UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

James and Lorie Jensen, as parents, guardians and next friends of Bradley J. Jensen, et. al, Plaintiffs, vs. Minnesota Department of Human Services, an agency of the State of Minnesota, et. al., Defendants.	Court File No.: 09-CV-1775 DWF/FLN **DECLARATION OF SHAMUS P. O'MEARA**

I, Shamus P. O'Meara, state and declare as follows:

1. I have served as lead counsel for the Settlement Class throughout this matter including prior to the commencement of the action, during all settlement negotiations, and throughout the implementation of the Stipulated Class Action Settlement Agreement approved by the Court in 2011.

2. Attached as **Exhibit A** is a copy of Defendant DHS public investigation memorandum dated February 24, 2017, identifying substantiated neglect of a vulnerable adult Class Member.

3. Attached as **Exhibit B** is a copy of Defendant DHS public investigation memorandum dated May 25, 2017, identifying substantiated abuse and neglect of a vulnerable adult member of Successful Project Life, a group connected with the settlement and related Court Orders.

4. Attached as **Exhibit C** is a true and correct copy of Defendant DHS public investigation memorandum dated June 20, 2017, identifying substantiated neglect of a vulnerable adult Class Member.

5. Attached as **Exhibit D** is a true and correct copy of Defendant DHS public investigation memorandum dated June 30, 2017, identifying substantiated neglect of a vulnerable adult Class Member.

5. Attached as **Exhibit E** is a true and correct copy of Defendant DHS public investigation memorandum dated October 11, 2017, identifying substantiated abuse of a vulnerable adult Class Member

6. On January 11, 2011, defendants' counsel provided our office with the enclosed email and redlined version of the draft Settlement Agreement (attached as **Exhibit F**) which added the words, "for two (2) years from its approval of this Agreement" to subpart B of the Dismissal and Retention of Jurisdiction section, and provided no further changes to this jurisdiction provision.

Dated: November 6, 2017

/s/ Shamus P. O'Meara

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Shamus P. O'Meara

SPO's Declaration.doc (rev.)

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: 20167621

Date Issued: February 24, 2017

Name and Address of Facility Investigated:

Community Living Option Hugo
17112 Farnham Avenue North
Hugo, MN 55038

Community Living Options
26022 Main Street
Zimmerman, MN 55398

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

License Number and Program Type:

1070501-H_CRS (Home and Community Based Services-Community Residential Setting)
1070470-HCBS (Home and Community-Based Services)

Investigator(s):

Lindsay Arth
Minnesota Department of Human Services
Office of Inspector General
Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
651-431-6537

Suspected Maltreatment Reported:

It was reported that a vulnerable adult (VA) failed to receive required supervision when s/he left the facility. Additionally, the VA left barefoot and was not diagnosed with second degree frostbite until three days later.

Date of Incident(s): December 16 through December 28, 2016

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 17, paragraph (a):

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.

EXHIBIT A

Summary of Findings:

Pertinent information was obtained during a site visit conducted on January 3, 2017; from documentation at the facility, law enforcement records, and medical records; and through 13 interviews conducted with the VA, the VA's guardian (G) who was also a family member of the VA, the VA's case manager (CM), a facility registered nurse (RN), facility staff persons (P2, P4, P5, P6, P7, P8, and P9), and two supervisory staff persons (P1 and P3). Attempts were made by phone to contact and interview three additional staff persons (P10, P11, and P13) but the attempts were unsuccessful.

The facility was located off of a dead end road; however, there was a two lane road (170th Street), with a speed limit of 55 miles per hour (MPH), located approximately one block from the facility. The facility was a split level home with three exterior doors including: in the entryway; off of the kitchen that lead into the garage; and a sliding deck door in the dining area. Each exterior door was equipped with alarms that when opened sounded with three "beeps," followed by audio that stated what door was opened, (i.e. "kitchen door"), when someone attempted to open it. There were also alarms on each window that sounded when opened, and did not stop, until the alarm was reset.

The *Individual Service Plan* stated that the VA's diagnoses included "moderate" autism spectrum disorder with "accompanying intellectual [and language] impairment" and "mild" developmental disability. The VA enjoyed crafts, cooking and baking, swimming, and listening to music.

The *Self-Management Assessment of Risks* dated May 20, 2016, provided the following information:

- The VA was able to report illness but may not report illness or injury "accurately." Staff persons were to "monitor [the VA] daily whether or not [the VA] appears to be injured or ill." If the VA "complains" of pain or illness, staff persons were to assess the VA and provide treatment according to their training or consult the facility nurse or the VA's physician. If the VA was in need of emergency medical attention, staff persons were to transport the VA to the nearest emergency room or call 9-1-1.

- The VA "may elope and lay in the middle of the road when [s/he was] upset." Staff persons provided "24 hour assistance" and were to use the "steps of graduated guidance [and/or] therapeutic intervention" techniques when the VA was "upset to attempt to prevent [the VA] from reaching the street and putting [him/her] self in danger." Additionally, staff persons were to check on the VA every 30 minutes while at the facility and be within visual range of the VA when s/he was in the community. If the VA attempted to leave the facility, staff persons were to block the exits and verbally cue the VA to "stop" and ask about the "issue that concerns [the VA]."

- The VA "may not dress suitably for weather conditions," and when the VA was "upset, [s/he] may go out into freezing winter conditions without adequate clothing, jacket, or shoes and lay on the ground." Staff persons were to provide reminders to the VA to wear weather appropriate clothing and assist the VA with making appropriate clothing selections if needed. Staff persons were to use the "steps of graduated guidance" and/or therapeutic intervention as necessary to attempt to prevent the VA from going outside without weather appropriate clothing.

- The VA "may not follow directions in dangerous circumstances" if s/he was "upset" and staff persons were to contact 9-1-1 or emergency personnel if necessary. The VA was unable to be without staff person supervision both at home and in the community.

The *What is Graduated Guidance* stated that graduated guidance were verbal cues, gestures, modeling techniques, prompts, or hand over hand assistance used to assist a person with participating in a desired behavior, such as brushing their teeth.

According to the *Quick Look*, the VA had a history of physical aggression, self-injurious behavior, and "elopement." The *Adult Rehabilitative Mental Health Services* dated March 23, 2015, stated that during a "relapse [or] crisis," staff persons were to assist the VA with using "sensory tools," including stuffed animals, games, or coloring a picture. The *Community Living Options Crisis Plan* stated that staff persons were to remain "within hearing distance of [the VA] at all times."

The staff schedule for December 2016, provided the following information:

- On December 15, 2016, P2 worked from 3 p.m. and did the overnight until 9 a.m. on December 16, 2016. On December 16, 2016, P1 worked from 7 a.m. to 3 p.m. P7 worked from 12:30 to 9 p.m. and P4 worked from 3 to 11 p.m. A staff person (P14) worked from 11 p.m. and did the overnight until 9 a.m. on December 17, 2016.

- On December 17, 2016, P5 worked from 9 a.m. to 11 p.m. P11 worked from 9 a.m. to 5 p.m. and P13 worked from 5 to 11 p.m. A staff person (P15) worked from 11 p.m. and did the overnight until 9 a.m. on December 18, 2016.

