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

April 7, 1987

Kenneth D. Gossett, Chief Executive Officer **CERTIFIED MAIL**
Cambridge Regional Human Services Center
1235 Highway 293
Cambridge, MN 55008

Dear Mr. Gossett:

Pursuant to Minnesota Statutes, section 245.801, subdivisions 3, 4, and 5 (1984) the Commissioner of Human Services is issuing you a license and making it probationary until May 1, 1988. This notice of probation results from substantiated noncompliance with Minnesota Statutes, section 626.557 and Minnesota Rules, parts 9525.0210 through 9525.0430, and parts 9555.8000 through 9555.8500.

On January 5, 6, 7, 8, and 9, 1987, the Cambridge Regional Human Services Center was reviewed to determine compliance with the provisions of Minnesota Rules, parts 9525.0210 through 9525.0430 and 9555.8000 through 9555.8500, which govern the licensure of residential facilities for persons with mental retardation. The licensed' capacity of the program was 401 persons. At the time of the review 367 persons were receiving services.

CORRECTION ORDER

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

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

1. Citation: Minnesota Statutes, section 626.557, subdivision 1.

Violation: The facility has not adequately protected vulnerable adults' or provided a safe living environment. For example:

a. At approximately 9 a.m., resident #0763 reported to staff in the day program that her "arm was broken." Medical attention was not immediately sought. A nurse was finally notified at about 1:30 p.m., and subsequently a physician determined her arm had been broken for approximately five hours. The physician also stated only two procedures could have caused the break: a basic "come-along" procedure, or falling with outstretched arms. The subsequent internal investigation revealed that the resident had had an altercation with an identified staff person while getting on the bus on the morning she reported her arm broken. Also, during the investigation, the resident indicated that a woman did it. Interviews with staff also revealed that manual restraint procedures were regularly used on the resident even though these procedures were not approved by the Human Rights Committee.

The undisputed fact that the resident's broken arm was not medically treated for five hours after she had reported it broken constitutes neglect under Minnesota Law. Nonetheless, an internal investigation team stated, "no evidence to support abuse/neglect."

b. On August 24, 1986, a resident's progress notes indicated that a staff person noticed a swollen and discolored shoulder and collarbone. The staff person properly notified the nurse. The nurse's notes stated "old bruise area, left collarbone area, slight swelling above collarbone - good range of motion in arm - raised arm without difficulty. [Doctor] aware. Will continue to be followed by unit nurse." On August 27, 1986, three days after the initial observation, the progress note stated, "Ate only with assistance. Very lethargic." On August 28, 1986, after staff reported that the resident seemed to be in pain, she was seen by a physician who diagnosed a fractured left clavicle.

The program did not consider that this may be possible abuse or neglect. An internal investigation was initiated only after the program was contacted and instructed to do so by an outside authority.

Time Frame for Correction: Beginning immediately, the program shall provide medical attention in each instance where medical intervention is indicated. Internal investigation reports must fully document the extent of the investigation. The program must take measures to ensure that persons assigned to conduct internal investigations of resident abuse or neglect are adequately trained, and that the results of abuse or neglect investigations are regularly reviewed by program administrators.

2. Citation: Minnesota Rules, parts 9525.0390, subpart 1. and 9525.0410.

Violation: There were not sufficient staff appropriately trained and qualified on duty to ensure adequate care and supervision, or assistance - in an emergency. The number of available direct care stiff was not related to each resident's degree of handicap and training needs. For example:

a. In the progress notes of resident #5882 (Cottage 8 South), the following sequence of events was recorded by a night staff person: "Got up to go to the bathroom, jumped out of bed felled (sic) to the floor, got up hit wardrobe, bounced into door jam, staggered to bathroom, stumbled into bathroom, hit corner of bathroom stall." The resident sustained a 11/4 inch laceration on the forehead as a result of this incident. During this sequence of events described, there was no record of any staff intervention.

D. A staff person who had been newly assigned to McBroom building, where residents with physical handicaps require lifting and repositioning, stated that it had been three or four years since she had received any training in how to lift and reposition residents with severe physical handicaps.

c. On East household, during peak programming time (approximately 4:30 p.m.) only one staff was available for approximately 16 residents. One resident with self-injurious behaviors required the complete attention of the staff person. The staff person was unable to attend to the care or training of the other 15 residents.

