical and other restraints, including life-threatening prone restraint.

Both person-specific and systemic issues are raised in this report. At its conclusion, the Court Monitor respectfully a) provides guidance and direction to DHS under his authority to "oversee" and "supervise" compliance,[3] and b) submits a formal recommendation to the Court with regard to possible "contempt, sanctions, fines, or additional relief" for a violation of an "outstanding order" of the Court.[4]

A[redacted] L. and K[redacted] H. have been clients of DHS and their counties for many years. The particulars of their current circumstances have been known to their counties and to DHS' Community Support Services (CSS) for years. A[redacted] L., identified specifically to move from Minnesota Security Hospital to a community home, was known to the highest levels within DHS. A[redacted] L.'s inadequate "transition" was found in non-compliance in 2013 by the Court Monitor and in non-compliance in early 2014 by DHS' independent reviewer. K[redacted] H. has been in a community program for years, with the provider carrying forward DHS' institutional use of a restraint chair for her; the provider regularly detailed to DHS the extensive restraint chair use (on about 15 days per month, and up to 9

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[3] *See* Order of September 3, 2014 at 12-13 (Dkt. 340).

[4] *Ibid* at 14.

hours daily), including sharing the data with the assigned CSS professional. DHS did not stop the use of the chair.

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agencies and departments which provide services and supports to clients, including CSS, Licensing, other DHS units, the counties and the community providers.

There appears to be a level of complacency among the state, counties and providers with respect to the importance of knowing exactly what is going on for clients on a day to day basis. There is an unmet need for necessary assistance to service providers for particular clients, as well as, on occasion, for the state to mandate others to take effective action. The Monitor's *Community Compliance Review's* conclusions corroborate this concern. The findings in this report raise a question about the extent that the department is indeed "one" department with a unifying vision and mission with each component carefully aligned with each other.

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The extent to which restraints and other aversive practices and devices are employed in the community is a useful "window" into overall quality of services. Like the canary in the coalmine, this component needs to be monitored continuously. Any use of mechanical restraints should be considered a "problem" to be addressed quickly. Complacency is to be avoided strenuously. At this point in the litigation, as the Court has indicated, urgency is to be embraced.

II. DHS KNOWLEDGE OF INTERVENTIONS

Summary

Before DHS collected the data below at the Court Monitor's request, DHS Community Support Services knew of only ***six clients*** for whom behavioral intervention devices are used. That number, we now know, is a small fraction of the number of clients for whom behavioral intervention devices and practices are used.

Over the last month, the Court Monitor requested DHS to compile and inventory of restraint devices in use in its community programs, and to document the circumstances of use of the devices and related aversive practices. Obtaining this information was a new project for DHS. The project is not yet complete. No inventory yet exists. DHS does not yet have a full picture of the extent of the state-wide use of these devices. Therefore, the information presented here is incomplete.

For HCBS Waiver programs, between July 1, 2013 and September 19, 2014: 40 persons were mechanically restrained and 70 persons were placed in a seclusion room.

Restraints used in Minnesota include such things as: seclusion rooms, chemical restraint, deprivation procedure, wrist restraints, "Velcro straps, bandana, posey," leveling plan, disengaging electric wheelchair, timeout room, and canopy bed.

There is significant community use of prone restraint (holding someone facedown). Prone restraint is forbidden by many state laws

and regulations, by many school systems, and many police departments. It is dangerous and life-threatening. Prone restraint is not therapeutic; it is not treatment. Its use should end immediately to avoid catastrophic outcomes.

Before this month's inquiry by the Court Monitor, DHS Community Support Services knew of only ***six clients*** for whom behavioral intervention devices are used.[5] Two use helmets for protection from head injuries, one uses devices to protect skin and body from self-injurious behavior, and one has pants and shirts sewn together to prevent rectal digging, The two others are A[redacted] L. and K[redacted] H., the subject of other portions of this report.

The above "six client" number, we now know, is a small fraction of the number of clients for whom behavioral intervention devices are used. The terminology requires some fine-tuning. [6]

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[5] Attachment 8 – BID Inventory for Devices CSS. "Behavioral Intervention Devices" is used here interchangeably with "Mechanical Restraints."

[6] The term "Behavioral Intervention Devices"(BID) includes "Mechanical Restraints" and also includes such things as "seat belt clips," muffs, mittens, straps, and medically-indicated devices, such as splints or controls to prevent self-injury. The use of seclusion and time out, and variations of these practices, is also reported to DHS under the BID rubric.

One report to DHS stated that a "canopy bed" was being used as a restraint. DHS' data on restraints also reports such things as "prone restraint" which, while not mechanical, needs special attention. See note at the end of this report.

After it became known that a class member was regularly strapped into a restraint chair, the Court Monitor sought to learn the extent of use of this and other mechanical restraints in community programs for people with developmental disabilities. The Court Monitor requested DHS to provide an inventory of mechanical restraint devices, and detailed information on the uses and types of mechanical restraint interventions.

This was a new project for DHS. DHS does not yet have a full picture of the situation. No inventory yet exists. DHS is working to refine and extend its mechanical restraint information.[7]

For HCBS Waiver programs under state statute 245D (which are not the whole universe of programs for people with developmental disabilities), DHS has received 12,121 reports between July 1, 2013 and September 19, 2014, from 398 providers. The aggregate data show:

963 persons manually restrained
40 persons mechanically restrained
70 persons secluded
22 persons using self-injury protection equipment
17 using seat belt/auxiliary restraints

Restraints used by reporting providers include:[8]

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[7] DHS obtained information from several sources. Reports received through the Behavior Intervention Report Forms for Waiver programs, surveys of providers and county lead agencies, restraints used in Positive Support Treatment Plans, and analyses of various data. The data is currently in multiple overlapping spreadsheets, with information not coordinated, and in some respects duplicative. DHS intends to refine the data.

[8] Attachment 3 – Provider Summary Report.

- Humane Wraps-Velcro straps used when the individual in in a supine position
- Arm splints/restraints
- Arm braces and a face mask
- Helmet and oven mitts
- Wrestling singlet under regular clothing
- Seclusion room
- Seat belt clip

Restraints used by reporting county lead agencies include:[9]

- Arm-orthotic and helmet with face mask.
- Tray on client's wheelchair
- Wrist restraints
- Stander with waist and leg straps
- Canopy bed
- Chest strap/seatbelt, ankle, waist and hip straps to avoid falling out of chair
- Seclusion room
- Gait belt
- Seat belt clip

For restraints used under "Positive Supports Treatment Plan,[10] there were 1,056 uses of mechanical restraint are reported; multiple individuals with repeated use of resrtaints are included in this number. Types included

- Mechanical restraints (Velcro straps, bandana, posey)
- Chemical and manual restraint
- Deprivation procedure
- Deprivation, EUMR, contingent exclusion
- Disengaging electric wheelchair
- Emergency use of mechanical restraint, chip removal
- Harness, chemical intervention
- Escort, baskethold, supine restraint
- Room timeout
- Seclusion
- Exclusionary timeout
- Go to room, deprivation

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[9] Attachment 4 – Provider Summary Report.

[10] Attachment 7 -- Positive Support Treatment Plan Data.

- Hats, mitten, bandana, Velcro straps, posey sleeves
- Leveling plan
- Limiting use of own property
- Mittens
- Mitts/splints
- Arm braces
- PRN medication

Prone Restraint. The examples above do not include a particular type of restraint – prone restraint -- which is cause for extraordinary concern.

There is significant use of prone restraint (forcibly holding someone facedown) in Minnesota community programs. Prone restraint is forbidden by many state laws and regulations, by many school systems, and many police departments. It is dangerous and life-threatening. Prone restraint is not therapeutic; it is not treatment. It is forbidden for facilities under the settlement agreement; it is to be banned under the Rule 40 modernization. Its use in the community should end immediately to avoid catastrophic outcomes.

DHS reports show that prone restraint is reported to have occurred dozens of times since the BIRF reporting started last year.[11] One client in the BSTP report is listed 7 times with notation "Prone Restraint, Timeout Room" (Client BH, Provider: Creative Care for Reaching Independence, Inc.). In DHS' "master" BIRF report, dozens of instances of prone restraint are reported.

[11] Attachment 16 – Master all BIRF Data table.

III. A[redacted] L.'s "Transition to the Community:" Moveable Walls and Segregation as Restraint

Summary

The Department of Human Services continues to be in non-compliance with the Settlement Agreement with regard to A[redacted] L., a [redacted] year old individual who lives in restrictive isolation in a modified industrial building, without a person-centered plan and without meaningful activities in his daily life. Sanctions and other relief are recommended.

A[redacted] L. is one of the three individuals the Settlement Agreement required the Department of Human Services to move from the Minnesota Security Hospital (MSH) "to the most integrated setting consistent with *Olmstead v. L.C.* 527 U.S. 581 (1999)" by December 1, 2011.

On December 12, 2012, Mr. L. was "transitioned to the community," DHS reported to the Court. He moved to a portion of a large industrial building at the end of a road flanked by similar buildings in [redacted], MN. He continues to live in the same building. The total operating expense for A[redacted] L.'s program is $1,001,004, $2,740 per day. (This does not include the expense for the school-age individual who lives in the same building).

After the Court Monitor found this placement to violate the Settlement Agreement, and recommended an external review, DHS contracted with the University of Minnesota, Institute on Community Integration (ICI), to perform that review.

The ICI study, dated April 3, 2014, agreed that the placement did not comply with the Settlement Agreement.

In the July 15, 2014 compliance update, DHS stated that it would take steps to achieve compliance for the individuals who left MSH under the settlement. DHS has failed to do so for A[redacted]L.[12]

On July 24, 2014, Plaintiffs protested A[redacted]L.'s placement. DHS defended it on August 22, 2014. In response, the Court Monitor visited the residence of A[redacted]L. on September 15, 2014.

Until the Monitor's visit five months after the ICI Report, DHS had not provided that report to its program director for A[redacted]L. or to the DHS Community Support Services staff (assigned under the Settlement Agreement) who was responsible for monitoring A[redacted]L's services. After the Monitor's visit and request for additional documentation, DHS began internally to consider action on his situation.

The DHS program is called [redacted] A park is across the street; Mr. L.'s activity logs do not include any excursions to the park. The building is at the end of a road flanked with similarly-sized industrial and manufacturing structures. The open warehouse-type space has been modified. It has two bedrooms opening out to adjacent spaces delineated by wood and Plexiglas partitions, some of which are chained together. There is a small back yard.

When Mr. L. engages in physical aggression toward others, [redacted] staff are directed to vacate the area and place themselves behind a closed locked door. Behavioral incidents rarely occur.

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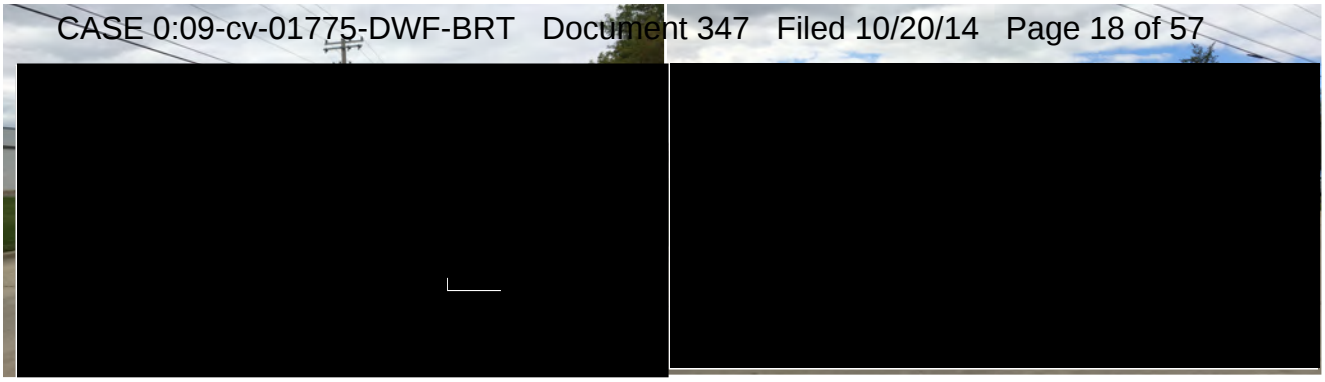
[12] The Court Monitor has not reviewed the care of the two other individuals which the ICI Report found in non-compliance.

He rarely leaves his room. A[redacted]L. almost never leaves his building. Less than a handful of times a month, he walks outside. Mr. L. also takes walks elsewhere – in his bathroom and in his bedroom.

Andrew L's life is highly controlled and viewed from an overriding concern to contain possible (though rare) aggressive behavior. The result is a very unnatural form of life.

DHS does not understand the causes and functions of A[redacted] L's behavior. MSH several years ago acknowledged its inability to serve him effectively. DHS' [redacted] approach has not had success. The "behavior problem" lens has subsumed all aspects of A[redacted] L.'s life. While address of negative behavior is extremely important, and staff safety is vital, DHS must also attend to the need to provide Mr. L. with the Court-mandated Positive Behavior Support in the "most integrated setting."

A[redacted] L. leads a lonely isolated life. There is no vision for A[redacted] L.. He has already spent a quarter of his young life in highly secure and abnormal environments. He needs and deserves more.



Above left: The road to A[redacted] L.'s residence

Above right: His residence at the right third of the building.

Below: A[redacted] L.'s personal area with chained partitions. The doors by the TV are to his bathroom and bedroom.

A. Transition Requirement & Its Independent Review

The Settlement Agreement (Doc. 104) provided that, beginning December 1, 2011, all individuals solely with a diagnosis of developmental disabilities, then living at the Minnesota Security Hospital (MSH), "shall be transferred by the Department to the most integrated setting consistent with *Olmstead v. L.C.* 527 U.S. 581 (1999)."[13] A[redacted] L. was one of the three individuals who was to have benefited from this provision of the settlement.

On November 19, 2012, Defendants reported that two of the three had been placed and that as of November 17, 2012, the third, A[redacted] L., was about to be placed: "The last individual is awaiting transition to the community pending county approval."[14] Defendants' next report to the Court stated in a January 17, 2013 update, "*The third individual has been transitioned to the community.* Exhibit 121."

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[13] Evaluation Criterion 97 (Settlement Agreement). *See* same requirement at Evaluation Criterion 84 (Comprehensive Plan of Action). The complete language of the requirement, as stated in the Settlement Agreement at 20 is:

> *No later than December 1, 2011*, persons presently confined at Minnesota Security Hospital who were committed solely as a person with a developmental disability and who were not admitted with other forms of commitment or predatory offender status set forth in paragraph 1, above, *shall be transferred by the Department to the most integrated setting consistent with Olmstead v. L.C.,* 527 U.S. 581 (1999). [emphasis added]

[14] Defe*ndants' Status Report* (September through October, 2012) at 61 (Dkt. 180).

(emphasis added).[15] The placement from MSH took place on December 12, 2012.

The Court Monitor on June 11, 2013 found "non-compliance" with EC 97 and recommended that *c*urrent supports, treatment and plans for the three individuals "should be independently reviewed for compliance with *Olmstead*."[16]

Accepting the Monitor's recommendation, DHS contracted on October 15, 2013 for an external review of the three placements. The University of Minnesota, Institute on Community Integration (ICI), study was completed with a report dated April 3, 2014.

ICI's first "key finding" confirmed the Court Monitor's finding:

> While there was much to applaud in the dedication and efforts of these support teams, the ultimate outcome of the review indicates that these transitions were, as the court monitor asserted, not completed with a person-centered plan or Olmstead analysis and that there was no evidence that the moves to the community took place with the required transition planning under the agreements.[17]

On May 12, 2014, DHS filed the ICI Report with the Court as an exhibit to a status report.[18] The next DHS status report, filed July 15,

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[15] Defe*ndants' Status Report* (November through December, 2012) at 68. (Dkt. 193).

[16] Court Monitor, *Status Report on Compliance* at 143 (Dkt. 217).