- On December 18, 2016, P6 worked from 9 a.m. to 3 pm. P9 worked from 9 a.m. to 9 p.m. and P8 worked from 2 to 11 p.m. P8 worked from 2 to 11 p.m. and P10 worked from 11:30 a.m. to 8 p.m. A staff person (P12) worked the overnight shift from 11 p.m. until 9 a.m. on December 19, 2016.

The *Incident Response Reporting and Review* policy stated that staff persons were to "respond to" and report all incidents in a "timely and effective manner" including "extensive second or third degree frostbite and other frostbite for which complications are present." If there was a medical emergency, unexpected serious illness, or significant unexpected change in an illness or medical condition, staff persons were to assess if the person required the program to call 9-1-1, seek physician treatment, or hospitalization. Staff persons were to provide first-aid as "trained" until additional medical care was sought. The facility also had a first-aid kid and first-aid manual "accessible" to staff persons. An untitled document stated that emergency use of manual restraint meant using a manual restraint when a person posed an "imminent risk of physical harm to self or others" and was the "least restrictive" intervention that would achieve safety.

The *Community Living Option Vulnerable Adult/Child Investigative* Summary, the *Health Notes*, law enforcement records, and medical records provided the following information:

- On December 16, 2016, around 6:50 a.m., the VA was "agitated" and P1 and P2 were "unsuccessful at redirecting or negotiating" the VA. P1 blocked the front door and the VA "grabbed and threw" the television (TV) while P2 "caught and secured the TV." During this time, the VA ran out the kitchen door into the garage and P2 asked the VA to come back inside and stated that it was "too cold for [the VA] to be outside." The VA was wearing pajama shorts, a t-shirt, and was barefoot, so P2 took off his/her coat and "offered" it to the VA. The VA walked to a "busy" road (170th street) and laid on the road. It was "dark and there was oncoming traffic" and P2 "pulled" the VA to the shoulder of the road to get the VA "out of the street as it was too dark for anyone to see [him/her]." Additionally, people driving by stopped to see if the VA and P2 needed help and "offered clothing and things to help keep [the VA] warm."

- At some point during the incident, P1 called P3 for "back up" and P3 advised P1 that it was "too cold "to wait for back up and to call 9-1-1. The *Washington County Sheriff's Office* report showed that 9-1-1 was called at 7:05 a.m. and an ambulance arrived and took the VA back to the facility. P1 spoke to the EMT's to see if there was anything they should "do or watch for" and the EMT's stated that the VA "was not outside for more than 15 [or] 20 minutes [and the VA] should be okay. [The VA] does not have any symptoms at this time."

- P1 noted in the *Health Notes* dated December 16, 2016, that there was some "redness" on the bottom of the VA's feet and left leg due to "being in the cold." Additionally, later in the day, P7 noted that the VA had blisters on his/her left foot and toes including an "open blister area" near his/her "big toe of right foot." The VA's "left outer leg" also had "redness."

- According to the *Health Notes*, on December 17, 2016, P5 noted that the VA had blisters on both feet and "some of the blisters have turn[ed] to wounds." Staff persons applied triple antibiotic ointment to the "wounds and blisters" and "will continue to monitor [the VA's] foot." At 11:15 p.m., P15 noted that the VA was "upset" and stated that his/her "feet hurt from the blisters [s/he] got from standing out in the snow and cold on [December 16, 2016]." A staff person gave the VA acetaminophen for "pain."

- According to the *Health Notes*, on December 18, 2016, at 9:50 a.m., P9 noted that the VA "requested cream for [his/her] blisters on the bottom of [his/her] feet." P9 applied triple antibiotic ointment and continued to "monitor." At 5 p.m., P9 noted that the VA "started picking at [his/her] frostbitten blisters" and began crying. At 6:35 p.m., the VA "soaked" his/her feet and P9 applied antibiotic ointment. P9 also noted that the VA "opened [his/her] frostbitten feet blisters." On December 19, 2016, P12 noted that s/he was "unable to follow up" on the "sores" on the VA's feet as the VA was asleep.

- On December 19, 2016, P1 and P3 were at the facility and noticed "open wounds" on the VA's feet. The *Health Notes* stated that the VA was taken to the hospital and diagnosed with second degree frostbite on both feet and toes and was prescribed Cephalexin 500 milligrams (mgs) three times a day to "help prevent infection due to [his/her] blisters and frost bitten feet." The VA was referred to the Hennepin County Medical Center (HCMC) wound clinic for his/her "wounds."

- The *Burn and Wound Clinic [HCMC] Initial Visit* dated December 20, 2016, stated that the VA had "superficial and partial thickness burns" to his/her right and left feet. Additionally, there were "several serous filled blisters" and "open areas with pink, moist, [and] blanching dermis." There was "some discoloration present" and the areas were "tender to touch." The VA had "pain" in his/her feet and the facility was giving the VA Tylenol and ibuprofen.

- On December 20, 2016, the VA again "eloped barefoot" and did not have anything on his/her feet except "bandages" for the frostbite. P4 was cooking dinner and heard the VA on the phone "agitated." P4 asked the VA if s/he wanted his/her as needed (PRN) medication and the VA "walked right out the front door while [P4] was at the stove." P4 called P1 and "asked for back up" but P4 then called P1 "back" and stated that s/he was "just calling 9-1-1 because it was too cold and [the VA's] feet were bare except for bandages." P4 called 9-1-1 and the EMT's and police arrived and brought the VA back to the facility.

- On December 28, 2016, the VA "demanded to go shopping" and P5 reminded the VA that a dance was planned for that night. The VA stated to P5, "If I do not get what I want, I am going to elope and get more frostbite." P5 offered the VA his/her shoes and coat if s/he "wanted to go outside but explained that it was not safe to go outside and offered games or crafts instead." P5 attempted to block the exit but the VA

> "shoved [P5] out of the way and exited [the] home." The VA was wearing socks but no shoes and did not have a coat on. P5 called 9-1-1 and followed the VA down a ""dirt road." The *Washington County Sheriff's Office* report showed that 9-1-1 was called at 2:20 p.m., and when law enforcement arrived, the VA was "located" in a "snowbank" and had on a short sleeve shirt, pants, and no socks. When the ambulance arrived, the VA was "less than coop[erative]" and the VA was transported to Fairview Riverside Hospital. The *Health Notes* stated that the VA was diagnosed with "two new blisters" on his/her right foot and two "new" blisters on his/her left foot. The VA also had blisters on his/her toes and one new blister on his/her left heel. Medical records from the Fairview emergency department stated that on December 28, 2016, the VA was seen for frostbite on both feet. The VA's feet were to be "protect[ed]" from the cold which was "the most important thing to do."