Time Frame for Correction: By June 1, 1987, submit a staffing pattern for each living unit which documents that sufficient numbers of staff, adequately trained, are assigned to meet residents' needs.

3. Citation: Minnesota Rules, part 9525.0280, subpart 13.

Violation: The program did not state the expected behavioral outcome or possible side effects when using chemical restraint (behavior-controlling medications). For example:

a. Resident records #s 5697, 5882, 5922, 4645, 4105, 5928, 4260, 4552, 4426, and 5581 did not state the expected behavioral outcomes.

b. The possible side or secondary effects listed in record #5922 were not specific to the prescribed medication.

c. In records for residents' #4645 and 4426, there were no objectives in the individual program plans to address the behaviors for which the medications were being given.

Time Frame for Correction: Beginning immediatley, behavior-controlling medications must not be used (other than in medical emergencies) unless measurable, behavioral outcomes have been identified and recorded in the resident's individual program plan and that staff have been trained to identify and respond appropriately to know side effects of the prescribed medication. By June 1, 1987, submit documentation that the individual program plans and records, for each of the residents listed, have been revised as necessary in the above violation.

4. Citation; Minnesota Rules, part 9555.8300, subpart 2.

Violation; Individual abuse prevention plan assessments were either incomplete or inconsistent with other individual assessment information. For example;

a. For resident #5770, the interdisciplinary team (IDT), which is required to develop the individual abuse prevention plan, did not develop the plan. The vulnerable adult assessment was completed on April 24 (the year of the assessment was not documented) and the individual abuse prevention plan was developed on March 26, 1986. The individual abuse prevention plan was not developed in conjunction with the annual program plan which was dated June 17, 1986. The individual program plan (IPP), individual vulnerable . adult assessment, and the nutrition assessment are in conflict. The vulnerable adult plan states that she "has trouble with chewing, swallowing and eating too fast." The nutrition assessment. … reads "Feeds self independently, slow, but steady, swallowing ability good." The IPP goal that addresses eating skills is limited to teaching this person to put her tray away.

b. The individual vulnerable adult assessment for resident #5581 (Cottage 14) showed that the resident's vulnerability would be reduced if the resident is taught to distinguish between male and female. However, assessment data and the resident's individual program plan shows that the resident knows the difference between male and female. In fact, the individual program plan states that the resident's ability to distinguish between male and female is an area of strength.

Time Frame for Correction; Submit a copy of the revised assessments, individual abuse prevention plans and individual program plans for each of the residents above by May 1, 1987. In addition each resident must be reassessed to determine the resident's vulnerability to abuse and neglect, and the results of the reassessment must be used by the interdisciplinary team in the next annual review and modification of each resident's individual program plan.

5. Citation; Minnesota Rules, part 9525.0280, subpart 9., and subpart 10.

Violation; Minnesota Rules limit the use of restraints to circumstances where it is necessary to protect the resident from injury to self or others. In many instances, restraint and aversive interventions are used because behavior management programs are either incomplete, or not being implemented as developed. For example:

a. For resident #5496 behavioral programs that include aversive procedures have been developed for self-injurious behaviors (SIB), property destruction, aggression, incontinence and feces-smearing, and dunking clothes in the toilet. These behaviors occur at a high frequency (e.g., 2,500 SIB incidents per shift, as recorded in progress notes dated December 1986). Since implementation of the aversive procedure, SIBs have continued at a high rate. Records show no evaluation to determine why the aversive procedures are ineffective (i.e., inconsistent implementation, staff training, etc.).

b. A program for resident #5784 utilized mechanical restraint for purposes other than protection of self or others. The procedure included strapping him in a restraint chair; securing his waist, upper and lower arms, and his ankles with straps; covering his eyes with a visual screen; and placing a cervical collar around his neck. This program is implemented if the resident becomes aggressive within five minutes after manual restraint was used. Therefore, the mechanical restraint is used as punishment, not to protect the resident from injury to self or prevent injury to others.

Time Frame for Correction: By July 1, 1987, submit a revised IPP which includes behavior programs for each resident listed above. Also submit evidence that staff are delivering the programs correctly and that data being collected are direct measures of progress on specific objectives. Submit a plan which requires IDTs to review and revise all programs that have been developed to address maladaptive behaviors by January 1, 1988.