[17] Research and Training Center on Community Living, Institute on Community Integration, University of Minnesota*, An Independent Review of Transitions: Three Individuals with Developmental Disabilities Who Moved from the Minnesota Security Hospital to the Community*, at 4 (April 3, 2014). The ICI Report is Exhibit 67 to the Defendant's *Second Compliance Update Repor*t (May 12, 2014)(Dkt. 299). The report is cited herein as "ICI Report."

[18] *Defendants' Status Report* (February 1 through April 30,

2014, described compliance with EC 97 as "incomplete" and stated that DHS would take steps to achieve compliance for the individuals who left MSH under the settlement; DHS commitment was this:

> Next steps: Respond to the University of Minnesota's Report and Recommendations. Discuss with Court Monitor on how to achieve compliance and next steps with regard to the 3 clients who transitioned from MSH.[19]

The DHS September 15, 2014 update again reports the status as "incomplete" but says nothing about the efforts to "achieve compliance" which were promised in the July 15 update quoted immediately above.[20]

The ICI Report's "most important findings" were "that no person-centered plans or views of these individuals were used to substantially guide services and that an Olmstead analysis was not a leading driver in services.[21]

DHS did not communicate to the Court Monitor or the Court any objection to ICI's general or individual-specific conclusions. DHS' compliance reports to the Court did not object to the ICI Report's findings.

Until the Monitor's visit to A[redacted] L.'s residence five months after the ICI Report, DHS had not provided that report to its program director for A[redacted] L. or to the DHS Community Support Services staff (assigned under the Settlement

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2014), at Ex. 67 (Dkt. 299).

[19] *Defendants' Status Report* (May 1 through June 30, 2014), July 15, 2014 Update at 272. (Dkt. 328).

[20] *Defendants Status Report* (July 1 through August 31, 2014) at 418 (Dkt. 342).

[21] *ICI Report* at 26.

Agreement) who was responsible for monitoring A[redacted] L's services. After the Monitor's visit and recent requests for additional documentation, DHS began internally to consider action on his situation.

B. The Parties' Dispute Regarding A[redacted] L.'s Community Transition

A[redacted] L.'s situation came to the Court's attention recently in the Plaintiff Class' response to the Court Monitor's June 20, 2014 *Community Compliance Review* (Doc. 313, 327). Plaintiffs protested on July 24, 2014 that A[redacted] L. was transitioned to a modified section of a pole barn, located in an industrial park" which is "not an integrated setting."[22]

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[22] Plaintiff Class' Letter to the Court (Dkt. 332) at 7-8 (July 24, 2014):

> Unbelievably, one class member was assigned to live in a unit alone with no other residents and was moved into a modified section of a pole barn, located in an industrial park: Most certainly, this does not constitute "choice," or the "most integrated setting." Rather, DHS chose for the individual based on anything but the person's aspirations and dreams. This class member is not allowed to receive services from the day training program adjacent to the pole barn, and apparently attends no other day program away from this "home." Staff have downplayed or ignored the class member's goal of wanting to live in the class member's hometown, stating that the class member's family has moved away and the town will not be like class member remembers it despite the class member's own experience growing up there, attending school and having a community based job before the class member began to have problems. It was clear that the program and the counties involved made most of the decisions for the class member rather that

Defendants objected to this characterization on August 22, 2014, stating: "The building is not a 'pole barn.' The site is in an area zoned for residential/commercial use that is [redacted] and licensed as a corporate adult foster care home. While the outside may be industrial-looking, the inside is far from it."[23]

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allowing him to make choices.

[23] Defendants' Letter to the Court, (Dkt. 338) at 3:

> In his letter, Class Counsel makes reference to one class member who was moved into a modified "pole barn" as an example of a setting that was not based on the class member's "choice" and not the "most integrated setting." There are numerous inaccuracies with Class Counsel's assertions. The building is not a "pole barn." The site is in an area zoned for residential/commercial use that is [redacted] and licensed as a corporate adult foster care home. While the outside may be industrial-looking, the inside is far from it. The site has a large back yard, two bedrooms, two bathrooms, and a large modern kitchen. [citation omitted] This client's parents and case manager were involved in choosing this site, and the client indicated his choices for furniture and other items prior to moving in. The client chose not to travel from MSH to view the home prior to moving in. This particular site was the best option available as the client's social worker had little success in garnering interest from service providers. The site is near a day work program that will allow the client to work during the day when he chooses to do so. At this time, however, this client believes he is not yet ready to work outside of the home. When the site was developed, his parents lived about 20 miles from the site but have since moved to northern Minnesota with plans to eventually move to Colorado.

In response to this exchange between the parties, the Court Monitor visited the residence of A[redacted] L. on September 15, 2014 in [redacted], Minnesota.[24] The space in which A[redacted] L. spends his time, named [redacted] by DHS, was observed. The director stated that the Monitor would not be permitted to see Mr. L. because the Monitor was delayed in arrival by about 30 minutes and that Mr. L., in light of that, did not want to have visitors.

This report describes A[redacted] L.'s personal background, early treatment, behavioral challenges, current living situation and daily life and routines.[25]

C. A[redacted] L.'s Childhood and Adolescence

A[redacted] L. was born in [redacted], 1987 at [redacted]'s Air Force Base[26] and raised with his biological family. He is the middle of three male children.[27]

Born with Cerebral Palsy, he did not reach his developmental milestones at the appropriate ages[28] and received a diagnosis of

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[24] The Monitor was accompanied by his assistant, Dr. Martin Elks. The director of the [redacted] program, Debra Dimler-Warnke, provided them with an extensive briefing, together with the DHS Community Support Services assigned monitoring staff person, Michael Scharr, Behavior Analyst III.

[25] The Court Monitor requested DHS to provide records regarding Mr. L. and DHS did so in a prompt and timely fashion. The director of Mr. L.'s program also provided records.

[26] State Operated Forensic Services — St Peter, Young Adult and Adolescent Program, *Individual Treatment Plan*, October 2. 2012, at 1.

[27] *Ibid*.

[28] *Individual Treatment Plan, op cit*. October 2, 2012, at 1.

Autism at the age of two.[29] He had extensive occupational and physical therapy, as well as speech therapy, growing up. A[redacted] L. was in mainstream classes in high school[30] and in special education.[31] As a young man Mr. L. participated in sports and was active in his church.[32] He worked at a grocery store during his senior year of high school.[33]

A[redacted] L. had limited problems until the 11th grade and it was in this junior year in High School when things began to escalate. A[redacted] L. is reported to have begun hitting his parents at the age of 17 during times of change or unexpected events.[34] Documents differ as to whether A[redacted] L. left the family home at age 17[35] or 19.[36]

There was some evidence of paranoia but this was managed on an outpatient basis. When aggression became a problem he was hospitalized in facilities in North and South Dakota, and also at St.

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[29] *Report of Dr Patrick Zhao, MD*, Child psychiatrist, CABHS, February 27, 2012, at 1.

[30] *Individual Treatment Plan*, October 2, 2012. State Operated Forensic Services — St. Peter. Young Adult and Adolescent Program at 1.

[31] *ICI Report* at 24.

[32] *ICI Report* at 24.

[33] *Consultation with Functional Assessment and Behavior Support Information*, Minnesota DHS, March 15, 2010 at 7.

[34] State Operated Community Support Services. *Consultation with Multimodal Functional Assessment and Behavior Support Information*. November 15, 2011 at 2.

[35] *ICI Report* at 24.

[36] *Individual Treatment Plan*, State Operated Forensic Services—St. Peter, Young Adult and Adolescent Program. October 2, 2012 at 1.

Peter Community Behavioral Health Hospital on two occasions.[37] He then lived in a community group home and a crisis home, followed by admission to Minnesota Security Hospital with a Mental Illness commitment. This was later changed to a Mental Illness/Developmental Disabilities commitment that in turn was changed to a Developmental Disabilities commitment. He remained at MSH for a little over 5 years.

Mr. L.'s diagnoses as of January 11, 2014 were Autism Spectrum disorder, psychotic disorder NOS, mood disorder NOS and anxiety disorder NOS; mild to moderate intellectual disability; obesity, hypothyroidism, Vitamin D deficiency, Gastro Esophageal Reflux Disease, constipation, GI upset and chronic pain.[38] His "cognitive functioning is at the high end of the Low Average range. His IQ scores have decreased significantly since testing in 2005. In addition, Mr. L. has demonstrated significant deficits in testing measuring adaptive functioning and also struggles with comprehension." [39]

D. Minnesota Security Hospital

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[37] Dr. F. Ferron, Southern Cities Community Health Clinic, Fairbault, MN, *Psychiatry Visit Notes*, November 6, 2012 at 2. Mr. L.'s pre-DHS "legal history consists of [redacted] however, these charges were dismissed." *Individual Treatment Plan*. State Operated Services—St. Peter. Young Adult and Adolescent Program, October 2, 2012 at 1.

[38] *Progress Notes*, Minnesota DHS, State Operated Services, Dr. Renee Koronkowski, Psychiatry, January 11, 2014 at 3.

[39] *Individual Treatment Plan*, State Operated Forensic Services—St. Peter, Young Adult and Adolescent Program, October 2, 2012 at 3.

A[redacted] L. was admitted to Minnesota Security Hospital Young Adult and Adolescent Program (MSH YAAP) on September 13, 2007.[40] His Mental Illness/Developmental Disability commitment was changed to Developmental Disability on March 10, 2008[41]

Forty-six episodes of aggression were recorded during his stay at MSH YAAP.[42] These incidents, which occurred over 35 months, may be broken down as follows: an average of one incident of kicking/striking/biting every two months; less than one incident of lunging/pushing/grabbing every two months and less than one incident of *attempting* to do one of these every two months. He was said to plan his assaults and will lie to accomplish them waiting two or more months until the opportunity arises.[43]

Minnesota Security Hospital constructed a special unit for Mr. L. with prison bars, reportedly at his request.[44] It is reported that A[redacted] L. "claimed he didn't want to hurt people and asked to be put in jail. As a result, a secluded unit was designed for AL-3. On this unit he had his own bedroom, bathroom and living area. There were

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[40] *Aftercare Plan*, State Operated Forensic Services. December 9, 2012 at 1

[41] *Individual Treatment Plan* , State Operated Forensic Services—St. Peter, Young Adult and Adolescent Program, , October 2, 2012 at 1.

[42] *Consultation with Multimodal Functional Assessment and Behavior Support Information*, State Operated Community Support Services.. November 15, 2011 at 3-9

[43] State Operated Community Support Services, *Consultation with Functional Assessment and Behavior Support Information,* March 15, 2010 at 2

[44] If his desire to be "put in jail" was, for that reason, acceded to by hospital professionals in their putting up bars in the facility, this would be quite puzzling.

prison-like bars from the floor to the ceiling and separated him from staff and others who came onto the unit. His food and interactions with other were made through these bars."[45]

The following are summaries of provisions made with regard to safety and work during his time at Minnesota Security Hospital:

- Mobile restraints [restraint chair] were used with two staff when outside his locked room. If not in mobile restraints, 3 staff were assigned.
- When showering, A[redacted] L.'s hands were secured behind his back using cuffs.
- [redacted] L. spent about 20 hours per day in his room. At night his room was locked.
- A[redacted] L.'s room had a tray door through which he could talk and receive items.
- A[redacted] L. performed work on the unit if work was brought in and he was given a task to do; he made paper logs and folded rags.[46]

At the end of his MSH institutionalization – with the end occurring due to the *Jensen* settlement – MSH "repeatedly reported" that MSH staff were not trained and MSH did not have the capacity to serve him. It appears that Mr. L.'s 5 year and 3 month stay at MSH did not benefit him. The restrictive conditions, and the rare but serious behavioral issues, did not change.

> At the time of his transition, his guardians, case manager and the MSH report they were told that he had to move due to the Jensen settlement. None of these individuals were supportive of him moving to the community. *At the same time, the MSH staff repeatedly reported that AL-3 [A[redacted] L.] was not appropriate for MSH and they were not trained and did not have the capacity to meet his needs.*

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[45] *ICI Report* at 25.

[46] *Consultation with Functional Assessment and Behavior Support Information,* State Operated Community Support Services, March 15, 2010 at 10.

> MSH staff reported the settlement provided an opportunity to help AL-3 obtain support in the community and that was more suited to him.[47] [emphasis added]

Despite MSH's judgment that it was unable to serve Mr. L., he was transferred to a new program which, aside from not including bars and a tray door, maintained a highly restrictive approach and an absence of habilitation.

E. [redacted]

A[redacted] L. was discharged from MSH to a large industrial warehouse-type building which DHS named [redacted] in [redacted], MN on December 10, 2012, with the commitment to expire on April 3, 2015. [redacted]; Mr. L.'s activity logs do not include any excursions [redacted].

The building is at the end of a road flanked with similarly sized industrial and manufacturing structures. No residential or commercial buildings are in the vicinity.

The total operating expenses for A[redacted] L.'s program is $1,001,004, $2,740 per day.[48] This figure includes funding for a complement of 17 staff. MSH records show that his life at [redacted] is the culmination of over 12 months transition planning that began in September, 2011.[49]

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[47] *ICI Report* at 25.

[48] *FY 2014,* [redacted] *Operating Budget*. The $1,001,004 does not include expenses for the school-age client who lives in the same structure.

[49] *Clinical Activity Log*, Minnesota Department of Human Services, MSH—St. Peter, Begin: June 1, 2011 End: December 31, 2011, September 28, 2011 at 1182

The Court Monitor and Assistant Court Monitor visited A[redacted] L's residence on September 15, 2014. It has two bedrooms opening out to adjacent spaces delineated by wood and Plexiglas partitions, some of which are chained together. There is a large wooden table in the open "commons" area that is bolted to the floor and has had the corners sawn off. There is a small backyard with a high wooden fence; the backyard is entered through the building. The kitchen is large for a residence of this size and is stainless steel with no kitchen island work area. Ceilings in the industrial building are high. TVs are mounted high on the walls and behind Plexiglas. The steel front door needs a code to open, from the inside as well as from the outside.[50]

The partitions are approximately waist high. They are not on wheels and can be pushed across the floor into different positions. The partitions are re-arranged for various purposes such as to block access to peer's bedroom door at mealtimes or to separate peer and commons areas from A[redacted] L.'s personal area.

A[redacted] L. is, in essence, sharing his two-bedroom apartment on a 24/7 basis with 4 other adults, 3 of whom are staff rostered from a list of 17. This number or people may explain why what would

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[50] The *ICI Report's* description is consistent with the Monitor's observations:

> His "home" is in an industrial building attached to a day program operated by the same community provider. He has his own bedroom and bathroom and a living area blocked off by see-thru and moveable Plexiglass and wood panels (designed to approximate the protection he felt from the floor to ceiling bars at MSH). He has no access to his kitchen. The "home" is fully alarmed and bears a sign on the door asking people not to knock but to call a number posted there.
>
> *ICI Report* at 25.

normally be called a living/dining area is referred to as the "commons" area. In addition, given staff turnover, A[redacted]'s roster of 17 staff include new faces which cause him discomfort. It is perhaps not surprising that learning to "improve his ability to tolerate others in his environment" is a goal of his individual support plan.[51]

Mr. L. "engages in physical aggression toward others. This may be in the form of hitting, kicking, scratching, biting and may include throwing/destroying objects that belong to him or others."[52] [redacted] staff are directed to vacate the area and place themselves behind a closed locked door such as the staff office, kitchen or his peer's bedroom should A[redacted] L. aggress.[53]

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[51] *Individual Support Plan*, Minnesota State Operated Community Services (MSOCS), June 27, 2014

[52] Indivi*dual Abuse Prevention Plan* (not dated). Mr. L's history includes causing a staff person a broken arm; this occurred many years ago in a hospitalization shortly after his behavior issues began.