According to www.wunderground.com, the temperature on December 16, 2016, in Hugo, ranged from 6 to 14 degrees Fahrenheit. At 6:50 a.m., the temperature was 10.4 degrees Fahrenheit. The wind speed was 5.8 miles per hour and the wind chill was 0.8 degrees Fahrenheit. On December 20, 2016, the temperature ranged from 26 to 39 degrees Fahrenheit and at 3:45 p.m., the wind chill was 27.1 degrees Fahrenheit. On December 28, 2016, the temperature ranged from 21 to 37 degrees Fahrenheit and at 1:45 p.m., the wind chill was 29.8 degrees Fahrenheit

The facility also had a National Weather Service *Wind-chill Chart* provided to them as part of a November 2012 letter from the Office of the Ombudsman for Mental Health and Developmental Disabilities. The chart determined based on temperature and wind what the wind chill temperature was outside. Then based on the wind child temperature there were four areas indicating "frostbite times:" no time indicated, 30 minutes, 10 minutes, and 5 minutes. The "frostbite times" for December 16, 20, and 28, 2016, were in the no time indicated portion of the chart.

The VA stated that s/he tried his/her "very hardest not to elope from other staff." According to the VA, a "couple weeks ago," s/he left the facility without staff person supervision "barefoot" and got frostbite on both the "top and bottom" of his/her feet. The VA stated that P2 followed the VA and the VA "wanted to lay" in the street but P2 "did not let me" and the VA "tried to bite" P2. The VA stated that s/he did not go to the doctor right away because s/he had his/her "quarterly" meeting but at some point during the meeting, the VA stated that his/her feet were "pretty sore."

P1 provided information to this investigator regarding the incident on December 16, 2016, that was consistent with the *Community Living Option Vulnerable Adult/Child Investigative* Summary, the *Health Notes*, and law enforcement records. P1 also provided the following information:

- On December 16, 2016, P1 did a "body assessment" following the incident and after the VA took a shower. According to P1, the VA "did not have any marks at the time; however, [the VA] had some redness on [his/her] feet and also a little redness on [his/her] body which is typical after [the VA] gets out of the shower." P7 arrived to the facility at 12:30 p.m., and P1 told P7 that the VA "eloped this morning," and was "barefoot," and that P7 should read the "log notes" regarding the incident.

- On December 19, 2016, at 7 a.m., P1 arrived to the facility and around 9 a.m., the VA awoke and P1 observed "a giant blister" on one of the VA's toes, but P1 did not recall which toe. P1 stated that the blister made him/her want to "puke." The VA's feet were also red with a "little bit of purple." P1 took the VA to the doctor where s/he was diagnosed with second degree frostbite. P1 also stated that s/he contacted and spoke to the RN on December 19, 2016, regarding the incident and the RN stated that s/he was "happy

[P1] got [the VA] into the burn clinic so quickly as those appointments were so hard to get." The RN asked P1 to call him/her after the appointment at the burn clinic and on December 20, 2016, after the VA's appointment, P1 called the RN and told him/her about the VA's "wound care plans."

- P1 stated that s/he received two phone calls from staff persons at the facility over the weekend (December 17 and 18, 2016) but none were regarding the VA's feet. P1 also stated that s/he was not aware of any staff person, including P8, attempting to call him/her regarding the VA's feet. P1 stated that s/he should have received a phone call regarding the status of the VA's feet and the VA should have been seen by a health care professional over the weekend. At some point following the incident, P8 and P10 told P1 that over the weekend, the VA stated that his/her feet were "really sore" and they observed blisters on the VA's feet. P1 told P8 and P10 that the VA "should have gone in that day and [the VA's feet] should not have been something they should have treated on their own." If a staff person had a medical concern, the facility had a "*who to call and when to call list*" that was posted. Staff persons were also trained to contact P1 or P3.

- P1 stated that the VA was "re-diagnosed" with frostbite following the December 28, 2016, incident. Staff persons were trained to block the facility doors if the VA was attempting to leave the facility. If the VA left the facility, staff persons were to follow the VA.

P2 provided information to this investigator regarding the incident on December 16, 2016, that was consistent with the *Community Living Option Vulnerable Adult/Child Investigative* Summary, the *Health Notes*, and law enforcement records. P2 also stated that s/he told the paramedics that the VA had been "outside for a while" but P2 did not know if they did an assessment on the VA's feet. P2 did not look at the VA's feet following the incident and did not know if P1 or P3 looked at the VA's feet. If the VA attempted to leave the facility, staff persons were trained to "block" the exits but at the time of the incident, P2 did not block the exits because the VA threw the TV and P2 was worried that the TV would hit another client who was present. If a staff person had a medical concern regarding a client, they were trained to notify the RN or P3.

P3 provided the following information:

- On December 16, 2016, a few minutes prior to 7 a.m., P3 received a phone call from P1 stating that the VA had "eloped" from the facility. P3 told P1 to call 9-1-1 as s/he "knew it was urgent" as it was "bitterly cold" and below zero outside. P1 told P3 that 9-1-1 arrived and "assessed" the VA and the EMT's told P1 that the VA was "okay" and that there was "no reason to go to hospital." Additionally, P3 did not think that the EMT's expressed any "concern" or provided any "instruction" for what staff persons should be "watching for" going "forward." Around 10 a.m., P3 arrived to the facility but did not look at the VA's feet because P1 had already observed them. The VA stated that his/her feet were "cold" but s/he did not indicate they "hurt." The VA had a quarterly team meeting already scheduled for the day and the VA's team discussed "upping" the VA's staffing ratio so the VA had one to one staffing and at some point, the facility submitted a request to the CM for one to one funding for the VA.

- The VA had "multiple elopements" and P3 was aware of the VA leaving the facility without staff person supervision "definitely more than 10" times. The VA had a history of going to a "busy road" with a speed limit of 55 miles per hour. The VA's team "request[ed]" that staff persons "physically" "block" the exits and P3 stated that staff persons were doing that "most of the time" but there were "several staff injuries [that occurred] when they were trying to block access." At some point, the G also asked if the facility could put locks on the doors but P3 told the G that they "could not" due to "other individuals in the home."

At some point, EMT's told P3 that the VA "did not belong [at the facility] and belongs in a facility with locked doors." P3 discussed that with the G who stated that s/he was "familiar" with those types of facility's but "did not know if [s/he] wanted [the VA] in a place like that."

- The facility trained staff persons to be "proactive," because staff persons could "tell if [the VA] was going to have a good day or bad day usually before [s/he] gets to that point." Staff persons were trained to offer the VA sensory items, including a weighted blanket or applying "deep pressure." Additionally, staff persons were trained to "negotiate and try to problem solve" with the VA and P3 stated that "more often than not that would work." Staff persons could also implement an emergency use of a manual restraint (EUMR) as a "last resort."

- Regarding the incident on December 16, 2016, P3 stated that s/he did not receive any phone calls from staff persons regarding the VA's feet and that s/he "cannot believe no one called us over the weekend." P3 thought that the VA "should have been brought in [for medical attention] over the weekend." Additionally, P1 and P3 were "available all weekend." Staff persons had the "ability" to seek medical care for a client, including taking them to the doctor or notifying the facility nurse and were also trained in first-aid. P3 spoke to staff persons following the incidents, including P4, and P4 stated to P3, "Why would I call you for frostbite?" According to P3, staff persons had a "feeling they cannot do anything for frostbite."