6. Citation: Minnesota Rules, part 9555.8500, subpart 2.

Violation: The program does not conduct adequate in-service training for mandated reporters to review the Vulnerable Adult Act (Minnesota Statutes, section 626.557), and Minnesota Rules, parts 9555.8000 - 9555.8500 (formerly Rule 10) at least annually. For example:

a. The training for employees of Boswell building consists of a quarterly test of approximately 18 multiple choice questions. The test is self-administered and self-scored. The test is not comprehensive and omits areas of the "Vulnerable Adults Act" and Minnesota Rules, parts 9555.8000 through 9555.8500 that are essential to the mandated reporters' understanding of their responsibilities.

b. The training for employees of McBroom building and Cottage 11 is limited to each staff person reading the unit policies and taking a self-administered test. However, the unit policies do not include the "Vulnerable Adults Act" and Minnesota Rules, parts 9555.8000 through 9555.8500. One staff person stated that the last time that a formal training session was held was "about three or four years ago."

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

7. Citation: Minnesota Rules, parts 9525.0330, and 9525.0430.

Violation: Assessment information contained in resident files from different evaluators is frequently inconsistent. For example:

a. The Professional Report Summary for resident #3989 states that the resident has good receptive and expressive language. The Occupational Therapy assessment dated August 29, 1986, states that the "resident expresses his wants and needs by limited verbal speech, gestures and sign language." An annual report states, "Resident attended most of the team meeting. However, due to his lack of ability to express himself completely, Sue E., social worker, acted as his advocate for this meeting." and "Resident's maladaptive target behaviors appear to be either a response to not getting what he wants or a frustration response due to an inability to communicate what he wants."

b. The Human Sexuality assessment dated October 10, 1986, for resident #3948, stated "not developmentally ready for any sexual interactions, does masturbate." The Annual Nursing Summary dated October 13, 1986, stated, "no interest in sex." The Annual Individual Program Plan under Human Sexuality listed his needs as "needs to learn to distinguish male and female, needs to learn to make choices." The Behavioral Assessment states as problems, "masturbation in public. . . ." There were no goals, objectives or training programs developed in the human sexuality area.

Time Frame for Correction: By July 1, 1987, submit evidence that the residents identified above have been accurately assessed and inconsistencies have been reconciled. Take measures to identify and accurately assess other residents who are similarly situated by October 1, 1987.

8. Citation: Minnesota Rules, parts 9525.0340, subpart 1, 9525.0350, and 9525.0430.

Violation: Objectives were not always specific and time limited; data were not sufficient to evaluate whether the resident was making progress or regressing. Frequently, program objectives were not implemented as written. For example: —

a. A program was written to increase adaptive skills and to reduce or eliminate aggressive behavior toward other people and property. However, there were no data to indicate the rate or severity of the behavior. Therefore, progress or regression could not be adequately determined.

b. For resident J. K. (McBroom building), a consultant recommended a gentle range of motion to right hip, two times a day five days a week. For a period of two months, however, notations in the resident record stated, "Did not receive treatment after August 19 due to staff on medical leave." Apparently, the resident did not receive the necessary treatment until sometime after October 11.

c. Frequently, there are lengthy delays in implementation of new or modified individual program therapies. These delays appear to result from programs not being implemented until the typed program forms are sent to the units. For example: On November 13, 1986, the IDT developed four new objectives for resident E.C. (McBroom,

East 1). One of these objectives was identified as a high priority objective. Nearly two months later, on January 9, 1987, only one of the objectives had been implemented. The objective that was implemented was not the high priority objective.

d. For resident #3915 (Boswell West 3), a goal for appropriate social overtures was developed in March but not implemented until five months later in August. Training on another goal was not started when scheduled because the music therapist was on temporary reassignment.

e. Progress or regression of residents in response to a training program cannot be determined because baseline data were not consistently available. This finding was particularly evident for McBroom building and Cottage 11 North and East.

f. The records for resident #4541 and #3915 on Boswell West 3 contained procedures for decreasing self-injurious behaviors. However, no specific time limited objectives had been developed to measure whether these procedures were having any effect on the behaviors.

g. Data on the implementation of a program that requires use of a "papoose board" for resident #3989, Cottage 11, South household, was not in the record on the resident's present living unit or his previous living unit.