[53] For example:

> October 13, 2013: In the late afternoon, staff called to Mr. L. in his room. "A[redacted] threw his covers off, jumped out of his bed and charged, running at staff. Staff moved into the locked kitchen as A[redacted] pushed over walls, punched plexiglass on doors, threw chairs and pushed on front safety door." The door unlocked after a delay and he went outside. Staff coaxed him inside, where he threw chairs and pushed some walls and paced for a few minutes before calming down.
>
> January 8, 2014: A staff person was cutting his fingernails. "Without warning, A[redacted] swung his open hand and his staff in the face. A[redacted] pushed the wall in attempt to move it. Staff held the wall. A[redacted] went for an opening to come out. Staff evacuated behind doors."

Behavioral incidents rarely occur. From March 1 to May 20, 2013, there were two incidents in and out of the house which required use of a controlled procedure, which the program's "6 Month Review"[54] described as "a significant drop from 6 during his previous review period." Contributing to the occurrence of the two incidents were a new staff addition, and that a roommate moved into the building.

Similarly, behavioral incidents continued to be infrequent through the end of 2013. "His last EUCP was on October 16, 2013, he has not had one since this time. During the time of December 30, 2012 to the present [one year], there has been a decrease in EUCP's averaging 1.44 per month from December 20, 2012 to August 20, 2013. A[redacted] had no EUCP's in September, two in October, and no EUCPs from October to present time for an average of 0.5 EUCP's per month."[55] The number of EUCP's decreased in 2013, according to his program director. The director's chart on the next page shows a decrease from 15 for all of 2013 to 5 for January to September, 2014. "Vacates" (where staff vacate the living space when Mr. L. is aggressive), however, increased from 1 in 2013 to 5 in 2014 through September 16, 2014. No "vacates" occurred from May 27, 2014 to September 16, 2014.

> February 18, 2014: "When he came out [of bathroom] he threw ice pack at staff and came through the walls. Staff was able to evacuate safely."
>
> May 24, 2014: After an outburst and a staff evacuation, "A[redacted] said he was mad because he was not getting what he wanted."

[54] *Six Month Review*, dated May 20, 2013.

[55] *Periodic Review of Support Plans & Services* (December 17, 2013).

There are very few people in A[redacted]'s life other than staff. A visitor log for the 5-month period May to September, 2014 indicates that A[redacted]'s father visited on two separate occasions (once with A[redacted]'s mother) with Ombudsman staff visited once coinciding with a parent visit. In the same period A[redacted] made two phone calls to his father, one phone call to his brother in Colorado, two calls to his mother, and received one call from his father.

A[redacted]L. almost never leaves his home, going out only a handful of times a year; he rarely leaves his room, spending about 90% of his day alone in his room, ICI found.[56] The Monitor's findings, based on [redacted] detailed records, are the same. Some months, he never leaves his building at all. Other months, he "walks outside" on a handful or fewer days in the month. "Walking outside" is walking in the small fenced in the building's backyard. For example, a review of the staffs' per-shift documentation in Mr. L.'s Progress Notes shows that he "walked outside" or was "outside:"

Occasions on Which A[redacted]L. is Outside the Building (2014)

0 times in January

4 times in February

3 times in March

0 times in April

5 times in May

5 times in June

2 times in July

5 times in August[57]

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[56] *ICI Report* at 25-26.

[57] [redacted] maintains meticulous notes of the dates and times of all his activities. These include, for example, the titles of movies

Mr. L. also walks elsewhere – in his bathroom and in his bedroom. For example, on August 12, 2014, he "walked in his bathroom for 11 minutes."[58] On August 20, 2014, he took "8 laps around his bedroom."[59]

The isolation is not fully self-imposed. "A[redacted] has talked about wanting to get out of the house more when the weather warms up to play disc golf at the park and is also interested in taking a van ride soon." [60]

F. Discussion

A[redacted] L's life is highly controlled and viewed from an overriding concern to contain possible (though rare) aggressive behavior. The result is a very unnatural form of life. For example, his mealtime protocol is extremely regimented, and marked by choreographed movement on his part, and movement of the walls by the staff.[61] Similar protocols exist for medication administration and

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watched, the number of bingo games played, what chores he did, and when he had a haircut. Time outside the building is similarly detailed.

[58] Progress Notes, August 12, 2014.

[59] Progress Notes, August 20, 2014.

[60] *Periodic Review of Support Plans and Services*, June 27, 2014.

[61] *Behavior Intervention Protocol* at 3:

> When A[redacted] is getting ready to eat a meal or snack, one staff person will position themselves at the corner of the two portable walls, another staff person near the break in A[redacted]'s two portable walls and another near the open kitchen door. A[redacted] will come out and sit in his chair (if he doesn't sit down, ask him to have a seat until we get the walls into position) and staff will ask A[redacted] how he is feeling today. After acknowledgment from A[redacted] that he is safe and ready to eat, staff will move the portable

going for a walk. What is present in his life is generally not age-appropriate. A[redacted] L. spends his time indoors and his activities are extremely limited. As the itemization of his activities shows (Appendix A, attached hereto), he watches TV and plays on his iPad for hours, watches many movies (the log provides the titles), does his devotions (regular prayer), showers and eats. Once a week he helps bake an item. Meaningful or educational habilitative activities are generally absent from his activity log.

DHS seems largely at a loss to understand the causes and functions of A[redacted]'s behavior. MSH acknowledged its inability to serve him effectively. DHS' [redacted] has had limited success in understanding his behavior. ICI critiqued the failure to obtain outside expertise; the Court Monitor, as well, notes the absence of such reaching out.

The "behavior problem" lens has subsumed all aspects of A[redacted] L.'s life. While address of negative behavior is extremely important, and staff safety is vital, the Court-mandated Positive Behavior Support in the "most integrated setting" should also address "improvements in quality of life, acquisition of valued skills, and access

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> walls to cover the opening in peer's area and move the other wall allowing enough space for A[redacted] to walk into the commons area to eat. After the walls have been moved, one staff person will position themselves in the office with the door closed, another in peer's area with either the bathroom door or peer's door open (choose one door, the other should remain closed and locked), the remaining staff will be in the kitchen with the door closed (make sure both sides of the pull down window are locked). A[redacted] will ask the staff in peer's area if it is ok to pass and staff will respond "yes you may, thank you for asking A[redacted].

to valued activities."[62] These are manifestly absent from A[redacted] L.'s life at [redacted]

A[redacted] L. leads a lonely isolated life. He does not "belong" anywhere. He is a full-grown adult but is treated as a child. He is chaperoned by 3 staff at all times. His life is starkly barren of aspects many people take for granted such as relationships, meaningful daily activities, a job and educational opportunities. He does not participate in any community activities and has no valued social roles. Indeed his social role and reputation is extremely devalued — someone to be watched, controlled and contained 24 hours a day, 7 days a week by a roster of continuously rotating staff. There is no vision for A[redacted] L.. He has already spent a quarter of his young life in highly secure and abnormal environments. He needs and deserves more.

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[62] Association for Positive Behavior Supports, *Positive Behavior Support Standards of Practice: Individual Level*, Iteration 1, Approved by The APBS Board of Directors: March, 2007 at 5. This association's standards are referenced in the Settlement Agreement in this case at 6 (Dkt. 104).

IV. K[redacted] H.: Restraint Chair Use

Summary

On August 11, 2014 an investigator for the Department of Human Services, Office of Inspector General, Licensing Division, responded to a private provider's report that a group home client had swallowed a peach pit. By chance, the investigator found the client restrained, strapped into a restraint chair. On September 9, 2014, DHS Licensing issued a investigation report finding that the client, K[redacted] H., had been abused during a year of use of a restraint chair, including denial of bathroom breaks and food, and neglected with regard to use of a medication. Licensing also cited the provider for neglect on account of misuse of medication.The provider agency (which has appealed the citation) was fined $2,000. The agency's position is that DHS knew of, and approved, the use of the restraint chair for K[redacted] H.

DHS Licensing did not know – and the provider agency did not know – that the client, K[redacted] H., is a Jensen class member. DHS' Jensen-related units had not provided DHS Licensing with the names of the class members or training in the Court's orders for consideration in investigations involving class members.

The provider agency had never been told that K[redacted] H. is a class member.

K[redacted] H. is [redacted] years old and has experienced 44 residential transfers before moving to the Meridian Services, Inc. home on June 15, 2011. She lived for the longest continuous periods of time at METO/Cambridge/Anoka (1/1997 to 8/2002) and the Minnesota

Security Hospital (8/2004 to 2/2010). She has been in a restraint chair regularly, sometimes daily, on dozens of occasions for years. She is strapped into the metal-framed wheeled chair. See photos below. The duration of the restraint varies; it has occurred for up to 9 hours at a time.

Ms. H.'s DHS CSS behavior analyst described the use of the restraint chair to the Court Monitor as "bad news." CEO of Meridian Services calls the restraint chair use "an outrageous thing." It is fair to say that, after the licensing citation, top management at DHS were appalled to learn the conditions and duration of the restraint chair use for K[redacted] H. However, key offices within DHS with deep knowledge and responsibilities for implementation of the Court's orders knew of the restraint chair use for K[redacted] H. for years and either approved or took no action.

K[redacted] H. is one of the 75 individuals whom DHS had been identified under the Settlement Agreement (CPA EC 69) for intensive monitoring and, if needed, intervention with additional supports and services.

When K[redacted] H. moved to its group home, Meridian Services, the provider agency, was told that K[redacted] H. needed to continue to use the restraint chair. Meridian regularly reported the restraint chair use to DHS through DHS' CSS unit and otherwise. Meridian's reports to DHS include the extent of K[redacted] H.'s restraint chair use, total hours for the quarter was well as monthly averages. Meridian also reported the restraint chair use to DHS through report forms. January 1, 2014. On many of these forms, Meridian checked off the BIRF statement to DHS that professional consultation was needed to address the client's needs. *None was provided by DHS*. Except for one inquiry in 2013 over the three years Ms. H. has been with Meridian, Meridian states that DHS

never questioned the use of the restraint chair for K[redacted] H. DHS did not follow up on Meridian's response to the single inquiry.

K[redacted] H. has a history of ingesting inedible items, self-injury and aggressive behavior. The restraint chair, however, is most often not invoked for behavior control when K[redacted] H. takes these actions. Rather, almost all the provider reports state that the restraint chair is used solely upon K[redacted] H. rolling her eyes, saying she has racing thoughts, or feeling anxiety.

The provider agency's July 9, 2014 policy states, "the restraint chair is NOT to be used involuntarily." However, DHS Licensing found that some staff report that the chair is sometimes used involuntarily.

To Meridian's credit, Ms. H. has significant community integration and, with the support of the CSS behavior analyst, Meridian began an effort this past July to reduce K[redacted] H.'s restraint chair use. K[redacted] H. has had success in he community. She is now developing relationships, going to a supported job, and looking forward to going to new places. The county case manager sees her now as "so much better than ever before and happy for the first time." After the licensing citation and the initiation of the Court Monitor's inquiry, CSS moved to advise Meridian Services "to make the use of the restraint chair irrelevant/ineffective" through "increasing her enjoyment of and integration into her community," providing other items to meet her sensory needs, and increasing use of a standard recliner chair.

There is nobody, and no agency or office, which has acted with accountability for the continued restraint chair use. The CEO of Meridian Services has expressed frustration to the Court Monitor remarking that "we are caught in the crossfire." The Monitor notes that, while CSS "observes" and reports on clients, it does not seemed to be charged to correct objectionable situations which may arise.

On the "disconnects" among the entities involved, the Court Monitor adopts the consultant's detailed analysis which states, in part, *"There appear to be "disconnects" among the agencies and departments which provide services and supports to K[redacted]H, including CSS, Licensing, other DHS units, the county, Meridian. For example, everyone directly involved with K[redacted] and her team was reportedly either directly aware or informed of the extent of K[redacted]H's use of the restraint chair through either observations or routine reports provided to them. However, there is no evidence of any objections to either the plans developed for K[redacted]H or Meridian's implementation of these plans until after a full investigation was initiated by DHS in response to a few specific concerns."*

The final words of the consultant bear repeating: "the absence of timely and positive communication . . . absolutely hinders cooperative efforts toward a common goal."

[redacted]

[redacted]

Her restraint chair

On August 11, 2014 an investigator for the Department of Human Services, Office of Inspector General, Licensing Division, responded to a private provider's report that a group home client had swallowed a peach pit.

By chance, the investigator found the client restrained, strapped into a restraint chair. On September 9, 2014, DHS Licensing issued a investigation report finding of maltreatment ("abuse") by use of the restraint chair between July 2013 and July 2014 and that K[redacted] H. had been denied bathroom breaks and food.[63]

K[redacted] H. was abused, DHS Licensing concluded:

> Information showed that between July 2013 and July 2014, the VA [Vulnerable Adult, that is, K[redacted] H.] used the restraint chair an average of 15 days each month and spent between 5 to 7 hours in the chair during each use. In July 2014, the VA used the restraint chair 25 times (sometimes more than once a day) and spent between ½ hour and 7 ½ hours in the chair during each use.
>
> There was no specific plan regarding the use of the restraint chair or specific criteria that had to be met for the VA to be released. Information from staff persons and documentation was inconsistent as to whether the VA voluntarily or involuntarily sat in the restraint chair. However, information was consistent that the VA was not to be released for bathroom breaks, regardless of how long the VA was in the chair, and food was not to be given to the VA while s/he was in the chair.
>
> Given the VA was secured in the restraint chair for several hours, not released upon his/her request, not given breaks for food or to use the bathroom, and was left

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[63] Minnesota DHS, Office of Inspector General, Licensing Division, *Investigation Memorandum* at 4 (September 9, 2014). The Memorandum, which is attached as Appendix B is referenced below as "Investigation Memorandum."

> in the restraint chair for up to one hour after urinating on himself/herself; there was a preponderance of the evidence that the VA was involuntarily and unreasonably confined to his/her restraint chair which was not therapeutic conduct and would reasonably be expected to cause the VA emotional distress.[64]

K[redacted] H. was also neglected, DHS Licensing concluded:

> In May 2014, there were five occasions when the VA was administered Benadryl while in the restraint chair. Benadryl was prescribed on an as needed basis to treat insomnia. In July 2014, the VA was administered an as needed medication but the facility had no record of what medication was given which was a violation of Minnesota Statutes, section 245D.05, subdivision 2, paragraph (c).
>
> Administering an insomnia medication to the VA without a plan while the VA was in the restraint chair was a violation of Minnesota Statues, section 245D.06, subdivision 5. In addition, it would reasonably be expected that a caregiver responsible for the health of the VA would administer an as needed medication only for its intended use unless directed otherwise by a physician. Therefore, there was a preponderance of the evidence that neglect of the VA occurred.[65]

On the same date, DHS Licensing fined the provider agency, Meridian Services, $2,000 with a recommendation regarding implementation of Ms. H's Positive Support Transitions Plans.[66]

The provider agency, Meridian Services, Inc., has appealed the licensing action, in part on the basis that DHS knew of, and approved, the use of the restraint chair for K[redacted] H.[67]

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[64] *Investigation Memorandum* at 4-5.

[65] *Investigation Memorandum* at 6.

[66] *Investigation Memorandum* at 7.

DHS Licensing did not know that the client, K[redacted] H., is a Jensen class member. The Court Monitor learned soon after the licensing citation that the offices within DHS responsible for compliance with the Court's orders had not provided DHS Licensing with the names of the class members or with an itemization and training in the Court's orders for consideration in investigations.

Given this lack of information, DHS Licensing did not evaluate (in K[redacted] H's case or in any others) whether and how to consider violation of the Court's orders in connection with investigations, whether on the merits or with regard to remedies such as fines and other action.

The provider agency had never been told that K[redacted] H. is a class member.

The Court Monitor has reviewed the situation with the assistance of an outside consultant whose report is Appendix C, attached hereto.[68]

The Court Monitor also finds:

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[67] Meridian Services, Inc., fully cooperated with the Court Monitor's inquiry, providing interviews and records, and full access to K[redacted] H. and her home.