P4 provided the following information:

- On the evening of December 16, 2016, P4 went to the facility and was told by a staff person, who s/he did not recall the name, that the VA had "eloped that morning" which was "not anything out of the ordinary." P4 read the progress notes and stated that they did not indicate how long the VA was outside or what actions staff persons needed to do including if staff persons needed to monitor the VA's feet. P4 did not look at the VA's feet because P7 was "already" at the facility and the VA did not express any concerns regarding his/her feet. P4 left the facility at 11 p.m., and did not come back until the "following Monday" when the VA had been diagnosed with frostbite. P4 stated that staff persons were trained to handle frostbite through their first-aid training. Additionally, staff persons could contact the RN but s/he was "not very easy to get a hold of."

- On December 20, 2016, P4 was in the kitchen making dinner and P9 was downstairs getting medications ready for a client. The VA was on the phone and P4 "noticed" that the VA was "getting upset." P4 offered the VA his/her PRN medication and the VA stated that s/he did not need it. The VA "seemed okay" and P4 continued cooking. At some point, P4 heard the "alarms go off" and P4 observed the VA "going out the front door." The VA was wearing hospital socks and his/her feet were "gauzed up." P4 called 9-1-1 because the VA already had frostbite from the December 16, 2016, incident and P4 "did not know how long [the VA] would be outside." P4 drove to 170th Street and the VA was sitting on the shoulder of the road. P4 offered the VA a blanket and the VA stated, "Leave me the fuck alone," and P4 waited until an ambulance arrived. Following the incident, P4 looked at the VA's feet and stated that they were "not wet or anything" and that the "gauze did not even need to be changed."

- According to P4, staff persons "need[ed] to check on [the VA] a lot and make sure [the VA] has attention," otherwise the VA could "at any point decide to go out the door." Staff persons were trained to block the exits and "not let [the VA] get out." P4 stated that "blocking" the exits worked if a staff person "can get in front of [the VA]," but staff persons "will still be attacked." Staff persons could also implement an EUMR but it was "tricky because [the VA] is pretty strong and [the VA] bites." When this investigator asked P4

what concerns s/he had regarding the incidents, P4 stated that the facility did not have enough "consistent" staff persons. P4 also stated that s/he "did not know [if this] kind of facility is something [the VA] should be in."

P5 provided the following information:

- The VA had a history of leaving the facility without staff person supervision when s/he was "upset if [s/he] cannot get what [s/he] wants." A "couple weeks" prior to January 3, 2017, the VA left the facility without staff person supervision and then "eloped a second time [December 28, 2016]," and received "more blisters." At some point, P5 observed "water blisters" on a "couple" of the VA's toes and on the sides and tops of both feet. Additionally, a couple blisters were open and P5 stated, "Oh my God. That does not look good," and the VA stated that the blisters did not hurt. P5 and P7 discussed that the VA go in for medical attention but P5 did not recall what day it was.

When this investigator asked P5 why s/he did not notify anyone regarding the entry s/he wrote in the *Health Notes* dated December 17, 2016, indicating that the VA had blisters on both feet and "some of the blisters have turn[ed] to wounds," P5 stated that P1 was at the facility "when it happened" and P1 did a "body assessment" and had "already cleaned the wounds."

- P5 stated that "last Wednesday [December 28, 2016]," around 1:30 p.m., the VA wanted to go personal needs shopping and P5 told the VA that it was "not an option" and that s/he was going on Friday. P5 also called the house manager who stated that the personal needs shopping was scheduled for Friday and that the VA could not go. P5 offered the VA games and the VA told P5 that s/he would "elope." P5 was the only staff person at the facility and s/he locked the doors and the VA "tried hitting me." The VA also "pushed" P5 and opened the back door and "started going outside barefoot." P5 also stated that the VA had "thick" socks on and bandages under the socks. P5 called P1 who told P5 to call 9-1-1 because it was "really cold outside" and the VA was not "properly dressed." P5 called 9-1-1 and followed the VA. Law enforcement arrived about 10 or 15 minutes "later" and took the VA to the hospital. Following the incident, P5 was told that the VA had "more frostbite" on his/her toe but at the time of the incident, the VA would not let P5 see his/her feet because s/he was "too tired."

- P5 stated that it worked well to have two staff persons working at the facility so one staff person could block the back door and one staff person could block the front door. If the VA was attempting to leave the facility, staff persons were trained to lock the doors. Staff persons were also trained to offer the VA crafts and "keep [him/her] busy." If there was a medical concern, staff persons were trained to notify the RN and the "managers" and fill out a "report."

According to P6, at some point (s/he did not recall the date), s/he arrived to the facility and P2 told P6 that the VA "eloped barefoot or without shoes" and that law enforcement had to "come and assist." P6 stated that s/he worked on December 18, 2016, but did not see the VA's feet. P6 stated that s/he asked the VA if s/he could "check [the VA's] feet out" or if the VA needed acetaminophen or ibuprofen but the VA stated, "No, because it did not work." At some point P6 was aware that the VA received frostbite on two different occasions. P6 did not have any concerns that there was a delay in seeking medical attention for the VA's frostbite because staff persons typically took in clients "right away" and from his/her "understanding," the VA was not taken in the day of the incident (December 16, 2016,) "because of what medical personnel [EMS] said." P6 stated that s/he was trained how to handle frostbite through his/her training and that the facility had a "weather grid" that was posted in the home which indicated temperatures at which a person could get frostbite. Staff persons could also call the RN or a supervisory staff person if they had medical concerns. The VA "usually threatens" to leave the facility "before [s/he] does it" and staff persons could "block the doors" with their bodies. Additionally, staff persons could lock

the doors but the VA was "able to unlock them [him/her] self." P6 stated that one of the risks when the VA left the facility was the highway and P6 stated that it was "not a good location for any individual that has [a history] of elopements." P6 stated that the facility was not a good place for the VA as it was "not safe for [the VA] or staff" and that the VA required "more one to one attention."

According to P7, on December 16, 2016, around 7 p.m., the VA was getting ready for bed and the VA stated that s/he had a Band-Aid on his/her feet from his/her day program that needed to be replaced. P7 observed that the VA's feet were "a little red" with a "couple tiny blisters." P7 stated that it was "not a major thing" and s/he "assum[ed]" the VA's shoes were "bothering [the VA]." P7 replaced the Band-Aids and the VA went to bed. P7 left the facility and "found out later," by "reading things," that the VA had "eloped that day." P7 stated that was "the only information I received" and no staff person had told P7 that the VA left the facility barefoot. The VA had a history of leaving the facility without staff person supervision "a lot." P7 stated that the VA would "straight out tell you" that s/he "will elope" prior to leaving. P7 redirected the VA and provided the VA crafts and talked with the VA. P7 also told the other staff person that "something seems to be coming" and that they needed to "watch" the doors or "be in those areas" if the VA tried to get out. P7 stated that "usually "worked and the VA "changed [his/her] mind." The facility typically had two staff persons for three or four clients but P7 stated that the VA "should" have a one to one staffing ratio. If a staff person had a medical concern, staff persons were trained to contact the on call nurse or manager or P3.