Time Frame for Correction: Beginning May 1, 1987, and on a continuing basis as annual reviews occur, (a) develop and implement program plans that are specific and time limited, (b) initiate a monitoring system to ensure that program plans are being implemented on a timely basis and that the record contains adequate baseline information and data collection on objectives, and (c) collect and evaluate data on resident responses to training programs to determine whether training programs are having the intended effect on resident behavior.

Citation: Minnesota Rules, part 9525.0280, subpart 14.

Violation: The program failed to consistently obtain and record appropriate consent for programs involving time out or aversive procedures.

a. The file for resident #5408 did not contain a signed consent.

b. A consent form for resident #3989 (Cottage 11, South household) was mailed to the county social worker on April 17, 1986. It states "If these forms are not returned by May 18, 1986, consent will be implied." This does not constitute consent. A valid consent requires an affirmative act by the person required to give consent. The program must not attempt to gain informed consent for. aversive procedures through a failure to respond to a request for consent.

c. The record for resident #5496, did not contain a signed consent.

d. Unit policy manuals for Cottage 8 and the Dellwoods instruct staff that time-out and aversive procedures may be used without the written consent of the parent/guardian and without the development of a written program.

Time Frame for Correction: By June 1, 1987, submit revised unit policies which prohibit the use of time out or aversive procedures without written consent of the resident or resident's guardian (if appropriate) and development or a written program by the interdisciplinary team, except in the case of emergencies. Also submit the appropriately signed informed consent forms for resident #5408, #5496, and #3989.

10. Citation: Minnesota Rules, part 9555.8200, subpart 5, and 9555.8400, subpart 7.

Violation: There was no documentation, in resident records reviewed, that residents and/or their representatives had been oriented to the program abuse prevention plan and the internal reporting system.

Time Frame for Correction: Submit evidence that the orientation has been provided to all residents and/or representatives by July 1, 1987.

11. Citation: Minnesota Rules, part 9525.0260, subpart 2. and subpart 3.

Violation: The program did not provide privacy and supplies in toilet areas and living areas. For example:

a. In Dellwood South and Cottage 8 West, curtains in toilet or tub areas were either absent or too narrow or too short to provide privacy.

b. In Boswell building, residents with physical handicaps were observed on toilets without the privacy curtains pulled. The residents were physically unable to close the curtains themselves. A woman in a wheelchair who had just completed bathing was wheeled through common areas to her room with only a towel to cover her.

c. Three bathrooms in Boswell building did not have toilet paper available.

Time Frame for Correction: By June 1, 1987, submit evidence that provisions have been made for privacy and appropriate supplies in all bathing and toileting areas.

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

Violation: The physical plant was not home-like and accessible because interior and exterior doors were frequently kept locked without accompanying individual program plans for teaching residents behaviors that would result in reduced use of locked doors. For example:

a. Cottage 8, 11, Dellwood and McBroom buildings and Building 6 day program all had exterior or interior doors locked. Locked doors included an emergency exit, kitchens (including some refrigerators and cabinets), and dining rooms, tub and shower rooms, windows and main entrances to buildings or households.

b. In all buildings where residents live, equipment, and supplies, such as T.V.s and stereos, personal grooming aides or program supplies, were locked or out-of-reach and inaccessible to residents. Cottage 8 policies specifically state that residents must have access to household furnishings, stereos and televisions, nonetheless this did not occur.

Time Frame for Correction: Identify where interior and exterior locks are being used and evaluate the current need for these locks. If locks are not necessary to protect residents from danger to their health or safety, remove the locks or develop individual program plans to address the behavior that made the continued use of locks necessary. Submit the results of the evaluation by June 1, 1987. Individual programs to eliminate the need for locks must be incorporated into each resident's individual program plan by September 1, 1987, or the IDT must document that such programs have been considered and given a low priority in light of each resident's other needs for training.

13. Citation; Minnesota Rules, part 9525.0280, subpart 4.

Violation; The rhythm of life on the adult living units did not resemble the cultural norm for nonhandicapped persons. For example:

a. In McBroom building, it was observed that some residents were given a bath and dressed in their pajamas as early as 4:30 p.m.

b. In Cottage 8, the recreation room contained children's puzzles and games for adult residents. The age-appropriate arts and crafts and other equipment were locked-up. In Boswell building, one living room area has a toy box with plastic children's toys. This equipment is not chronologically age-appropriate for use with adults. The skills that are learned through the use of such equipment are largely irrelevant to the functional living skills needed by adults.