[68] Ronnie Cohn, *Report to the Court Monitor: K[redacted][H.]* (October 9, 2014) (Cohn Report). Upon receipt of the licensing citation, and confirmation that K[redacted] H. is a class member, the Court Monitor began a multi-pronged investigation. He retained a consultant to visit Ms. H,'s home, meet her, review records and interview appropriate persons. He requested records regarding Ms. H.'s care and analyzed all the special Behavior Intervention Report Forms (BIRF) which Meridian had submitted to DHS documenting the use of the restraint chair with Ms. H. Finally, the Court Monitor required DHS to conduct a special project to identify all uses of mechanical restraint state-wide, including the types of restraint.

1. The MSHS-Cambridge facility ended the use of mechanical restraints under the December 5, 2011 Settlement Agreement. More recently, after the Court Monitor found that the Anoka Metro Regional Treatment Center was using restraint chairs on people with developmental disabilities, including class members, AMRTC eliminated the restraint chairs on their unit.
2. K[redacted] H. is [redacted] years old and has experienced 44 residential transfers before moving to the Meridian Services home on June 15, 2011. She lived for the longest continuous periods of time at METO/Cambridge/Anoka (1/1997 to 8/2002) and the Minnesota Security Hospital (8/2004 to 2/2010).[69]
3. K[redacted] H. has been in a restraint chair regularly, sometimes daily, on dozens of occasions for years. She is strapped into the metal-framed wheeled chair. *See* photos above following the blue-shaded summary. The duration of the restraint varies; it has occurred for 9 hours at a time. The chart on the next page shows dates along the vertical scale; the length of the bars shows the duration in hours.
4. After the licensing citation, and the initiation of the Court Monitor's inquiry, Ms. H.'s DHS CSS behavior analyst described the use of the restraint chair to the Court Monitor as "bad news." He had urged reduction and fading of the restraint chair, but had not required the provider agency to do so. The CEO of Meridian Services described the restraint chair use to the Court Monitor as "an outrageous thing."

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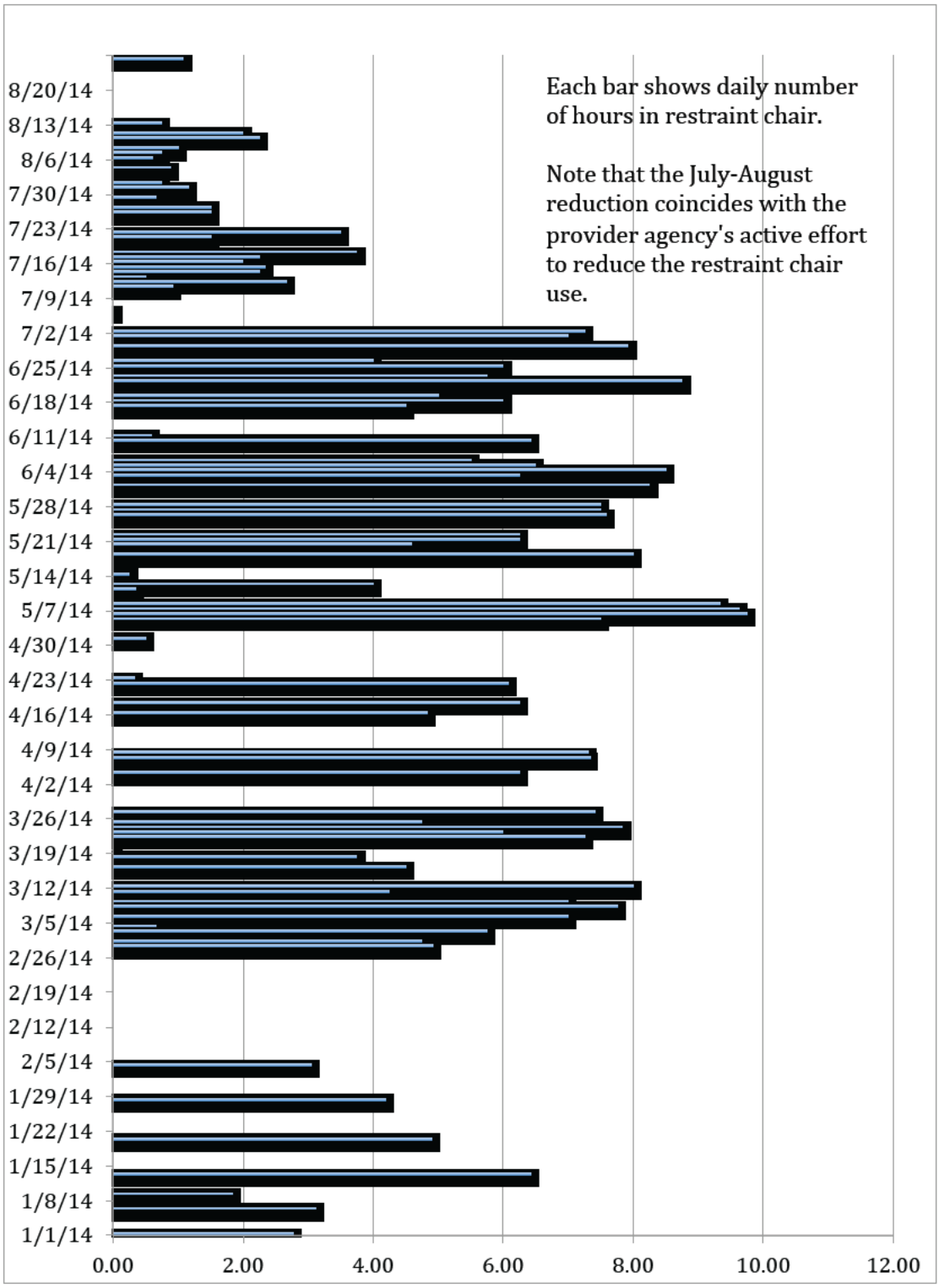
[69] At the Minnesota Security Hospital, K[redacted] H. received 37 Electroconvulsive Therapy, which were described as not very effective.

5. It is fair to say that, after the licensing citation, top management at DHS were appalled to learn the conditions and duration of the restraint chair use for K[redacted] H.
6. However, key offices within DHS with deep knowledge and responsibilities for implementation of the Court's orders knew of the restraint chair use for K[redacted] H. for years and either approved or took no action.
7. K[redacted] H. is one of the 75 individuals whom DHS had been identified under the Settlement Agreement (CPA EC 69) for intensive monitoring and, if needed, intervention with additional supports and services.

DAILY HOURS IN RESTRAINT CHAIR: January 2014 to August 2014



8. The restraint chair use on Ms. H. reportedly began in 2002. CSS has been involved with Ms. H. for at least 10 years, beginning with her transition from a group home to the Security Hospital in 2004 and continuing at her current home. The same CSS behavior analyst has provided supports to her throughout this time and her county case manager has known her for fifteen years.
9. When K[redacted] H. moved to its group home, Meridian Services, the provider agency, was told that K[redacted] H. needed to continue to use the restraint chair. Meridian regularly reported the restraint chair use to DHS through DHS' CSS unit and otherwise. Meridian's reports to DHS include the extent of K[redacted] H.'s restraint chair use, total hours for the quarter was well as monthly averages. Meridian also reported the restraint chair use to DHS through the Behavior Intervention Report Forms (BIRF), beginning January 1, 2014. On many of the BIRF forms for Ms. H., Meridian checked off the BIRF statement to DHS that professional consultation was needed to address the client's needs. *None was provided by DHS*.
10. Except for one inquiry in 2013 over the three years Ms. H. has been with Meridian, Meridian states that DHS never questioned the use of the restraint chair for K[redacted] H. DHS did not follow up on Meridian's response to the single inquiry.
11. Despite Meridian's diligent reporting to DHS, the Monitor's consultant found that "DHS and CSS revealed a lack of awareness of the extent of K[redacted]H's current use of the

restraint chair."[70]

12. K[redacted] H. has a history of ingesting inedible items, self-injury and aggressive behavior. The restraint chair, however, is most often not invoked for behavior control when K[redacted] H. takes these actions. Rather, almost all the provider BIRF reports state that the restraint chair is used upon K[redacted] H. rolling her eyes, saying she has racing thoughts, or feeling anxiety. However, the provider's Positive Support Transition Plan, January 30, 2014 does not state that the restraint chair is to be used when those symptoms are displayed. The Positive Support Transition Plan targets use of restraint chair for elimination, does not mention use of the restraint chair as a support/intervention at any time and states that

> By remaining consistently engaged in a daily schedule, receiving motivation in the form of a reinforcement program (token economy), engaging in a variety of social and leisure activities both in home and in the community, utilizing sensory calming activities (including proprioceptive exercise), K[redacted] may find diversion from upsetting mental states. Positive activities may also become so preferable to self-seclusion via mechanical restraints that they become a replacement.[71]

13. The provider agency's July 9, 2014 policy states, "the restraint chair is NOT to be used involuntarily." However, DHS Licensing found that some staff report that the chair is sometimes used involuntarily.

14. To Meridian's credit, Ms. H. has significant community integration and, with the support of the CSS behavior analyst,

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[70] *Cohn Report* at 6.

[71] *Positive Support Transition Plan*, January 30, 2014 at 3.

Meridian began an effort this past July to reduce K[redacted] H.'s restraint chair use.

15. K[redacted] H. has had success in he community. She is now developing relationships, going to a supported job, and looking forward to going to new places."[72] The county case manager sees her now as "so much better than ever before and happy for the first time."[73]

16. After the licensing citation and the initiation of the Court Monitor's inquiry, CSS moved to advise Meridian Services "to make the use of the restraint chair irrelevant/ineffective" through "increasing her enjoyment of and integration into her community," providing other items to meet her sensory needs, and increasing use of a standard recliner chair.[74]

There is nobody, and no agency or office, which has acted with accountability for the continued restraint chair use. The CEO of Meridian Services has expressed frustration to the Court Monitor, remarking that "we are caught in the crossfire." The Monitor notes that, while CSS "observes" and reports on clients, it does not seemed to be charged to correct objectionable situations which may arise.

On the "disconnects" among the entities involved, the Court Monitor adopts the consultant's detailed analysis:

> There appear to be "disconnects" among the agencies and departments which provide services and supports to K[redacted]H, including CSS, Licensing, other DHS units, the

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[72] *Cohn Report* at 8, citing Minnesota Life Bridge, *Assessment Report* (September 15, 2014).

[73] *Cohn Report* at 8.

[74] DHS, Community Support Services, *CSS' Service Summary for 2004-2014*, generated on September 18, 2014.

> county, Meridian. For example, everyone directly involved with K[redacted] and her team was reportedly either directly aware or informed of the extent of K[redacted]H's use of the restraint chair through either observations or routine reports provided to them. However, there is no evidence of any objections to either the plans developed for K[redacted]H or Meridian's implementation of these plans until after a full investigation was initiated by DHS in response to a few specific concerns. The significant differences between the findings of the DHS investigation described herein and the content of Meridian's appeal of DHS's determination illustrate this problem, which appears likely to be more widespread than just between this one provider and external agencies or even within a particular agency that houses many departments. While everyone involved with K[redacted]H undoubtedly regards her best interests as the highest priority, the absence of timely and positive communication prior to the investigation in this situation absolutely hinders cooperative efforts toward a common goal.

The final words of the consultant bear repeating: "the absence of timely and positive communication . . . absolutely hinders cooperative efforts toward a common goal."

V. Recommendations

These recommendations are respectfully submitted in the context of the Court's Order of September 3, 2014 at 11-14 (Dkt. 340) directing the Court Monitor to "make findings of compliance" including "recommendations that will facilitate the goals and objectives of the Court's Orders, including recommendations for contempt, sanctions, fines or additional relief." *Id.* at 11 (oversight and supervision functions are also set forth at 12-14).

The Court will recall that the Monitor's June 20, 2014 Community Compliance Review ("Review") urged "robust remedial action" and stated that "such remedies would *appropriately be founded upon orders of the court providing additional relief*." (Review at 38.) (emphasis added). As stated above, the Court's order on the Review directed the Monitor to bring forward recommendations including for additional relief. The Monitor urged that the "remedy should entail:

- a zealous initiative with focused committed leadership;
- an integrated, coordinated, state-wide training and implementation effort;
- a program focused on prompt urgent action;
- accountability and monitoring are key."[75]

The Department of Human Services, to its credit, has responded in part to these propositions, but has not yet brought focus and accountability, and urgent action, to bring this litigation to an end by achieving sustained and substantial compliance.

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[75] Community Compliance Review at 38-39.

The first two recommendations below address the situations of A[redacted] L. and K[redacted] H. The remedy will benefit them. Of equal importance, implementation of these recommendations will provide a replicable model for how DHS and counties can bring resources to bear for other clients who need extensive supports under the Court's orders.

DHS reported that A[redacted] L. "transitioned to the community." He did not. He left a large institution to move to a very small institution. With regard to A[redacted] L., non-compliance has been found twice before, and DHS has failed to fulfill its promise (in its reports to the Court) to take remedial steps. Pursuant to the September 3, 2014 Order, sanctions are appropriate. Whether they are immediate or contingent on compliance, is submitted to the Court's decision.

Recommendation 3 is for enhanced community oversight and accountability. Currently, that function is scattered among several offices within DHS; it is too often the case that they communicate inadequately or untimely. There is no single locus of responsibility and authority for providers, clients and family. Compliance would best be served by addressing these issues organizationally.

A Training Consortium is the fourth recommendation. DHS in accepting the Rule 40 Advisory Committee report spoke to the need to change the "culture" in order to implement the Committee's recommendations. State-wide, DHS, the counties and the providers need to be "on the same page" and to have a common vision and base of experience. A training consortium which continues after the Court's oversight ends will assist in maintaining the clients' quality of life contemplated by the Court's orders.

The final recommendation is to enhance the staffing of the Jensen Implementation Office (JIO) to address specific client and provider situations which raise concerns at the compliance level

(rather than simply individual clinical considerations. In the Monitor's opinion, experience since the Comprehensive Plan of Action was adopted has taught that the minimum of four professional staff is insufficient. The JIO director needs staff whom she may deploy as trouble-shooters to gather information and to respond, especially to urgent and unexpected situations.

Recommendation 1: A[redacted] L.

For A[redacted] L., DHS shall secure additional expertise, including expertise external to DHS and approved by the Court Monitor,[76] to develop an age-appropriate, community based, person-centered vision that includes positive behavior supports in which A[redacted] L. is a contributing member of his chosen community and lives in a new location in the "most integrated setting." This plan shall be written by December 1, 2014, and fully implemented within three months thereafter. Beginning immediately, DHS shall implement changes consistent with the Court's orders at A[redacted] L.'s current residence.

Pursuant to the Court's Order of September 3, 2014 at ¶5, the Court Monitor recommends that, should DHS fail to timely comply with the requirements of the preceding paragraph, the Court consider imposition of monetary and/or other sanctions, or impose sanctions now.[77]

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[76] This element of the recommendation echoes that in the ICI Report, which stated, "Despite his ongoing social isolation, disengagement and lack of progress in behavioral change, his team has not sought outside help with continued clinical assessment to understand the roots of his aggression, his disengagement, and what might be motivating him." *ICI Report* at 26.

[77] The Court Monitor finds that the actions under this recommendation satisfy in all respects the requirements of the Order of September 3, 2014 at ¶5. The recommendation necessary to achieve

Recommendation 2: K H.

For K H., DHS shall secure additional expertise, including expertise external to DHS and approved by the Court Monitor, to (a) discontinue the use of the restraint chair as soon as possible based upon best practices, and (b) develop an age-appropriate, community based, person-centered vision that includes positive behavior supports in which K H. is a contributing member of her chosen community and a plan for its achievement and implementation by December 1, 2014.