P8 stated that at some point around December 20, 2016, s/he worked with P9 and P10. P8 was told by P9 and P10, and also read in the VA's health notes, that the VA had been diagnosed with frostbite the "day before." The VA had red and pink blisters on both his/her feet and P8 could "tell they were trying to heal." At some point during P8's shift, the VA was "having a behavior" and was "picking" at his/her feet and "crying" a lot. The VA began "peeling" the blisters and P8 stated that the blisters were not open until the VA began "peeling them." P8 tried calling "whoever was on the emergency list," including P1, regarding the VA picking at his/her blisters, but no one answered. At some point that day, P9 spoke to the RN who stated that they needed to "wait until [the VA] calms down." P9 also spoked to P1 who stated that staff persons needed to "deal with it on [their] own." P8 soaked the VA's feet and P10 applied antibacterial cream on the VA's feet and "wrapped" them. P8 was aware of two incidents where the VA received frostbite but s/he did not have additional information because s/he did not work at the facility "that often." When this investigator asked P8 why the staff schedule showed that s/he worked on December 18, 2016, prior to the VA being diagnosed with frostbite, P8 denied working and stated that s/he worked "after" the VA was taken to the doctor and diagnosed. If P8 suspected a client had frostbite, s/he would contact the house manager or the RN or s/he would "take [the VA] in personally." P8 stated that the VA would "tell you" that s/he was going to leave the facility and staff persons were trained to "keep an eye" on the VA, redirect the VA, and block the door.

According to P9, approximately a "week before Christmas," s/he read in the VA's "health notes" that the VA "eloped." When this investigator asked P9 if s/he worked with the VA prior to the VA seeking medical attention (on December 19, 2016,), P9 stated that s/he "was not there." This investigator told P9 that the schedule indicated that s/he worked on December 18, 2016, and P9 stated that s/he recalled working but that P10 "took care of [the VA's] feet" and that s/he did not see the VA's feet. When this investigator asked P9 why s/he documented in the *Health Notes*, on December 18, 2016, that s/he applied triple antibiotic ointment to the VA's feet and then at 5 p.m., noted that the VA "started picking at [his/her] frostbitten blisters" and "opened [his/her] frostbitten feet blisters," P9 stated that P10 "told me" and P9 documented what P10 told him/her. P9 stated that staff persons "usually" documented what they observed and did not document for other staff persons. If a staff person had a medical concern with a client, staff persons were trained to call P1, the house manager, or the on call staff person. If a staff

person could not reach a supervisory staff person, P9 stated that s/he would "take [the client] in" to seek medical attention. P9 "did not think" that the facility provided any training regarding how to treat frostbite but stated that s/he did receive first-aid training but "did not know" if frostbite was covered.

The RN stated that s/he was aware of the incident on December 28, 2016, where the VA got frostbite but was not aware of the incident on December 16, 2016, and stated that was "another boo boo." According to the RN, s/he was notified "a day or two" after the (December 28, 2016,) incident and stated that it does "not feel right" that s/he was notified about the VA's frostbite after the incident. The RN stated that it was his/her job to "direct" staff persons what to do s/he and if s/he was notified, s/he would have told staff persons that it was "minus 27 degrees" outside and that it was "common sense" that the VA should go to the hospital. The RN was concerned that s/he was not notified of the incident right away and stated that it was "not safe for the clients if the nurse do not know." According to the RN, some staff persons did not have "common sense" and the facility had "frequent" staff turnover and did not have a house manager. At some point, the VA also had a "respiratory infection" and was treated with an antibiotic. The RN stated that it "might be possible" for the VA to get the respiratory infection from being outside in negative 27 degree temperatures but it was "so hard to tell." The RN trained staff persons to notify him/her if anything occurred medically or if staff persons were "in doubt." The RN stated that s/he was available "24 hours a day" and that staff persons were to notify him//her about medical concerns.

The G stated that the VA had a "history of eloping" and "usually goes to a busy road" and "sits down." The facility was "very aware" of the VA's "elopement history." Staff persons were not always able to "run after" the VA due to staffing. On December 16, 2016, at some point between 7 and 8 a.m., the VA left the facility and was "most likely barefoot." The G stated that s/he was concerned that staff persons did not "pick [the VA] up and carry [him/her] inside." Staff persons told the G that "because of new statutes [they are] not able to do much." On December 19, 2016, the G received an email from "coordinator" stating that they were taking the VA to the hospital to have blisters on his/her feet from the December 16, 2016, "elopement" looked at "as they are open sores after [the VA] pick[ed] at them on [December 18, 2016,] when upset." The G stated that this was the "first time" that s/he was made aware of the blisters even though staff persons "first" noted them on the evening of December 16, 2016. The G was told that the VA was diagnosed with second degree frostbite. On December 20, 2016, the G was notified by the "manager" that the VA had "eloped again while not wearing proper clothing [and] was barefoot and not wearing a jacket."

The CM stated that the VA required 24 hour supervision. The VA had "frequent" "elopements" and had been leaving the facility "more often" in the past "couple months." After the incident on December 16, 2016, the VA's team discussed getting one to one staffing for the VA but the CM stated that "a week and a half later" s/he "had not received it [the paperwork]." The CM stated that the VA was moving into a "crisis" facility but that s/he "would have liked to receive the [one to one staffing pattern information] much sooner." The CM was also "concern[ed]" that there was no "physical intervention" "earlier" during the December 16, 2016, incident and that it put the VA's "safety at risk." The CM was also concerned that s/he did not receive incident reports for all of the VA's elopements.

The untitled behavior tracking for December 2016, showed that on December 16, 20, and 28, 2016, the VA had "elopement[s]." Additionally, on December 1, 17, 18, 21, and 23, 2016, the VA had "threatened" or "tried" attempts of "elopement."

The *Elopement Procedure for [the VA]* stated that if the VA left the facility without staff person supervision, staff persons were to do an "initial search" of the facility and property for "at least 15 minutes" or follow the VA if s/he was seen "eloping." If the VA was "not seen or heard and there [were] no indications of which direction [the VA]

may have gone," staff persons were to call the house manager or P3 and the "supervisor will decide if the authorities need to be notified."

The *Positive Support Transition Plan* dated September 8, 2015, stated that the VA had six emergency use of manual restraints (EUMR) in the "last six months [as of September 8, 2015,]" due to physical aggression, property destruction, and "danger to self-due to elopement to busy roadway."

The *Home and Community Based Services Service Recipient Rights* stated that the VA had the right to be free from staff persons physically holding him/her or using a restraint "unless it is an emergency and the restraint is necessary to protect me or to protect others."

The *Incident Reporting Requirements Who Must Be Notified within 24 Hours* stated that the RN was to be notified for "serious injury," any medical emergencies, and unexpected serious illness or significant unexpected change in illness or medical condition that requires the program to call 9-1-1, physician, or hospitalization. The RN was also to be notified for a physical injury which is "not reasonably explained." The *Protocol* stated that the RN was to be notified for any "health concern."

Personnel files from the facility showed that P1, P2, P3, P4, P5, P7, and the RN were trained on EUMR, first aid, and the Maltreatment of Vulnerable Adult's Act. P1, P2, P4, P5, P6, P7, and P8 were trained on the VA's plans including his/her Community Support Service Plan (CSSP), CSSP addendum, crisis plan, elopement procedure, self-harm protocol, and Individual Abuse Prevention Plan.