Time Frame for Correction; By June 1, 1987, submit a plan that will result in the replacement of the program's age-inappropriate equipment (other than residents' personal belongings), and activities with chronologically age-appropriate equipment and activities. The equipment and activities must be replaced by January 1, 1988.

Suggested Method of Correction; A plan to address the chronological . age-appropriateness of equipment should first consider items which are not personal property of residents. Residents' personal preferences should be supported and could be documented in the individual program

plan when they are not chronologically age-appropriate. Efforts should be undertaken to teach residents the value of, and how to use chronologically age-appropriate personal items. Similar efforts should be undertaken to inform staff, resident's family and friends of the value of age-appropriate personal belongings and gifts.

14. Citation; Minnesota Rules, part 9525.0280, subpart 11.

Violation; The facility did not record a description of the precipitating behavior, expected behavioral outcome, and actual behavioral outcome for each use of restraint or seclusion. For example:

a. Resident #5697 has a program which requires time-out in a seclusion room for aggressive behavior. Entries in the time-out recording sheet did not describe the behavior(s) that caused time-out to be used.

b. On Cottage 8 (Y household), recordings simply stated where the resident was before the behaviors occurred (e.g. in the hall, in the dining room, by the bathroom), but did not describe the behavior that caused time-out to be used.

Time Frame for Correction; Beginning immediately, provide instructions and training to ensure that staff know the precipitating behavior, expected behavioral outcome, and actual behavioral outcome whenever any type of restraint is used and, that complete and accurate records are kept when restraint or seclusion is used.

15. Citation: Minnesota Rules, part 9525.0300, subpart 1.

Violation; Residents of McBroom West building were not provided with adequate clothing. At least five residents were diapered and left with no clothing over the diapers.

Time Frame for Correction; Effective immediately, take measures to ensure that all residents are dressed appropriately.

16. Citation: Minnesota Rules, part 9525.0310, subpart 3., and subpart 5.

Violation; Observations in McBroom building revealed that although dining room tables were available for meals they were not being used. The tables were pushed against the wall and residents must use lapboards to eat their meals because the resident's wheelchairs would not fit under the tables.

Time Frame for Correction; By June 1, 1987, submit evidence that all residents are eating at tables, and that people using wheelchairs are eating at a table suitable for use with wheelchairs.

17. Citation; Minnesota Rules, part 9525.0340, subpart l.B.

Violation; The IDT did not consider the proper exercise of the residents' and parents' civil and legal rights, including the "right-to adequate service.

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

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

18. Citation: Minnesota Rules, part 9525.0340, subpart l.F.

Violation: The program did not consistently consider whether there was a need for continued guardianship or conservatorship or restoration to capacity of the resident at the annual individual program review. Frequently, the only rationale that the IDT offered for continued guardianship was a statement, "determined appropriate." None of the records contained any information supporting the IDT's decision.

Time Frame for Correction: Beginning May 1, 1987, and on a continuing basis as annual IDT reviews occur, the IDT of each resident shall document the rationale for the need for guardianship, conservatorship, or restoration to capacity. By June 1, 1987, submit three residents' annual reviews that contain this documentation.

19. Citation: Minnesota Rules, part 9525.0280, subpart 2.

Violation: The program did not consistently carry out the responsibility of developing and maintaining a warm, family or home-like environment conducive to the achievement of optimal development by the resident. The program is not designed to use naturally occurring situations to teach residents functional living skills. For example:

a. In Cottage 11, North, staff were observed carrying out household chores without including residents in the activities. Household chored are naturally occurring opportunities to teach social interaction skills or functional daily living skills.

b. In McBroom building, observations on three consecutive days revealed a lack of staff interaction during peak programming hours between 4:15 and 7:15 p.m. Television was the only activity or source of stimulation at the times of the observations. During two observations, all of the staff persons were seated In the dining room while residents were in the living area. During these observations, there were no interactions between residents and staff, nor was any training provided.