Recommendation 3:
Enhanced Community Oversight & Accountability

DHS shall immediately develop an enhanced community oversight and accountability function with, sufficient staff, state-wide coverage, and high level expertise in Positive Behavior Supports and Person Centered Thinking and Planning, and compliance with the Court's orders, to (a) provide resources and assistance to community-based providers and clients as needed or upon request, (b) have the authority to give direction to counties and providers with regard to supporting clients, and (c) recommend sanctions and enforcement action for practice that is not consistent with best practices or under the Court's orders, and (d) serve as a single point of accountability and communication on a client-specific and provider-specific basis. This

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compliance with an outstanding obligation under the Court's orders, for example, the Settlement Provision specifically benefiting the individuals moved from Minnesota Security Hospital under the standard set forth in that provision. *See* the sequence of events in the above discussion of A L.

high level expertise shall be secured via external consultants, approved by the Court Monitor, from time to time and where necessary.[78]

Recommendation 4: Training Consortium

DHS shall immediately create and support a training consortium charged with developing a comprehensive, coordinated, statewide training plan to include all levels of training but especially applied subjects such as creating "home," eliminating the use of mechanical restraints and other aversive devices and practices, valued social roles, customized employment and other topics, especially topics nominated by direct care providers, consumers and families.. A training consortium is a means to recruit relevant expertise within and external to the state and to coordinate a large statewide training initiative.[79] Such a training consortium will include, at a minimum, the DHS, the University of Minnesota, Institute on Community Integration, the Governor's Council on Developmental Disabilities, the Ombudsman for Mental Health and Developmental Disabilities,

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[78] The Court Monitor does not specify here whether this function may be performed through existing or new mechanisms, or DHS offices. What is essential is that there be a single, central clearinghouse and action vehicle so that all of DHS' "hands" know what its "other hands" are doing with regard to client- and provider-specific situations. This function is quite different from that of the *Jensen* Implementation Office.

[79] This recommendation is an outgrowth of a recommendation from the Court Monitor's *Community Compliance Review* that called for "an integrated, state-wide training and implementation effort."

DHS is currently, and on an urgent basis, implementing "Phase One" of a state-wide training plan. The Monitor's recommendation is complementary and not critical of that plan. Rather, this recommendation should be considered as a further, and overlapping, training effort which – if sustained – will assist the Department in achieving the culture change which the Department has espoused.

consumers, families, advocates, large and small service providers. The training consortium will include a leadership development component where young leaders are mentored and supported to develop skills to be used in the state.

Recommendation 5: JIO "Trouble Shooter" Staff

The Jensen Implementation Office shall be enhanced with additional staff to address specific client and provider situations which raise concerns at the compliance level (rather than simply individual clinical considerations), compliance concerns, and under the leadership of the JIO director, to act proactively, rather than reactively, to anticipate such concerns. The number of additional staff will be determined in consultation with the Court Monitor.

VI. CONCLUSION

This report is respectfully submitted to this Honorable Court for its consideration.

Respectfully submitted,

David Ferleger
Court Monitor

October 17, 2014

APPENDIX A

December 2013 Activity List

date	time	# people	type	note	staff
12/3/13	9:00 AM		Cleaning Chor	cleaned bathroom and did laundry	Sam
12/5/13	10:15am		Cleaning Chor	Cleaned is bedroom and did memoves	Clarissa
12/5/13	2:00pm		Socializing	Talked with Shawn	Bernie
~~12/5/13~~	~~6:00pm~~	~~"1/1"~~	~~TV~~	~~Guiness Book of World Records~~	~~Bernie~~
12/5/13	7:00pm	"1/1"	TV	Full House	Bernie
12/6/13	12:30pm			allowed full set of vital signs	Bernie
12/7/13	1pm		TV	Watched TV	Priscilla
12/7/13	6:00pm		TV	Watched the brady bunch movie	Sam
12/8/13	7pm		TV	Watched Amazing Race	Dave
12/10/13	10-11am			cleaned his room, did Move moves	Dave
12/10/13	11am			Did laundry	Dave
12/11/13	6:30-9		TV	watched tv in his area	Dave
12/12/13	4pm			Andy cleaned his room, Staff put up Christmas lights in his room	Dave
12/12/13	6:30-9pm		TV	watched tv in his area	Dave
12/13/13	10am-12pm		TV	watched tv in his area	Bernie
12/13/13	6:30-7pm		TV	watched tv in his area	Dave
12/13/13	7-9pm			watched a movie in his room	Dave
12/14/13	10am-12pm		TV	watched tv in his area	Bernie
12/14/13	6:30 AM		TV	watched tv in his area	Sam
12/15/13	7-10pm		TV	watched tv in his area	Mike
12/16/13	1pm		TV	watched tv in his area	Dave
12/17/13	9am			Psych appt via vidyo	Bernie
12/17/13	10-11am		Cleaning Chor	laundry, cleaned bathroom	Bernie
12/17/13	3:15pm			calendar planned	Bernie
12/17/13	4:30-5:10pm			laid on his bathroom floor	Bernie
12/17/13	3:30-8:30pm		TV	watched tv in his area	Sonja
12/19/13	10:30am		TV	watched tv in his area	Clarissa
12/19/13	11am		Cleaning Chor	Cleaned his room and did me moves	Clarissa
12/19/13	6:30-9		TV	watched tv in his area	Dave
12/20/13	2pm		phone calls	vidyo chat with his dad	Bernie
12/20/13	6pm	community grou	Socializing	Christmas Bingo- 4 games	Bernie
12/20/13	7-10pm			movie in his room	Bernie
12/21/13	1pm			Andy did his baking	Dave

January 2014

date	time	# people	type	note	staff
1/8/14	10-noon		TV	watched TV in his area	Priscilla
1/8/14	noon			Staff cut fingernaiols. Hit staff after clipping a couple of nails	Priscilla
1/10/14	10:30 AM		Socializing	watched TV in his area	Dave
1/11/14	2-4pm		Socializing	watched TV in his area	Dave
1/14/14	2-4 pm		Socializing	watched TV in his area	Dave
~~1/15/14~~	~~10:45am~~		~~Socializing~~	~~watched TV in his area~~	~~Clarissa~~
1/16/13	10 -11am		Cleaning Chon	Cleaned room and watched TV in his area	Bernie
1/16/14	6p-9p		Socializing	watched TV in his area	Sara
1/17/14	6:30p-7p		Socializing	watched TV in his area	Mike
1/18/14	10am		Socializing	Shower	Priscilla
1/18/14	10:30am		Socializing	me moves	Priscilla
1/18/14	1:00pm		Socializing	Baking	Bernie
1/18/14	2:00pm		Socializing	watched TV in his area	Priscilla
1/20/14	10:30 AM		Socializing	Shower	Bernie
1/21/14	10-10:45am		Socializing	Shower, laundry and Life moves	Dave
1/21/14	4:30p-10p			Video games and movies in his room	Bernie
1/23/14	10:20am		Socializing	Did me moves in his area	Clarissa
1/24/14	2:15pm		Socializing	Talked to BA3 - recovery plan and calendar	Chad
1/24/14	2:45pm			Clipped his own nails	Chad
1/24/14	7-10pm			watched a movie in his room	Dave
1/31/14	7-10pm			watched movie in his room	Dave

A[redacted] 2/2014

2/3/14	7-10pm			played video games and watched movies in his room	Dave
2/4/14	10:30am		Cleaning Chor	cleaned bathroom, did laundry, & did life moves with staff	
2/4/14	7-10pm			video games and watched movies in hus room	Dave
2/5/14	6:30-9		TV	Watched TV in his area	Clarissa
2/6/14	10am		TV	Watched TV in his area	Clarissa
2/6/14	6:30-9pm		TV	Watched TV in his area	Dave
2/7/14	10am		TV	Watched TV in his area	Clarissa
2/7/14	6:30pm		TV	Watched TV in his area	Clarissa
2/8/14	2-4pm		TV	Watched TV in his area	Dave
2/8/14	7-9pm			played video games and watched movies in his room	Dave
2/9/14	7:30pm		outdoors	Walked outside	Clarissa
2/10/14	5:20pm		outdoors	Walked outside	Clarissa
2/10/14	7pm		TV	Watched TV in his area	Clarissa
2/11/14	10am		Cleaning Chor	cleaned bathroom, did laundry, & completed life moves	Bernie
2/11/14	5pm		outdoors	Walked outside	Dave
2/12/14	5pm		outdoors	Walked outside	Dave
2/13/14	7:45pm		Socializing	Andy played catch with Staff	Dave
2/17/14	3pm-10pm			played video games and watched movies in his room	Bernie
2/20/14	3-4:30		Cleaning Chor	cleanded room and area	Bernie
2/21/14	6-10pm			watched movie/played video games in his room	Bernie
2/22/14	10:30am		TV	Did Life moves	Clarissa
2/22/14	2-4pm		TV	Watched TV in his area	Clarissa
2/22/14	7-8pm		TV	Watched TV in his area	Clarissa
2/23/14	2-5:15pm		TV	Watched TV in his area	Clarissa
2/25/14	10am		Cleaning Chor	laundry, cleaned bathroom, me-moves	Bernie
2/25/14	7-9:30pm		TV	Watched TV in his area	Clarissa
2/26/14	7-9pm		TV	Watched tv in his area	Bernie
2/27/14	10am			cleanded room and area	Bernie
2/27/14	1pm			Went to his eye appointment/got pop	Bernie
2/27/14	6:30-9pm		TV	Watched TV in his area	Clarissa

[redacted]'s March Activity Log

date	time	# people	type	note	cost	staff
3/1/14	1pm		Baking			Bernie
~~3/1/14~~	~~2pm~~		~~Watching TV in his area~~			~~Bernie~~
3/2/14	6-9pm		Watching TV in his area			Sam
3/4/14	7-9pm		Watching TV in his area			Bernie
3/5/14	7-9pm		Watching TV in his area			Sonja
3/6/14	9:45am		Put his blanket and sheet in laundry			Sam
3/6/14	7-10pm		Watching TV in his area			Clarissa
3/7/14	1pm		Watching TV in his area			Sonja
3/7/14	7-9pm		watched a movie in his room			Dave
3/8/14	10:30am		Did Life Moves in his area			Dave
3/8/14	1pm		Baking			Dave
3/8/14	1:45pm		outdoors Walked outside			Dave
3/8/14	2-2:30pm		Watching TV			Dave
3/9/14	3-8pm		watching tv			Dave
3/9/14	8-10pm		watching movies in his room			Dave
3/10/14	6pm		outdoors walked outside			Sonja

3/11/14	10:15am	Did Life Moves in his area	Clarissa
3/12/14	4pm	walked and played outside	Dave
3/12/14	7-8pm	watched tv	Dave
~~3/14/14~~	~~7-9pm~~	~~watched movie in his room~~	~~Dave~~
3/15/14	11-3pm	watched TV from his area	Bernie
3/15/14	1:30pm	outdoors played in the snow	Bernie
3/16/14	2-7pm	watched TV from his area	Bernie
3/16/14	5pm	outside playing in the snow	Sonja
3/17/14	2pm	had video chat with pyschiatrist	Sonja
3/18/14	6:00pm	played in the snow	Sonja
3/19/14	3-5:30	played video games in his room	Bernie
3/19/14	12:00 AM	watched Survivor in his area	Bernie
3/20/14	10:30 AM	Cleaning ChoresCleaned his room	Sam
3/20/14	10:45AM	Watched exercise DVD in his area	Sam
3/20/14	6-10pm	Watched TV in his area	Clarissa
3/21/14	1pm	Andy got his hair cut	Clarissa
3/22/14	1pm	Andy did his baking	Clarissa
3/22/14	2pm	Andy watched tv in his area	Clarissa

3/22/14	4-6pm	Watched TV in his area	Sam
3/23/2014	11:45am	Bible reading with staff	Bernie
3/24/2014	12:30-2:30pm	played video games in his room	Bernie
~~3/25/2014~~	~~10am~~	~~Cleaned his bathroom~~	~~Bernie~~
3/25/14	10:15am	Completed Life Moves	Bernie
3/25/14	10:30am	started his laundry.	Bernie
3/25/14	1pm-5:30p	played video games in his room	Bernie
3/25/14	6:30 AM	Watched Wheel of Fortune in his area	Bernie
3/25/14	7-10pm	played video games and watched a movie in his room	Bernie
3/26/2014	10:30-12:30pm	played video games in his room	Bernie
3/27/14	3pm-3:35pm	Visit with Dad	Dave
3/27/14	6-10pm	Watched TV in his area	Clarissa
3/28/14	6-7pm	watched TV from his area	Bernie
3/28/14	7-10pm	watched a movie in his room	Bernie
3/29/14	2pm	watched Dog Eat Dog from his area	Bernie
3/29/14	7-9pm	Watched TV in his area	Bernie
3/30/14	11:30am	Devotions reading with staff	
3/30/14	7pm	Watched TV in his area	Bernie

3/31/14	6:30-10pm	TV	Watched TV in his area	Sam

A [redacted] April 2014

4/2/14	4pm-5:30pm			Watched DVD in his room		Bernie
4/2/14	6:30-9pm		TV	watched TV in his area		Bernie
4/3/14	6:30-9pm			watched TV in his area		Dave
4/5/14	2-3pm		TV	watched TV in his area		Clarissa
4/5/14	4:30pm			threw stuffed animals in his area		Dave
4/10/14	2pm		Socializing	Did his journal reading with BA3		Dave
4/10/14	6:30-9:30p		TV	watched TV in his area		Clarissa
4/11/14	6:30-10pm			TV and movie watching		Bernie
4/12/14	1:00pm		Socializing	Andy completed his baking with staff assistance		Sonja
4/12/14	2pm		phone calls	Watched Dog Eat Dog from his area		Bernie
4/12/14	3:30p			Video games in his room		Bernie
4/13/14	7pm			watched TV in his area		Dave
4/14/14	6:30-10pm		TV	watched Tv in his area		Bernie
4/15/14	10-10:30		Cleaning Chores	cleaned bathroom, mattress, washed laundry/Me Moves		Bernie
4/16/14	2:15pm		outdoors	Andy went to DR apt		Bernie
4/17/14	10:30 AM		Cleaning Chores	did me moves and then cleaned his room		Clarissa
4/17/14	6:30-9		TV	watched TV in his area		Clarissa
4.18.14	6:30-7		TV	watched TV in his area		Bernie
4/18/14	7-8pm			watched a movie in his room		Bernie
4/18/14	8-10pm			played video games in his room		Bernie
4/19/14	1pm	"1/1"	Socializing	Baking activity with staff		Sonja
4/19/14	2-4:30p		TV	watched TV in his area		Bernie
4/19/14	6:30-10pm		TV	watched TV in his area		Bernie
4/19/14	7:30p		phone calls	left messages w/ mom, dad and cousin-mom called @ 8:30p		Sonja
4/20/14	10:30am	"1/1"		Devotional reading with staff		Bernie
4/20/14	6pm		TV	Charlie Brown Easter Special in his area		Bernie
4/20/14	7-9pm		Socializing	Bingo, Easter egg hunt, visiting with staff		Bernie
4/23/14	10:30am			Andy did Me Moves		Dave
4/28/14	6:30pm		TV	TV in his area		Dave
4/29/14	10am		Cleaning Chores	cleaned bathroom, mattress, washed laundry/Me Moves		Bernie
4/30/14	1-5pm			played video games in his room		Bernie
4/30/14	7pm		TV	watched TV in his area		Bernie