Relevant Rules and/or Statutes:

Minnesota Statutes, section 245D,06, subdivision 7, states that physical contact or instructional techniques must use the least restrictive alternative possible to meet the needs of the person and may be used to redirect a person's behavior when the behavior does not pose a serious threat to the person or others and the behavior is effectively redirected with less than 60 seconds of physical contact by staff.

Minnesota Statutes, section 245D.061, subdivision 2, states that emergency use of manual restraint must meet the following conditions: (1) immediate intervention must be needed to protect the person or others from imminent risk of physical harm; and (2) the type of manual restraint used must be the least restrictive intervention to eliminate the immediate risk of harm and effectively achieve safety. The manual restraint must end when the threat of harm ends.

Conclusion:

A. Maltreatment:

Regarding the VA failing to receive required supervision when s/he left the facility:

The VA's plans stated that the VA had a history of leaving the facility and "may elope and lay in the middle of the road when [s/he] [was] upset." Staff persons were to use the "steps of graduated guidance [and/or] therapeutic intervention" techniques when the VA was "upset to attempt to prevent [the VA] from reaching the street and putting [him/her] self in danger." If the VA attempted to leave the facility, staff persons were to block the exits and verbally cue the VA to "stop" and ask about the "issue that concerns [the VA]." If the VA was successful in leaving the facility, staff persons were to do an "initial search" of the facility and property for "at least 15 minutes" or staff persons were to follow the VA if s/he was seen "eloping." If the VA was "not seen or heard and there [were] no indications of which direction [the VA] may have gone," staff persons were to call the house manager or P3 and the "supervisor will decide if the authorities need to be notified."

Although the VA left the facility on December 16, 20, and 28, 2016, and sustained frost bite on his/her feet, given that staff persons attempted to prevent the VA from leaving using the least restrictive interventions which were in accordance with Minnesota Statutes, section 245D.061, subdivision 2, and section 245D.06, subdivision 7 by blocking the door, verballing redirecting the VA, following the VA outside, and calling supervisory staff persons and 9-1-1 immediately, there was a preponderance of the evidence that there was not a failure to provide the VA with reasonable and necessary care including supervision.

It was determined that neglect did not occur (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.)

Regarding the VA sustaining frost bite on December 16, 2016, and not being taken to a doctor until three days later:

Information obtained showed that on December 16, 2016, around 6:50 a.m., the VA left the facility barefoot, wearing pajama shorts and a t-shirt. P2 followed the VA outside and offered the VA his/her coat and unknown motorists offered the VA "clothing and things" to keep warm. The temperature was 10.4 degrees Fahrenheit and the wind chill was 0.8 degrees Fahrenheit. After the VA was returned inside, P1 asked the EMT's if there was anything staff person should "do or watch for" and the EMT's stated that the VA "was not outside of more than 15 [or] 20 minutes [and] should be okay. [The VA] does not have any symptoms at this time."

Facility documentation and interviews with staff persons showed that throughout the weekend, December 16, 2016, through December 19, 2016, staff persons observed "wounds" and "blisters" develop and worsen on the VA's feet.

P7 noted in the *Health Notes* dated December 16, 2016, that the VA had blisters on his/her left foot and toes including an "open blister area" near his/her "big toe of right foot."

On December 17, 2016, P5 noted that the VA had blisters on both feet and "some of the blisters have turn[ed] to wounds." The VA also stated that his/her "feet hurt from the blisters [s/he] got from standing out in the snow and cold on [December 16, 2016,]" and the staff person gave the VA acetaminophen for "pain."

On December 18, 2016, P9 noted that the VA "started picking at [his/her] frostbitten blisters" and began crying. P9 also noted that the VA "opened [his/her] frostbitten feet blisters."

On December 19, 2016, P1 and P3 noticed "open wounds" on the VA's feet and took the VA to the hospital where s/he was diagnosed with second degree frostbite and prescribed Cephalexin to "help prevent infection."

It was reasonable for staff persons to initially inquire with the EMT's regarding what staff persons should "do or watch for," and given that the EMT's stated that the VA did not have symptoms "at this time" and "should be okay," it was reasonable to not take the VA to the doctor immediately. However, beginning that same day and for the next three days, the VA showed signs of sustaining frostbite, including blisters and discoloration on his/her feet which continued to worsen and open and caused the VA pain, yet no staff person contacted a health care professional or a facility nurse to seek guidance or direction. When the VA was taken in the VA was diagnosed with second degree frostbite and prescribed an antibiotic. Therefore, there was a preponderance of the evidence that there was a failure or omission to provide reasonable and necessary care to the VA.
It was determined that neglect occurred (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:
>
> (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.

According to the VA's plans, staff persons were to "monitor [the VA] daily whether or not [the VA] appears to be injured or ill." If the VA "complains" of pain or illness, staff persons were to assess the VA and provide treatment according to their training or consult the facility nurse or the VA's physician. If the VA was in need of emergency medical attention, staff persons were to transport the VA to the nearest emergency room or call 9-1-1.

The *Incident Response Reporting and Review* policy stated that staff persons were to "respond to" and report all incidents in a "timely and effective manner" including "extensive second or third degree frostbite and other frostbite for which complications are present." The *Incident Reporting Requirements Who Must Be Notified within 24 Hours* stated that the RN was to be notified for "serious injury," any medical emergencies, unexpected serious illness or significant unexpected change in illness or medical condition that requires the program to call 9-1-1, physician, or hospitalization. The RN was also to be notified for a physical injury which is "not reasonably explained." The *Protocol* also stated that the RN was to be notified for any "health concern."

The VA sustained injuries consistent with frostbite, including blisters that opened and discoloration on his/her feet, and had complaints of pain. At least eight staff persons working with the VA were aware that the VA was outside for a period of time, observed the condition of the VA's feet, and failed to contact a health care professional or a facility nurse. The RN, P1, and P3 each stated that they did not receive any calls from staff persons on December 17 and 18, 2016, regarding the condition of the VA's feet.

Multiple staff persons failure to ensure that the VA's "blistered" "wounds" which "hurt" causing the VA to cry, were evaluated by a medical professional represented a systemic failure. Therefore, the facility was responsible for maltreatment of the VA.

Action Taken by Facility:

Regarding the December 16, 2016, incident, the facility completed an internal review and determined that policies and procedures were adequate but not followed as "blocking exit from home should have been priority rather than securing TV" but it "seems as though staff did try to do both and responded very quickly but may have been able to get to door if [staff] had let TV land on its own." The facility trained staff persons on the importance of calling emergency responders, "immediately in a situation where there is not time for a backup staff to come," and when the staff person present was not able to assist due to maintaining safety or other individuals in the home.

Regarding the December 20, 2016, incident, staff persons should have "intervened with [the VA] as soon as they heard [the VA] become upset on the phone so they were prepared when [the VA] hung up the phone." Staff persons were trained on "turning off the store and postponing dinner prep when [they] heard that an individual is agitated" to de-escalate before it became a "bigger behavior."

Additionally, the facility sent out an email to P3 and the RN that the facility had a full time nurse "at your fingertips." Staff persons were reminded to call the nurse when there were injuries, illness, and "questions." Additionally, it noted that it was "very important" that staff persons kept the RN "updated on conditions and situations that involve any medical treatment."

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

On February 24, 2017, the license holder was ordered to forfeit a fine of $1000 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.