Time Frame for Correction: Develop a plan for and provide training to direct care staff to teach them how to use naturally occurring situations to teach functional living skills to residents. Submit the plan by August 1, 1987, and complete the training of staff by January 1, 1987.

20. Citation: Minnesota Rules, part 9525.0280, subpart 7.

Violation: Many resident bedrooms were devoid of personal belongings or personal belongings were locked away. For example:

a. In Cottage 11, there were no personal possessions observed in the East and North households; one resident had a locked box of personal letters adjacent to her bed, but had to ask a staff person for a key to gain access to her personal letters.

b. In Cottage 8, the residents had to request keys for access to personal televisions, stereos, and radios in resident bedrooms in South and East households.

Time Frame for Correction: By June 1, 1987, submit a plan to provide residents with access to personal possessions. All residents shall have free access to their personal possessions by September 1, 1987, unless their individual program plans contain documentation as specified in item #8.

21. Citation: Minnesota Rules, part 9525.0330, subpart 2. Behavioral Assessment.

Violation: Records for residents #5770, #4426, #3948, #5220, and #5581, contained no evidence that the resident participated in the behavioral assessment process, when he/she was capable of participation, or that data were supplied by his/her parents, when appropriate.

Time Frame for Correction: At the time of the annual IDT meeting, each resident must be included in the behavioral assessment process when he or she is capable and behavioral assessment data must be requested from his/her parents, when appropriate, or the record must document why the resident or the resident's parents were not involved in the behavioral assessment process. —

22. Citation: Minnesota Rules, part 9555.8200.

Violation: The vulnerable adult assessments and program abuse prevention plans did not address each site (building) where services are delivered.

Time Frame for Correction: By May 1, 1987, submit assessments and plans of the physical plant, population, and environments that are specific to each building or living unit and evidence that the plan has been posted at each site.

23. Citation; Minnesota Rules, part 9555.8200, subpart 3.

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

Time Frame for Correction: By May 1, 1987, submit a program abuse prevention plan for each building.

24. Citation: Minnesota Rules, part 9555.8200, subpart 4.

Violation: The Regional Human Service Center's governing body is required to review the program abuse prevention plan on an annual basis, and revise as necessary. With the exception of Boswell unit day program, the program abuse prevention plans that were reviewed had not been updated since August 1985.

Time Frame for Correction: By May 1, 1987, submit evidence that the governing body has reviewed the plan.

RECOMMENDATIONS

The following recommendations are not requirements of Minnesota Rules or laws governing your services or program. These recommendations are provided to call your attention to areas where your program or service is in minimum compliance with the requirements of rules or laws but it would be advisable to strengthen your efforts in these areas.

Failure to follow these recommendations will not result in a fine or action against your license at this time. However, should failure to follow recommendations result in a violation of rules or laws at a future date, you will be cited for noncompliance and may be subject to fines or action against your license.

1. Minnesota Rules, part 9525.0280, subpart 4., require the rhythm of life "on the living unit to resemble the cultural norm for nonhandicapped peers." Observations indicated few opportunities for community integration as part of the day program. It is recommended that the coordinator of the day program contact a regional treatment center which has been successful at placing residents in community employment to discover ways of funding community employment. It is recommended that the facility contact the program director at Faribault Regional Treatment Center.

   There is a lack of active recreational activities. Observations and activity logs showed typical activities were primarily passive. It is recommended that the program evaluate the type of activities offered and plan a variety of activities to fulfill residents' needs.

2. It is recommended that the IDT review changes in placement within the facility. One resident had three placements internally in approximately 14 months. No documentation of the need for this individual to move was found.

PENALTY FOR FAILURE TO CORRECT VIOLATIONS

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

RIGHT TO APPEAL

The decision to issue a probationary license may be appealed by notifying the Commissioner of Human Services in writing, within ten days of receipt of this letter.

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

Sincerely,

Charles C. Schultz
Deputy Commissioner

RH/6mesl

cc: Sandra S. Gardebring, Commissioner of Human Services
Margaret Sandberg, Assistant Commissioner
Al Hanzal, Assistant Commissioner
Maria Gomez, Assistant Commissioner
Beverly Heydinger, Assistant Attorney General
Julie Brunner, Welsch Compliance Unit
Mary Stanislav, Special Assistant Attorney General