A [redacted] May 2014

5/1/14	10:30am		[redacted]	Cleaned his area; declined cleaning his room	Bernie
5/1/14	1-6-5pm			Played video games in his room	Bernie
5/1/14	6:30-9pm		TV	Watched TV in his area	Bernie
5/2/14	7-9pm		TV	watched a movie in his room	Dave
5/3/14	4:30pm		outdoors	walked outside	Dave
5/3/14	1-4pm		TV	Watched TV in his area	Dave
5/3/14	7-10pm		TV	Watched TV in his area	Dave
5/4/14	4:30pm			walked outside	Bernie
5/4/14	2-4:30p		TV	Watched TV in his area	Bernie
5/5/14	11:30am			Devotion reading	Bernie
5/5/14	6:30-9pm		TV	Walked outside	Dave
5/7/14	4:30pm			Walked outside and threw/kicked a ball in the yard	Bernie
5/8/14	4-5:45pm			video games in his room	Bernie
5/8/14	6-10pm			DVDs in his room	Bernie
5/10/14	6:30-10p		TV	TV in his area	Chad
5/11/14	11:30 AM	"1/1"		Devotion reading	Bernie
5/12/14	6:30 AM		TV	Watched TV in his area	mike
5/13/14	:30-11:30am			Me Moves, cleaned bathroom, started laundry	Sonja
5/13/14	2:30pm			Calendar planning and turned in menu	Bernie
5/14/14	5pm			Walked outside and threw/kicked a ball in the yard	Sonja
5/15/14	10;30AM			Me Moves, cleaned bedroom, refused to clean his area	Bernie
5/15/14	6:30-9pm			Watched TV in his area	Clarissa
5/17/14	2-5pm			Watched TV in his area	Bernie
5/17/14	7-10pm			TV in his area then movie and games in his room	Bernie
5/18/14	7-9pm			TV in his area	Bernie
5/20/14	10:45am			Life Moves in his area	Bernie
5/20/14	11:45am		Cleaning Chor	Cleaned his bathroom	Bernie
5/20/14	11am		Cleaning Chor	Laundry	Bernie
5/20/14	2pm	"1/1"	Socializing	Calendar planning and turned in menu	Bernie
5/20/14	6:30pm		TV	Watched TV in his area	Melisa
5/21/14	6:30pm	"1/1"	TV	Watched TV in his area for a couple minutes before aggressing	Bernie
5/22/14	7-10pm			Played video games in his room	Dave
5/23/14	7-10pm			watched a movie in his room	Dave
5/25/14	1-4pm			Movie and video games in his room	Bernie
5/26/14	2-10pm			Movie and video games in his room	Dave
5/27/14	1pm	"1/1"		Recovery plan and therapy with CRS	Dave
5/29/2014	10:30am			cleaned his area and vaccumed his rug and floor	Dave
5/30/2014	7pm			Movie and video games in his room	Priscilla
5/31/2014	2-6pm			Watched TV from his area	Bernie

June 2014

[redacted]	11:45am		Devotion reading with staff/church				Dee	
6/1/14	7-9p	"1/1"	Watched The Bachelorette				Priscilla	
6/1/14	7-9p	"1/1"	Watched The Bachelorette	TV			Sonja	
6/2/14	10:30a		Cleaned/mopped bathroom - laundry				Sonja	
6/3/14	3pm		Calendar planning and turn in meal/baking list				Dee	
6/4/14	11am		Math worksheets				Dee	
6/5/14	7-10p	"1/1"	Socializing	White watching TV- House			Priscilla	
6/6/14	6:30-8:30p			Watched Fear Factor	TV		Dee	
6/6/14	8:30-10p			Watched a movie in his room			Dee	
6/7/14	1pm			Andy did his bathing activity			Bernie	
6/7/14	4:30pm			Andy walked outside			Dee	
6/7/14	6-10pm			Andy watched TV in his area	TV		Dee	
6/7/14	9pm-12:30am			Watched a movie in his room	TV		Bernie	
6/8/14	12:30am			Tossing stuffed toys in his room			Bernie	
6/8/14	11:30am			Devotion reading with staff/church			Bernie	
6/8/14	7pm			he watched tv in his area			Chelsea	
6/9/14	12:00 PM			Devotion reading with staff/church			Mike	
6/9/14	3pm			Andy walked outside			Dee	
6/9/14	7-9pm			watched TV in his area			Dee	
6/10/14	10am		Cleaning Chet	Started his laundry and cleaned his bathroom			Mike	
6/10/14	10:15am			Did Like Moses in his area			Mike	
6/10/14	1pm		Socializing	Calendar planning and turn in meal/baking list			Mike	
6/11/14	11am			Did his math sheets			Mike	
6/11/14	7-10pm			watched TV in his area			Dee	
6/13/14	7pm-9pm			Watched Fear Factor then his area			Priscilla	
6/14/14	10:30am			Did "No Noses" in his area			Chelsea	
6/14/14	1pm		Socializing	Did his bathing in common area			Mike	
6/16/14	11:30am	"1/1"		devotion reading and math problems with staff			Bernie	
6/16/14	7-10pm		TV	watched TV in his area			Chelsea	
6/17/14	10:30am			Did his laundry and washed his stuffed animals			Chelsea	
6/17/14	3:30p-10pm		TV	watched TV in his area			Sam	
6/18/14	6:30-9pm			watched TV in his area			Bernie	
6/18/14	11a-12		Socializing	talked with parents			Mike	
6/20/14	2:30-3:30pm			Video games in his room			Bernie	
6/21/14	10:30am			Did his moves in his area			Bernie	
6/21/14	1pm			Batting with staff			Chelsea	
6/21/2014	1-6pm		TV	Watched TV from his area			Bernie	
6/21/2014	6:30-10pm			TV and video games in his room			Bernie	
6/22/2014	11:30am			Devotion reading with staff/church			Bernie	
6/23/14	6p		outdoors	Relaxed Outside			Priscilla	
6/24/14	3:30-6p		TV	watched TV in his area			Chelsea	
6/24/14	6:30-10pm		TV	watched TV in his area			Mike	
6/25/14	6:30-10pm		TV	watched TV in his area			Chelsea	
6/26/14	3pm			snack outside and went on the swing, threw water balloon				
6/26/14	6:30-9pm		TV	watched TV in his area			Priscilla	
6/27/14	4p		Socializing	Had his hair cut			Priscilla	
6/27/14	6:30p-7p		TV	watched TV in his area			Priscilla	
6/27/14	7p-8p			watched a movie in his room			Priscilla	
6/28/14	10:30am			Did his moves in his area			Dee	
6/28/14	2-6pm			watched TV in his area			Dee	
6/28/14	6pm			eat outside on swing			Dee	
6/28/14	6-9pm			played video games and watched a movie in room			Dee	
6/29/14	7-9pm			watched TV in his area			Dee	
6/30/14	6pm			eat outside on swing, splashed			Bernie	
6/30/14	6:30-9pm		TV	watched TV in his area			Bernie	

			Cleaning Chore	Laundry, cleaned bathroom, Me-Moves					Bernie
7/1/14	10a-11am			Laundry, cleaned bathroom, Me-Moves					Bernie
7/1/14	2pm	"1/1"		Waited with CRS					Bernie
7/1/14	6:30pm-9		TV	watched TV in his area					Dave
7/2/14	1-2pm			cleaned his inventory, threw some stuff out					Priscilla
7/2/14	6:30-9pm		TV	watched TV in his area					Dave
7/3/14	6:30-9pm		TV	watched TV in his area					Dave
7/3/14	3pm			had snack outside on swing					Dave
7/4/14	6:30-10pm		TV	Watched Fireworks in his area					Clarissa
7/5/14	10am			life moves in his area					Dave
7/5/14	1pm			Andy did his Baking					Bernie
7/7/14	6:30pm-9		TV	Andy watched TV in his area					Clarissa
7/10/14	11:30am			Completed Me Moves/clean his room					Dave
7/10/14	2pm	"1/1"		Walked with CRS and reviewed journal					Sonja
7/11/14	7pm			watched movie 'Shark Tale' in his room					Priscilla
7/12/14	10:30am			life moves in his area					Dave
7/12/14	7-9pm			played video games in his room					Dave
7/14/14	6:30-9pm		TV	watched TV in his area					Dave
7/16/14	7-9pm		TV	watched TV in his area					Mike
7/17/14	3:30pm			walked outside and threw some water balloons					Clarissa
7/17/14	7-9pm		TV	watched TV in his area					Sonja
7/18/14	12:30pm			Andy had a lesson on his I-pad					Mike
7/19/14	4:45pm			walked outside					Priscilla
7/20/14	7pm-9pm		TV	watched TV in his area					Clarissa
7/21/14	7-9pm		TV	watched TV in his area					Bernie
7/22/14	7-9pm		TV	watched TV in his area					Dave
7/23/14	7-9pm		TV	watched TV in his area					Dave
7/24/14	10am-11am			Andy did life moves and cleaned his bedroom					Dave
7/24/14	7pm-9pm		TV	watched TV in his area					Clarissa
7/24/14	1pm			Got Ipad to get watch Fear Factor in his room					Clarissa
7/25/14	1-5:45pm			Ipad in his room; games in his room					Bernie
7/25/14	6-10pm		TV	I pad and TV watching in his room					Bernie
7/26/14	10am			Life moves in his area					Clarissa
7/26/14	1pm			Andy did his Baking					Clarissa
7/26/14	1:30pm-			watched TV from his area and played on his Ipad					Clarissa
7/27/2014	11:45am			Devotion reading with staff					Bernie
7/27/2014	7-10pm		TV	watched TV in his area					Bernie
7/28/14	11:50 AM			Completed his devotion with staff					Bernie
7/28/14	6:30-9pm		TV	watched TV in his area					Dave
7/29/14	10:15am			completed life moves					Dave
7/29/14	12:00pm			Did Laundry					Dave
7/29/14	6:30pm-9			Spent time watching TV and playing on his Ipad					April
7/30/14	7-9pm			Playing on his I pad and watching tv on it					Dave
7/31/14	10:20am			Did life moves in his area					Clarissa
7/31/14	3-10pm			I-Pad and DVDs in his room					Bernie

8/18/14	8:45pm		Watched a movie in his room	Melisa
8/19/14	6:30pm		Watched TV in his area	Melisa
8/19/14	8:30pm		Played games in his room	Melisa
8/19/14	2:15pm		Meet with BA III	Melisa
8/20/14	6-6:30p		Andy swang on the swing outside	Clarissa
8/20/14	6:30-8p		Andy watched tv in his area	Clarissa
8/21/14	10:15am		Andy completed me moves	Melisa
8/21/14	10:30 AM		Andy cleaned his area	Melisa
8/21/14	8-9pm		Andy watched tv in his area	Priscilla
8/22/14	3-5:30pm		Played on I-Pad	Bernie
8/22/2014	7pm		played "stump the staff" then watched a movie in his room	Bernie
8/23/2014	1pm		baking with staff	Bernie
8/23/14	4:30 AM		Walked outside and sat on the swing	Melisa
8/24/14	11:30am		Devotion reading with staff	Bernie
8/25/14	6:30-8pm		Watched TV in his area	Clarissa
8/26/14	6:30-7pm		Watched TV in his area	Clarissa
8/27/14	6-10pm		watched I-pad in room	Dave
8/28/14	3pm		visit from his dad	Bernie
8/28/14	8-9pm		watched Big Brother in his area	Bernie
8/30/14	2:30pm		Walked outside and sat on the swing	Bernie
8/31/14	7-9pm		Watched TV in his area	April

A [redacted] August, 2014

8/2/14				watched I-pad in room		Dave
8/3/14	11:30am			Andy completed devotions with staff		Bernie
8/3/14	1p-10p			watched I-pad in room		Bernie
8/4/14	2pm			Met with CRS and BA3		Bernie
8/5/14	10am			Completed Me moves		Sonja
8/5/14	10:30am			Clean bathroom and did laundry		Sonja
8/5/14	2:05pm			Met with BA3		Sonja
8/5/14	7pm-9pm			Watched TV in his area		Clarissa
8/6/14	10am			Completed Me moves		Dave
8/6/14	1pm			Played on I-Pad		Dave
8/6/14	6:30pm			Watched TV in his area		Dave
8/7/14	8-10pm			Watched TV in his area		Clarissa
8/8/14	12:00 AM			Watched Ice Age in his room		Clarissa
8/10/14	12:00pm			Completed devotions		Bernie
8/10/14	7-10pm			Watched TV in his area		Bernie
8/13/14	2:30 AM			Walked		Bernie
8/13/14	6:30pm			Watched TV in his area		Bernie
8/14/14	10am			Andy completed his shower/memoves and cleaned his area		Bernie
8/14/14	7-9pm			Andy watched tv in his area		Clarissa
8/15/14	7-9pm			Andy watched a movie in his room		Dave
8/16/14	1pm			Andy completed baking with staff		Dave
8/16/14				Andy watched tv in his area		Clarissa
8/17/14	11:30am			Devotion reading with staff		Bernie
8/17/14	7-9pm			Watched TV in his area		Clarissa
8/18/14	12pm			Devotion reading with staff		Dave
8/18/14	2:30pm			Walked		Melisa
8/18/14	6:30pm			Watched TV in his area		Melisa

APPENDIX B

Minnesota Department of **Human Services**

INVESTIGATION MEMORANDUM
Office of Inspector General, Licensing Division
Public Information

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

Report Number: 20143062

Date Issued: September 9, 2014

Name and Address of Facility Investigated:

Disposition: Substantiated as to abuse and neglect of a vulnerable adult by the facility.

Meridian Colorado South
4600 Colorado Ave N
Crystal, MN 55422

Meridian Services
9400 Golden Valley Rd
Minneapolis, MN 55427

License Number and Program Type:

1068651-H_CRS (Home and Community Based Services-Community Residential Setting)
1068630-HCBS (Home and Community-Based Services)

Investigator:

Stephanie Payne
Minnesota Department of Human Services
Office of Inspector General
Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
(651) 431-6593

Suspected Maltreatment Reported:

Allegation One: It was reported that the facility used a restraint chair with a vulnerable adult (VA) for up to ten hours with no food or water breaks being offered.

Allegation Two: It was reported that facility staff persons administered the VA as needed medications while in the restraint chair as a form of behavior management.

Date of Incident(s): Ongoing and prior to July 14, 2014

Nature of Alleged Maltreatment Pursuant to Minnesota Statutes, section 626.557, subdivision 9c, paragraph (b), and Minnesota Statutes, section 626.5572, subdivision 15, and subdivision 2, paragraph (b), clauses (2) and (3); and subdivision 17, paragraph (a):

Conduct which is not an accident or therapeutic conduct which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to:

- the use of repeated or malicious oral, written or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening;

- the use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult; and

The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to food, clothing, shelter, health care, or supervision which is reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult and which is not the result of an accident or therapeutic conduct.

Summary of Findings:

Pertinent information was obtained during a site visit conducted on August 11, 2014; from documentation at the facility; and through interviews conducted with the VA, three supervisory staff persons (P1, P2, and P3), three staff persons (P4, P5, and P6), a case manager (CM) for the VA, and a guardian (G) for the VA.

The VA was diagnosed with mild intellectual disability, schizo-affective disorder, and borderline personality disorder. The VA enjoyed joke telling, playing cards, and beading.

The VA was the only consumer who the facility provided services for at the facility. The VA had full access to the main level of the facility except for the kitchen which was blocked by a locked half door. The VA required the supervision of three staff persons during day time hours and one awake staff person during night time hours.

Allegation One: It was reported that the facility used a restraint chair with the VA for up to ten hours with no food or water breaks being offered.

According to the VA's *Individual Service Plan*, the VA began the use of a restraint chair in 2002 and the use of the restraint chair followed the VA to all subsequent placements including the facility. The VA was admitted to the facility on June 15, 2011.

This investigator observed the restraint chair on June 13, 2014. The VA's restraint chair had a metal frame with plastic padding for the back, seat, and arms. The restraint chair had a footrest platform and was on wheels so it could be moved. The restraint chair had a cloth harness strap that went over both of the VA's shoulders, a waist strap, individual arm straps, and straps for the VA's feet. P1 stated that pressure was applied to tighten and loosen the straps.

P1 and P3 worked with the G, the CM, and other professionals in the field to develop a *Positive Support Transition Plan (PSTP)* that met the requirements of Minnesota Statues, Chapter 245D (Home and Community Based Services). Prior to the development of the *PSTP*, the VA had a R*ule 40 Plan.*

Regarding the documentation on the VA's restraint chair:

- The VA's *PSTP* implemented on January 30, 2014, listed mechanical and manual restraints as interventions targeted for "elimination." The VA's target behaviors were listed as: self-injury, aggression toward others, and requests for mechanical restraint. De-escalation techniques, sensory therapies, community integration, and daily structure were listed as the ways to eliminate the need for the restraints. The VA relied on the restraint chair as a "primary coping mechanism." The plan listed "calm/idea," "triggers," "escalation," "crisis," and "recovery" as the different phases that the VA might go through. During the "crisis" phase, staff persons were instructed to "physically intervene" which might include the following: blocking, guiding, turning, or the performance of a multi-person manual restraint. There was no description of the mechanical restraint, when the restraint should be used, or when the VA would be released listed in the plan.