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: 20171472

Date Issued: May 25, 2017

Name and Address of Facility Investigated:

Divine House Inc.
7200 58th Avenue SE
Wilmar, MN 56201

Divine House Inc.
328 5th Street SW Suite 5
Wilmar, MN 56201

Disposition: Substantiated as to abuse and neglect of the VA by SP1 and neglect of the VA by SP2.

License Number and Program Type:

1084573-H_CRS (Home and Community Based Services-Community Residential Setting)
1069140-HCBS (Home and Community-Based Services)

Investigator(s):

Sarah Schumacher
Minnesota Department of Human Services
Office of Inspector General
Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
651-431-6555

Suspected Maltreatment Reported:

It was reported that during an incident a staff person (SP1) called a vulnerable adult a "fat bitch" and told the VA that SP1 would "smack the shit out of you if you hit me one more time." During the same incident, another staff person (SP2) shoved the VA three times.

Date of Incident(s): March 4, 2017

EXHIBIT B

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), clause (2); 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 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 March 28, 2017; from documentation at the facility; and through five interviews conducted with the VA, a facility manager (P1), SP1, SP2, and the VA's guardian (G).

The VA's diagnoses included type two diabetes, asthma, anxiety, hypothyroidism, fetal alcohol syndrome, bipolar, personality disorder, and affective psychosis. The VA's *Self-Management Assessment Plan* and *Individual Abuse Prevention Plan* both stated that the VA had a history of aggression towards others, property destruction, leaving without supervision, and self-injurious behaviors. In addition, the VA had a history of threatening and attempting suicide. Staff persons were to remind the VA of possible consequences, and then ask the VA to stop the behavior of concern and ask if s/he would like to talk about what was upsetting him/her. If that was unsuccessful, staff persons were to verbally redirect the VA to another task and continue to verbally encourage the VA to talk about what was upsetting him/her. It that was unsuccessful, staff persons were to use the least restrictive actions necessary to ensure the VA's health and safety. Staff persons were to call 9-1-1 if the VA was in imminent risk of self-injurious behaviors or suicide attempts. The VA had the supervision of two staff persons at all times. The VA enjoyed visiting with friends, talking on the phone, being outside, and going out in the community.

The VA was the only resident living at the facility. The VA required the supervision of two staff persons at all times. The facility had two levels. The upper level had a living room, dining room, a door that led to a patio, the VA's bedroom, and a bathroom. The lower level had a living area and two exits; one leading to a driveway and one leading to a garage.

The facility had video surveillance, some with audio and some without, of inside of the facility and outside. The incident began around 6:30 p.m. and ended around 7 p.m. when paramedics arrived. The incident was recorded and viewed by this investigator. On March 4, 2017, the following occurred:

- SP1 and SP2 were in the living room and the television was on. The VA entered the room and sat in a chair. The VA said that s/he wanted to call P1 on the phone. SP1 said s/he did not know where the phone was. The VA again said, "Can I call [P1] please?" SP1 and SP2 did not respond. The VA yelled, "Hello?" SP1 again replied that s/he did not know where the phone was.

- The VA went to the television and unplugged a cord. SP1 told the VA that s/he could not do that. The VA said it was his/her house. SP1 said it was "technically" the facility's house. Then the VA went over to SP1 and hit him/her. SP1 said, "Did you just hit me? You can't hit me." Then SP1 repeatedly said, "Hit me

again," "Touch me again and see what happens," and "Try to hit me again and see what happens." The VA and SP1 were yelling back and forth. Then SP1 said, "I'll put you in a fucking hold I swear to God."

- The VA hit SP1 again. SP1 said, "I will smack the shit out of you if you touch me one more time." SP2 tried to intervene by telling the VA not to touch SP1 and putting his/her hand on SP1 saying, "Hold on, hold on." The VA hit SP1 again. SP1 called the VA a "fat bitch." SP2 told the VA to "sit the fuck down." The VA threatened to get a knife and went into the kitchen which was next to the living room.

- In the kitchen, the VA went to the dishwasher to look for a knife. SP2 stepped in front of the dishwasher to block the VA from getting a knife. The VA then went after SP2 and pulled the hood of SP2's sweatshirt over SP2's head and face pulled it tight. SP1 attempted to put the VA in a restraint from behind. The VA let go of SP2 and went to the floor.

- The VA grabbed SP1's leg and was attempting to bite SP1's leg and threatened to break SP1's leg. SP2 attempted to help SP1 get his/her leg free. The struggle continued as SP1 tried to get the VA to let go. The VA remained on the floor. SP2 said, "Calm down [VA], calm down." Then, SP2 said that they would take the VA to the hospital and told the VA to "get into the fucking van." The VA then let go of SP1's legs.

- The VA started throwing eggs from the refrigerator at SP1 and SP2. Then the VA broke open a locked cabinet and then was breaking dishes on the kitchen floor. SP1 and SP2 went outside on a patio and closed the patio door. SP1 opened the patio door and told the VA not to hurt him/herself and that "they will put [the VA] in a 24 hour hold."

- The VA grabbed an extension cord that was plugged into the wall. SP1 called the VA a "crazy ass." The VA attempted to go onto the patio but SP1 held the door shut so the VA could not open the door. The VA went to the lower level of the facility.

- SP1 opened the patio door and said, "[VA], what's up? Don't be going outside and being stupid. If you break my car Divine House will pay for it." Then SP1 and SP2 went back into the facility and the VA went outside.

- Outside, the VA used something s/he picked up from the ground to break the window on one of the staff person's cars and broke the passenger's side mirror off of the car. Shortly after, SP1 and SP2 went outside. The VA threw what s/he had in his/her hand at SP1 and SP2 and then broke the driver's side mirror off of the same car. The VA chased SP2 while swinging the extension cord.

- SP1 was by a second car and the VA went toward SP1 swinging the extension cord. When the VA rose his/her hand with the cord to hit SP1, SP2 shoved the VA from behind with two hands on the VA's back causing the VA to take a step forward. SP1 then ran away. The VA hit the car with the cord and was going to break the driver's side mirror off when SP2 again shoved the VA on the shoulder with two hands. The VA swung the cord at SP2 who ran away.

- The VA continued to swing the cord at SP1 and SP2 and hit SP1 with the cord three times. SP1 got a car window ice scrapper from his/her car and held it up in front of him/her. The VA swung the cord at SP1 again. Then the VA went to the first car and hit it with the cord multiple times. SP2 used two hands to shove the VA's shoulder and the VA swung the cord at SP2. The VA went inside the facility. SP1 and SP2 remained outside.

- There was no audio on the camera outside but a camera inside had audio and recorded some of the things being said while the VA was outside. One of the two staff persons said, "What the fuck are you doing, "Do not touch my car you stupid bitch," and "stupid ass bitch."

- Once the VA was inside, s/he broke into a locked office and came out of the office with a very large kitchen knife. SP2 was looking in the window and saw the VA and said, "[The VA] has a knife." The VA took two quick slices at his/her wrist causing it to bleed. The VA stared at the knife and then at the cuts back and forth. The VA went toward the door that led outside with the knife and then turned around and went into the office and called 9-1-1.