- The VA's *Four Stage Crisis Plan* which was undated still referenced the VA's former *Rule 40 Plan* and listed "optimal function," "warning signs," "crisis," and "resolution" as the different phases that the VA might go through. Staff persons were instructed to "allow" the VA to enter his/her restraint chair during the "warning signs" phase, and "guide" the VA to the restraint chair or use a manual restraint during the "crisis" phase.

- The VA's *Risk Management Assessment and Plan* started on July 17, 2014, instructed staff persons to refer to the VA's *PSTP*, *Four Stage Crisis Plan*, and *Behavior Management Policy* in regards to the VA's behaviors.

- The VA's *Person Centered Outcome Plan* started on July 16, 2014, *Site Specifics*, and *Consumer Specific Form* provided redirection and therapeutic techniques that were to be used with the VA but did not mention the use of mechanical or manual restraints with the VA.

- None of the above documents described how to use the mechanical restraint, when the mechanical restraint should be used with the VA, how long the VA could remain in the restraint, what criteria the VA needed to meet to be released from the restraint, or what should be implemented to prevent the use of a restraint chair.

Regarding the use of the VA's restraint chair:

- Staff persons documented the use of mechanical restraints with the VA in the VA's *Rule 40 Log.* The *Rule 40 Log* had columns for: date, behaviors leading to use, voluntary or involuntary use, time, attempted release attempts, total duration of the restraint, and staff initials.

- According to the VA's *Progress Review* between July 2013, and June 2014, the VA used the restraint chair an average of 15 days each month, spent between 82 and 157.25 hours in the restraint chair each month, and spent between 5.5 and 6.9 hours in the chair at a time.

- The VA's *Rule 40 Log* for July 2014, showed s/he used the restraint chair 25 times, spent 3016 minutes or 50.27 hours in the restraint chair and spent between 30 and 446 minutes in the chair at a time. There were days when the VA used the restraint chair multiple times.

- The VA's *Rule 40 Log* for July 2014, included the following: two occurrences where the VA remained in the restraint chair while sleeping, was not released, and it was documented as a voluntary restraint; one other occurrence where the VA stated that s/he was "ok," was not released, and it was documented as a voluntary restraint; and another occurrence where the VA was involuntarily placed in the restraint chair, documented as voluntary, the VA was quiet, and was not released.

- P1, P2, P3, and P5, each stated that the only time the restraint chair was used was if the VA voluntarily used the restraint chair. P4 and P6 each stated that the restraint chair could be used both voluntarily and involuntary with the VA. Mostly consistent information was received from P1, P2, P4, and P5 that the VA was released when the VA no longer had a blank facial expression, his/her eyes no longer fluttered, s/he no longer clenched his/her fists, and s/he appeared "calm."

- On May 21, 2014, there was an entry in the *Communication Book* where staff persons "escorted" the VA to the restraint chair and on the way s/he "decided" to go in "voluntarily."

- The facility's *Restraint Chair Reminders* updated January 8, 2014, stated that the VA was "not allowed to exit the chair for bathroom use." If the VA urinated on himself/herself and was "not released within the next hour, at least two staff [persons] provide[d] assistance with changing the [VA's] clothing." In addition, "no food of any kind" was to be given to the VA while in the chair. Prior to being released from the chair, all staff persons present were to agree that the VA was safe to be released from the chair.

- P1, P4, and P5 each stated that the VA was not released from the restraint chair for bathroom breaks regardless of how long the restraint lasted. If the VA urinated on himself/herself and s/he was not calm enough to release at one hour, staff persons assisted in cleaning the VA.

- P1, P2, P4, P5, and P6 each stated that the VA was not offered or given food while in the restraint chair or released for breaks involving food.

P1, P2, and P3 each stated that the goal was to reduce the VA's use of the restraint chair. P1 stated that the VA's schedule, sensory therapies, and community integration were the active programming that was used to reduce the VA's dependence on the restraint chair. (The *PSTP* did not list any steps that would be taken to reduce the use of the mechanical restraint).

Facility personnel records showed P1, P2, P3, P4, P5, and P6 were each trained on the Reporting of the Maltreatment of Vulnerable Adults Act and P2, P4, P5, and P6 each received training specific to the VA.

Related Rules and/or Statutes:

Minnesota Statutes, section 245D.06, subdivision 5, prohibited the use of a mechanical and chemical restraint or aversive or deprivation procedure as a substitute for adequate staffing, for behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for staff convenience.

Conclusion:

A. Maltreatment:

Information showed that between July 2013 and July 2014, the VA used the restraint chair an average of 15 days each month and spent between 5 to 7 hours in the chair during each use. In July 2014, the VA used the restraint chair 25 times (sometimes more than once a day) and spent between ½ hour and 7 ½ hours in the chair during each use.

There was no specific plan regarding the use of the restraint chair or specific criteria that had to be met for the VA to be released. Information from staff persons and documentation was inconsistent as to whether the VA voluntarily or involuntarily sat in the restraint chair. However, information was consistent that the VA was not to be released for bathroom breaks, regardless of how long the VA was in the chair, and food was not to be given to the VA while s/he was in the chair.

Given the VA was secured in the restraint chair for several hours, not released upon his/her request, not given breaks for food or to use the bathroom, and was left in the restraint chair for up to one hour after urinating on himself/herself; there was a preponderance of the evidence that the VA was involuntarily and unreasonably confined to his/her restraint chair which was not therapeutic conduct and would reasonably be expected to cause the VA emotional distress.

It was determined that abuse occurred (conduct which is not an accident or therapeutic conduct which produces or could reasonably be expected to produce physical pain or injury or emotional distress including, but not limited to: the use of repeated or malicious oral, written or gestured language toward a vulnerable adult or the treatment of a vulnerable adult which would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing, or threatening; and the use of any aversive or deprivation procedure, unreasonable confinement, or involuntary seclusion, including the forced separation of the vulnerable adult from other persons against the will of the vulnerable adult or the legal representative of the vulnerable adult).

B. Responsibility pursuant to Minnesota Statutes, section 626.557, subdivision 9c, paragraph (c):

> When determining whether the facility or individual is the responsible party for substantiated maltreatment or whether both the facility and the individual are responsible for substantiated maltreatment, the lead agency shall consider at least the following mitigating factors:
>
> (1) whether the actions of the facility or the individual caregivers were in accordance with, and followed the terms of, an erroneous physician order, prescription, resident care plan, or directive. This is not a mitigating factor when the facility or caregiver is responsible for the issuance of the erroneous order, prescription, plan, or directive or knows or should have known of the errors and took no reasonable measures to correct the defect before administering care;
>
> (2) the comparative responsibility between the facility, other caregivers, and requirements placed upon the employee, including but not limited to, the facility's compliance with related regulatory standards and factors such as the adequacy of facility policies and procedures, the adequacy of facility training, the adequacy of an individual's participation in the training, the adequacy of caregiver supervision, the adequacy of facility staffing levels, and a consideration of the scope of the individual employee's authority; and
>
> (3) whether the facility or individual followed professional standards in exercising professional judgment.

Given that the use of the restraint chair was a violation of Minnesota Statutes, section 245D.06, subdivision 5 and the facility did not have a detailed plan regarding the use of the restraint chair for the VA, the facility was responsible for the maltreatment of the VA.

Allegation Two: It was reported that facility staff persons administered the VA as needed medications while in the restraint chair as a form of behavior management.

According to the VA's *Medication Administration Records (MARs)* the VA was prescribed Benadryl for "insomnia" on an as needed basis. According to the VA's *MARs* and *Rule 40 Log,* on May 5, 21, 22, 27, and 28, 2014, the VA was administered Benadryl while in the restraint chair. The VA's *MARs* showed multiple staff persons administered the VA's Benadryl on these occasions.

According to the VA's *PRN Administration Plan* for Benadryl, the VA could receive the medication when s/he had difficulty sleeping or if s/he complained about medication side effects. P1 and P3 each stated that Benadryl should not be administered to the VA while in the restraint chair.

According to *Rule 40 Log* for July 26, 2014, the VA was administered an as needed medication, but the facility had no record of what medication was given. According to the VA's *Personal Outcome Plan*, the VA was prescribed an as needed nasal spray, inhaler, eye drops, topical ointment, two medications for ear pain, and Benadryl.

The VA's *PSTP* did not address the use of Benadryl as a form of behavior management.

Related Rules and/or Statutes:

Minnesota Statutes, section 245D.05, subdivision 2, paragraph (c), states (in part) that the license holder must note when a medication or treatment is started, administered, changed or discontinued

Minnesota Statutes, section 245D.06, subdivision 5, prohibited the use of a mechanical and chemical restraint or aversive or deprivation procedure as a substitute for adequate staffing, for behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for staff convenience.

Conclusion:

A. Maltreatment:

In May 2014, there were five occasions when the VA was administered Benadryl while in the restraint chair. Benadryl was prescribed on an as needed basis to treat insomnia. In July 2014, the VA was administered an as needed medication but the facility had no record of what medication was given which was a violation of Minnesota Statutes, section 245D.05, subdivision 2, paragraph (c).

Administering an insomnia medication to the VA without a plan while the VA was in the restraint chair was a violation of Minnesota Statues, section 245D.06, subdivision 5. In addition, it would reasonably be expected that a caregiver responsible for the health of the VA would administer an as needed medication only for its intended use unless directed otherwise by a physician. Therefore, there was a preponderance of the evidence that neglect of the VA occurred.

It was determined that neglect occurred (the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to food, clothing, shelter, health care, or supervision which is reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult and which is not the result of an accident or therapeutic conduct).

B. Responsibility pursuant to Minnesota Statutes, section 626.557, subdivision 9c, paragraph (c):

> When determining whether the facility or individual is the responsible party for substantiated maltreatment or whether both the facility and the individual are responsible for substantiated maltreatment, the lead agency shall consider at least the following mitigating factors:
>
> (2) whether the actions of the facility or the individual caregivers were in accordance with, and followed the terms of, an erroneous physician order, prescription, resident care plan, or directive. This is not a mitigating factor when the facility or caregiver is responsible for the issuance of the erroneous order, prescription, plan, or directive or knows or should have known of the errors and took no reasonable measures to correct the defect before administering care;
>
> (3) the comparative responsibility between the facility, other caregivers, and requirements placed upon the employee, including but not limited to, the facility's compliance with related

regulatory standards and factors such as the adequacy of facility policies and procedures, the adequacy of facility training, the adequacy of an individual's participation in the training, the adequacy of caregiver supervision, the adequacy of facility staffing levels, and a consideration of the scope of the individual employee's authority; and

(4) whether the facility or individual followed professional standards in exercising professional judgment.

P1 and P2 each stated that the VA should not have received Benadryl while in the restraint chair. However, Benadryl was administered to the VA while in the restraint chair on five occasions in May 2014, and one occasion in July 2014, and where an unidentified medication was administered to the VA. The medications were administered by multiple staff persons. The facility failed to ensure the medications were used for their intended use. Therefore, the facility was responsible for maltreatment of the VA.

Action Taken by Facility:

The facility completed an Internal Review and determined the policies and procedures were not adequate with regards to the VA's PSTP and the administration of the PRN Benadryl. The facility updated and provided staff persons training on the PTSP and the PRN protocol for Benadryl.

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

On September 9, 2014, the license holder was ordered to forfeit a fine of $2000 as a result of the substantiated maltreatment for which facility was responsible. The maltreatment determination and the Order to Forfeit a Fine are each subject to appeal.

On September 9, 2014, the facility was issued a recommendation regarding implementation of consumer's Positive Support Transitions Plans.

APPENDIX C

Ronnie Cohn 250 Garth Road Scarsdale, New York

Report to the Court Monitor: K[redacted]

Findings

-Findings are based upon reviewer's 9/15/2014 visit with K[redacted] and her staff at her home; interviews with representatives of Meridian Services, DHS (Minnesota Department of Human Services) including specifically CSS (Community Support Services), Jensen Implementation Office, Life Bridge; conversations with K[redacted]'s adoptive father (who is her biological uncle and guardian and whom K[redacted] refers to as her dad) and her Hennepin County case manager; review of documents provided prior to, during and subsequent to visit. Documents include, but are not limited to:

-Behavioral/ Psychiatric Crisis Response Plan (4/28/2010, Updated 6/8/2011)

-Behavior Support Plan when Psychotropic Medications are Prescribed (7/24/12)

-Behavior Management Plan with Controlled Procedures (Rule 40 Plan 10/14/2013-1/11/2014)

-Behavior Intervention Report Forms (2014) and Meridian's charts of K[redacted]'s use of her restraint chair (7/2013-8/2014)

-CSS Clinical Activity Logs and Psychiatry Consults (8/1/2012-9/13/2014)

-CSS Extended Supports Quarterly Reports (8/3/2012-8/3/2014)

-CSS Service Summary 2004-2014 (9/18/2014)

-DHS/CSS Consultation with Functional Assessment and Behavior Support Information (12/21/2009)

-DHS Investigation Report (9/9/2014) and associated correspondence

-Four Stage Crisis Plan for K[redacted]

-Hennepin County Individual Service Plans (7/23/2013 and 7/16/2014)

-Meridian Appeal to DHS investigation finding of Maltreatment (9/26/2014)

-Meridian Coordinated Service Support Plan Addendum 7/23/13-7/23/14 and 7/17/14-7/17/15 (which includes K[redacted]'s Person Centered Outcome Plan as well as a Risk Management and Assessment Plan; an Individual Abuse Prevention Plan; a Personal Outcome Plan chart which describes K[redacted]'s personal interests, relationships, communication abilities, personal

strengths, physical abilities, health, support needs, skills and talents, personal outcomes; an Intensive Support Services Assessment, which addresses K[redacted]'s health and medical needs, personal safety, self-management of her symptoms and behaviors)

-Meridian Annual Progress Reviews (7/2013, 7/2014)

-Meridian HCBS Service Recipient Rights

-Meridian Restraint Chair Reminders (1/8/2014) and Token Bin Rules (2/21/14)

-Minnesota Life Bridge Positive Behavior Support Agency Evaluation Tool Summary (9/12/14)

-Positive Support Transition Plan (1/30/14-12/30/14, including 8/20/14 update)

- State Operated Services (SOS) DD/MI Discharge Plan with Pre-Placement Assessment (6/15/2011)

-Upon reviewer's arrival at K[redacted]'s home, K[redacted] was sitting in her restraint chair and strapped in, reportedly per her request. Once she was ready to leave that situation, she relaxed on the couch in the living room and used her IPad. She appeared to be tired but conversed with the program administrator and with the reviewer. Little interaction was observed between K[redacted] and her direct support staff, none of whom had worked with K[redacted] in this home for more than eight months. K[redacted] was cordial toward the reviewer and indicated she would be going with staff to dinner at Red Lobster, the restaurant she chose and to which she had never gone. When not in close proximity to K[redacted], the program administrator noted to reviewer that "going out to dinner" meant that K[redacted] and her staff would drive to the restaurant and go in to order food to bring home, as K[redacted] is not able to stay and eat in restaurants other than fast food places where there is not a wait to served. Staff noted that this is a major accomplishment for K[redacted] as when she first moved into this home, as well as in previous living situations, she would rarely choose to leave her own room to venture into common areas.

-Documentation related to K[redacted]'s community experiences included descriptions of K[redacted] staying in the van with two staff while the third staff went to purchase something for K[redacted]. Most recently, however, it is reported that K[redacted] spends more of her time in the community interacting with others and going into a variety of places such as church, the mall, fast food restaurants, a roller rink, and a cheese factory in Wisconsin.

-K[redacted] is diagnosed with "Mild MR, Borderline Personality Disorder, BiPolar and Schizoaffective Disorder". Since her move to her current home, K[redacted] has been seeing a psychiatrist who comes

to her home approximately monthly and with whom she appears to have established a positive relationship.

-K[redacted] is [redacted] years old and, according to her most recent Individual Service Plan (ISP) completed by her Hennepin County case manager in September, 2014, she has experienced 44 residential transfers prior to moving to her current home in the community on 6/15/11. She lived with her biological parents for her first four years, interrupted by 8 hospitalizations as well as a shelter and foster home placement. The next 29 years included K[redacted] living for approximately six years (following the involuntary termination of her biological parents' parental rights) as a child with her adoptive parents, who are her biological uncle and his wife, and then enduring a multitude of hospitalizations, crisis settings, group homes, transition homes, METO/Cambridge/Anoka. In 1996 alone, she moved 17 times. She lived for the longest continuous periods of time at METO/Cambridge/Anoka (1/1997- 8/2002) and St. Peter Security Hospital (8/2004-2/2010). Between 2002 and 2004, K[redacted] lived in a group home until "her level of need changed" in that she was exhibiting more intense and frequent target behaviors such as self injury, aggression toward others and property destruction. At that time, the previously effective strategies, including mechanical restraints, medication changes and behavioral programming, were no longer successful and her provisional discharge was revoked. Her psychologist then recommended Electroconvulsive Therapy (ECT) and she was transferred to St. Peter where she received 37 ECT treatments, which were described as not very effective. Subsequent treatment modalities at St. Peter, which reportedly had more positive outcomes at times, included "protective isolation " and use of restraints. When St. Peter was transitioning into a more forensically focused facility in early 2010, K[redacted] moved to Anoka for 8 months and then to MSOCS Crestview transition site where she lived for 8 months until moving to her current home, which is operated by Meridian Services.

-On 1/5/2006, while K[redacted] was living at St. Peter Security Hospital, the psychologist completed a Functional Assessment which included the following statements in the recommendations:

-"It is important to closely evaluate the setting that would be the best option for [her] future living. She has [been] in regional treatment centers and security settings for many years and to place her in a small community-based home (e.g., a four bed group home) could, at this time, invite deleterious results."

-"Above all, it is important to focus on [her] overall quality of life, both now and in the future."

-On 3/9/2006, K[redacted]'s adoptive parents submitted to CSS the following written statement, which they signed with her county case manager as a witness:

-"As the co-guardians we have considered risks and safety issues for our daughter…. We prefer that [she] be given the opportunity to live as safe as possible in the community and not remain at St. Peter Security Hospital (MSH). We understand that by taking this position, that [her] life expectancy could be shortened." (See Attachment 1 herein.) During a telephone conversation with this reviewer, K[redacted]'s dad stated that he is very satisfied with her services now and that he participates in all of her planning meetings. He noted that he feels she is "doing pretty good considering how she used to be" and that he wishes she could "just stop getting so angry". He also said that the restraint chair should be used only when she is "out of control".

- According to documents provided by CSS, K[redacted] was provided with no opportunities to go into the community while living at MSH and MSH was not in support of CSS visiting her there. Nevertheless CSS and K[redacted]'s county case manager continued transition planning, despite MSH explaining in 5/2008 that any move into the community had to be put on hold due to an increase in K[redacted]'s target behaviors. CSS generated an updated Functional Behavior Assessment in 11/2009 and K[redacted] moved to AMRTC (Anoka) on 2/10/2010. It is noted in a document dated 9/18/2014, which CSS provided to this reviewer, that MSH did not prepare K[redacted] for this move or even tell her in advance that she was moving.

-CSS has been involved with K[redacted] for at least 10 years, beginning with her transition from a group home operated by Provide Care to St. Peter Security Hospital in 2004 and continuing at her current home. The same behavior analyst has provided supports to her throughout this time and her county case manager has known K[redacted] for fifteen years.

-In her current home, K[redacted] has an apartment on one side of a duplex and has 3:1 staffing which includes awake overnight staff. Per her Coordinated Service Support Plan Addendum for the period 7/17/14 to 7/17/15, staff must remain within visual range of K[redacted] from 6am to 10pm due to her history of ingesting inedible items, self injury, aggressive behavior toward others and her inadequate safety skills in the community.

-On 9/9/2014, DHS issued an "Investigation Memorandum" with respect to suspected maltreatment of K[redacted]. There were two allegations: one alleging use of the restraint chair for up to ten hours with no food or water breaks being offered to K[redacted] and the other alleging staff administered to K[redacted] "as needed medications" while in the restraint chair as a form of behavior management. Questions also arose as to K[redacted]'s voluntary versus involuntary use of the restraint chair and cited the use of the restraint chair as a violation of Minnesota statutes (245D.06). It was also noted that K[redacted]'s home did not have a detailed plan regarding the use of the restraint chair. The investigation resulted in a determination of maltreatment for which Meridian was deemed responsible and a fine was imposed.

-On 9/16/2014, an administrator at Meridian told reviewer that her agency was asked to serve [K] "because of our reputation for working with people who have extremely challenging behaviors and histories of discharges from many placements".

- On 9/26/2014, Meridian Services filed an appeal of DHS' determination of maltreatment as well as the fine imposed. This appeal includes, among many other responses questioning the findings and outcome of the investigation, the following statements:

-"We have documentation of [K's] history including the use of the mechanical restraint chair which began in 2002. Meridian Services was asked by Hennepin County to develop services for [K]. Her psychiatrist at that time recommended that the restraint chair continue as part of her program because of her dependence on the restraint chair as a coping mechanism."

-Quoting K's current psychiatrist in a progress note from 1/16/2014: "We developed some assessment questions and strategies to approach the idea of removing the restraint chair with a plan to also decrease manual restraints. We are all guarded regarding how to best accomplish this as [K] used restraints for years when institutionalized and just prior to her move to Meridian homes. Challenges include how highly reinforced this is for her and the risks of 'extinction', for example. Her team will continue to evaluate and come up with strategies to maximize success and minimize risk to both [K] and others given her history of dangerous behavior."

-"In the routine submission of our reports and plans for over three years, we were not provided feedback, criticism or recommendations that our procedures needed to be modified."

-Comparison of data regarding the number of hours per month K spent in the restraint chair prior to and following her move to her current home in June, 2011 indicates both decreases and increases over the past three years, with significant progress noted most recently in February, April, July and August, 2014. One comparison provided by Meridian compares the number of hours K spent in the restraint chair in April of each of the past four years, as follows:

4/2011- 200 hours

4/2012- 123.75 hours

4/2013- 85.75 hours

4/2014- 38.25 hours

(See attachment 2 herein for details of the period 7/2013 through 8/2014, which shows a great deal of variability from month to month, with a low of 27.25 hours in 8/2014 and a high of 157.25 hours in 1/2014.)

-Meridian has reportedly been submitting quarterly reports to DHS for the past three years describing the extent of K[redacted]'s use of the restraint chair in total hours for the quarter as well as monthly averages. Throughout this time, there was reportedly only one inquiry regarding the data, in 2013, to which Meridian responded without further contact from DHS. Meridian's administrator further indicated to reviewer that a Hennepin County Supervisor, K[redacted]'s county case manager and the CSS team were part of the initial planning process for K[redacted]'s move to her current home and that "we made a good faith effort to follow Rule 40 in the past and to implement the 245D revisions including the Positive Transition Support Plan and all required submissions of our reports".

-Reviewer's interviews with DHS and CSS revealed a lack of awareness of the extent of K[redacted]'s current use of the restraint chair.

- At the time of this reviewer's visit on 9/15/2014, the restraint chair was being removed from K[redacted]'s home one day each week in an effort to decrease her dependence on its use. Over the following few weeks, it was determined that the chair would then be removed two days per week.

-It is reported by both CSS and Meridian that, ironically, as K[redacted] is experiencing more success in the community and enjoying more time in more varied environments, she requests her restraint chair about as frequently as she had previously, but for much shorter periods of time. The explanation provided by both is that even as K[redacted] enjoys her successes in the community, she still at times experiences significant anxiety before she goes out or after she returns home and that K[redacted] prefers the "security" of her voluntary use of the restraint chair to the risk of engaging in undesirable behaviors as a result of those feelings. It was noted by CSS that K[redacted] has even started referring to the restraint chair in derogatory terms as she describes her feelings when it is unavailable.

-K[redacted]'s current outcomes in her Personal Outcome Plan are: to increase her social interaction, participation in activities, and overall structure to each day; to improve her overall physical health; to develop appropriate interactions with community members; to learn more about her community and the world around her. Meridian's Quarterly reports and annual progress reviews include discussions of progress and recommendations related to each outcome as well as Behavior Support Plan data and a summary of progress related to behavioral objectives. Tracking of targeted behaviors and restraint chair usage are also included. K[redacted]'s Behavior Support Plan is being translated into a fifth outcome for the year that began 7/16/14 in order to

focus on her maintaining positive relationships with others by decreasing both her self-injurious behavior and physical aggression toward others.

-Meridian's Annual Progress Review for K[redacted] for the period 7/24/13-7/24/14 includes a section entitled "Relevant Events". Among these are 10 incidents of K[redacted] assaulting others; 12 incidents of self-injurious behavior, most of which involve ingesting inedible items; and 3 incidents of K[redacted] falsely reporting situations involving her staff. However, there are also descriptions in 12 positive notes regarding K[redacted] enjoying visits with her father and with her psychiatrist, attending medical and dental visits without any incidents, thoroughly enjoying community opportunities, spending time with peers, and attending a Halloween party. In addition, K[redacted] experienced: a full month (2/2014) without any attempts to harm herself or others, with more successful community experiences than previously and with fewer times of using the restraint chair; 2 weeks in 4/2014 without using her restraint chair and 12 days in 5/2014 without using her restraint chair.

-On 1/17/2014, K[redacted]'s psychiatrist discontinued PRN medications for "racing thoughts/ unsafe behavior". These medications (Zyprexa and Clonidine) were added to her regular regiment based on reviewing her usage patterns. Adjustments are made in scheduling, dosages and types of medications if deemed necessary.

-A note from the program manager at K[redacted]'s home dated 7/11/2014, following a staff meeting at K[redacted]'s home on 7/9/2014, indicates that "the restraint chair is NOT to be used involuntarily".

-On 9/15/2014, the Minnesota Life Bridge management and clinical team issued a Positive Behavior Support Agency Evaluation Tool Summary of Findings, based upon a visit to K[redacted]'s home on 9/12/14. The report addresses the physical environment, social setting, K[redacted]'s schedules and routines, her community access and involvement, staff and staff training, interactions between staff and K[redacted], monitoring and decision making, person centered planning, medical and clinical services. The summary of findings notes a pleasant environment, but inadequate training in Positive Behavior Supports and Person Centered Planning as well as K[redacted]'s and staff's reliance on the regular use of the restraint chair as a calming coping tool. Efforts to reduce K[redacted]'s use of restraint chair through removing it from the home one day per week are noted. The conclusion therein is that "the provider and staff appear to adequately provide for the individual's wellbeing and community access. There are several areas where the provider is using best practices but there remain some areas that, if strengthened, may increase their success in working with this individual, and ultimately the individual's success in using positive coping skills over the use of a restraint chair."

-CSS' service summary for 2004-2014, generated on 9/18/2014, notes in the final entry that CSS is "providing/embedding ongoing feedback and ideas to Meridian to fade the use of [K[redacted]'s]

requests and subsequent use of the restraint chair. Strategies to make the use of the restraint chair irrelevant/ineffective for [K]" include increasing her enjoyment of and integration into her community, replacing the chair with other sensory items that can meet her sensory needs, using the recliner chair in the same room as the restraint chair as a more comfortable alternative to the restraint chair while removing the restraint chair periodically (e.g. one day a week, then two days, etc.), inviting K to participate in designing the schedule for fading the chair.

-CSS behavior analyst told reviewer on 10/6/2014 that K is succeeding in a "huge way" as she was previously terrified of any new experiences, "even just going to the nurses' station from her room at Anoka", and she is now developing relationships, going to a supported job, and looking forward to going to new places.

-K 's county case manager told reviewer on 9/16/2014 that she sees K now as "so much better than ever before and happy for the first time".

-As of the time of reviewer's visit, there was no readily available information regarding statewide use of restraint chairs in Minnesota.

-At the time of the reviewer's visit to K 's home on 9/15/20014, there was a total lack of awareness on the part of Meridian staff as well as of the agency's administration as to the nature of the Jensen Settlement Agreement and the entitlements of class members. It was also noted in Meridian's appeal referenced above that the agency was not, until the reviewer's visit, aware of K 's "status as a protected person under the Jensen Settlement".

-On 9/16/20016, reviewer was informed by the Jensen Implementation Office that every agency serving Jensen class members is being notified of a mandatory training session on 10/2/2014 regarding the Jensen Settlement Agreement.

Conclusions

-There is evidence of significant efforts to decrease the frequency and duration of K 's use of her restraint chair while increasing her opportunities in the community which are incompatible with such use.

-Meridian has responded to DHS' questions regarding K 's use of PRN medications and her solely voluntary use of the restraint chair.

-Part of the problem noted in the Life Bridge report referenced above with regard to staff training may be due to the fact that staff who work directly with K do not always remain

with her for a significant amount of time. Those present during the reviewer's visit had been with K for no more than eight months.

-There appear to be "disconnects" among the agencies and departments which provide services and supports to K, including CSS, Licensing, other DHS units, the county, Meridian. For example, everyone directly involved with K and her team was reportedly either directly aware or informed of the extent of K's use of the restraint chair through either observations or routine reports provided to them. However, there is no evidence of any objections to either the plans developed for K or Meridian's implementation of these plans until after a full investigation was initiated by DHS in response to a few specific concerns. The significant differences between the findings of the DHS investigation described herein and the content of Meridian's appeal of DHS's determination illustrate this problem, which appears likely to be more widespread than just between this one provider and external agencies or even within a particular agency that houses many departments. While everyone involved with K undoubtedly regards her best interests as the highest priority, the absence of timely and positive communication prior to the investigation in this situation absolutely hinders cooperative efforts toward a common goal.

-Those most closely involved with K have a shared goal of enabling her to live and participate in the community safely, without needing a restraint chair or three staff with her in order to do so.

-Those who have been closely involved with K over many years, including clinicians, her case manager, her adoptive parents, along with Meridian's agency administrators gratefully acknowledge the strides she has made over the past few years, most obviously her willingness to spend time out of her room in common areas of her home and her ability to interact more positively with others in the community. There is a clear appreciation of how far she has come despite her current challenges and need for ongoing significant supports.

Recommendations

-Provide additional training to direct support staff in 's home regarding positive behavior supports, person centered planning, and entitlements for Jensen class members. Such training should be provided as frequently as necessary to be timely for new hires.

-Expectations for staff's documentation of K's use of her restraint chair and her participation in the community should be clarified, in an effort to improve communication among all involved.

- Improve communications between the provider and external agencies involved with K[redacted], with initial steps being addressing the conflicting information in DHS' investigation and Meridian's appeal and clarifying whether appropriate parties within DHS are receiving as well as reviewing routine reports sent by Meridian.

-Develop more efficient channels of communication among units within DHS as well as between state, county and private providers.

-Develop a statewide tracking system, which is updated often, related to the use of mechanical restraints.

-Meridian should provide frequent updates, even if it involves temporarily going beyond typically required reporting, to relevant agencies and individuals regarding the progress of eliminating K[redacted]'s use of the restraint chair.

-The service summary generated by CSS on 9/18/2014 is a useful tool. Perhaps, in an effort to facilitate communication among all involved, an abridged (including less historical information) version of this document could be updated regularly with internal information as well as the ongoing input described above from Meridian and be shared with K[redacted]'s county case manager, her dad, Meridian and DHS.

Respectfully submitted by Ronnie Cohn

October 9, 2014