- Shortly after, first responders, paramedics, and law enforcement arrived at the facility. SP2 had also called 9-1-1 when s/he saw the VA with the knife. The first responders treated the VA's cuts and said the cut was not bleeding much. Then, the paramedics transported the VA to the hospital.

Interviews with staff persons and information from the facility's *Internal Review of an Alleged Maltreatment Report* provided consistent information regarding the details of the incident seen on the surveillance cameras.

The VA provided mostly consistent information with the video. The VA stated that SP1 hit him/her with the ice scrapper but that was not seen in the video.

P1 stated that SP1 and SP2 did not act appropriately during the incident. SP1 should not have called the VA names and SP2 should not have shoved the VA. P1 stated that SP1 and SP2 were not "bad" staff persons but they were not the right staff persons to be working with the VA because they were not able to handle the incident. The VA did not have any injuries from the incident other than the self-inflicted cuts on his/her wrist

SP1 provided the following additional information:

- Prior to the VA asking to call P1 when the incident started, the VA requested to call P1 and SP1 and SP2 did do so "about twelve times" and were unsuccessful in reaching P1.

- SP1 said s/he remembered telling the VA s/he was going to "smack the shit" out of the VA and calling the VA a "fat bitch." After the VA hit SP1 in the face "several times," SP1 was "pretty pissed off."

- When showed the video by a facility administrator and asked if s/he saw a problem with what occurred, SP1 said, "Yes." SP1 stated that the VA had been having behaviors for a while that day and SP1 "lost [his/her] cool" because the VA hit him/her multiple times.

- SP1 grabbed the ice scrapper from his/her car to defend him/herself from being hit by the extension cord and used it to block the VA's attempts at hitting SP1 with the cord. SP1 stated that s/he would never use it to hit the VA.

- SP1 did not think that SP2 shoved the VA "maliciously" but only try to keep the VA away from the vehicles to prevent further damage.

- SP1 stated that s/he "understood" that "unintentionally" his/her behavior only intensified the VA's behavior and SP1 should not have said the "stupid" things s/he said.

- SP1 told this investigator that the "heat of the moment" got to him/her and SP1 "should have been smarter" about how to react to the situation.

SP2 provided the following additional information:

- SP2 gave the details of the incident as it was seen on the video. SP2 stated that s/he would be "mindful" of the words that came out of his/her mouth and his/her actions in the future.

- SP2 stated that the reasons s/he shoved the VA was to distract the VA and turn the VA's attention on SP2. SP2 did not deny any of the events shown on the video.

SP1 and SP2 were each trained on Alternatives to Manual Restraint Procedures Training, on the Safe and Correct Use of Manual Restraint on an Emergency Basis, on De-escalation Techniques, and on the VA's plans.

Conclusion:

A. Maltreatment:

On March 4, 2017, an incident occurred at the facility involving the VA, SP1, and SP2. Video surveillance, some with audio, recorded the details of the incident.

Regarding Emotional Abuse:

Video surveillance with audio showed that after the VA hit SP1 several times, SP1 said, "Hit me again," "Touch me again and see what happens," and "Try to hit me again and see what happens." The VA and SP1 were yelling back and forth and SP1 said, "I'll put you in a fucking hold I swear to God." The VA hit SP1 again and SP1 said, "I will smack the shit out of you if you touch me one more time." When the VA hit SP1 again, SP1 called the VA a "fat bitch." SP1 also called the VA "crazy ass." In addition, during the incident, SP2 told the VA to "sit the fuck down" when the VA was hitting SP1, and when the VA was holding SP1's leg and threatening to break it, SP2 said that they would take the VA to the hospital and told the VA to "get into the fucking van." Neither SP1 nor SP2 denied what was seen in the video and heard on the audio. SP1 stated that after the VA hit him/her s/he was "pretty pissed off" and "lost [his/her] cool."

Although SP2 swore twice during the incident with the VA, there was not a preponderance of the evidence whether these single statements caused emotional distress to the VA. However, given the consistent information provided regarding SP1's repeated non-therapeutic and threatening conduct and language toward the VA, there was a preponderance of the evidence that SP1's conduct produced or could reasonably be expected to produce 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).

Regarding Neglect:

Video surveillance with audio showed that at the start of the incident, SP1 and SP2 were watching television when the VA asked to use the phone, and SP1 replied that s/he did not know where the phone was. When the VA asked

again, neither SP1 nor SP2 answered the VA causing the VA to become upset. After the VA unplugged the television, SP1 made statements that continued to upset the VA such as telling the VA s/he could not unplug the television and that the house was "technically" the facility's house and not the VA's. Then after the VA hit SP1, SP1 said, "Did you just hit me? You can't hit me" and continued to engage the VA rather than helping the VA to calm down and deescalate. Other than one attempt when SP2 told SP1 to "hold on," SP2 did not intervene to stop SP1's conduct. In addition, while outside, SP2 used both of his/her hands and shoved the VA with three times: once while the VA was attempting to hit SP1 with an extension cord; once when the VA was going to break a mirror off of one of the cars, and once when the VA was attempting to hit SP2 with the cord. SP2 stated that s/he shoved the VA to get the VA's attention off of what s/he was doing and onto something else.

The VA's *Self-Management Assessment Plan* and *Individual Abuse Prevention Plan* stated that when the VA was being aggressive, staff persons were to remind the VA of possible consequences, and then ask the VA to stop the behavior of concern and ask if s/he would like to talk about what was upsetting him/her. If that was unsuccessful, staff persons were to verbally redirect the VA to another task and continue to verbally encourage the VA to talk about what was upsetting him/her and to use the least restrictive actions necessary to ensure the VA's health and safety.

Neither SP1 nor SP2 followed the VA's plans during the incident. In addition, SP1 and SP2 did not verbally redirect the VA to another task but instead continued to engage with the VA causing the VA to continue to escalate. Given that SP1's and SP2's actions at the beginning of the incident likely caused the VA's agitation by not talking with the VA about making the phone call, and that after the VA was agitated and aggressive, SP1's and SP2's actions and words likely continued to escalate the VA, and that SP1 and SP2 did not follow the VA's plans, there was a preponderance that SP1's and SP2's actions represented a failure to provide the VA with reasonable and necessary care and services.

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:
>
> (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.

SP1 and SP2 were trained on Alternatives to Manual Restraint Procedures Training, on the Safe and Correct Use of Manual Restraint on an Emergency Basis, on De-escalation Techniques, and on the VA's plans. Given that SP1 and SP2 engaged in the conduct viewed on the surveillance video, SP1 was responsible for abuse and neglect of the VA and SP2 was responsible for neglect of the VA.

C. Recurring and/or Serious Maltreatment:

The Office of Inspector General is required to evaluate whether substantiated maltreatment by an individual meets the statutory criteria to be determined as "recurring or serious." Individuals determined to be responsible for recurring or serious maltreatment are disqualified from providing direct contact services. Minnesota Statutes, section 245C.02, subdivision 16, states:

> "Recurring maltreatment" means more than one incident of maltreatment for which there is a preponderance of evidence that maltreatment occurred and that the subject was responsible for the maltreatment.

Minnesota Statutes, section 245C.02, subdivision 18, states:

> "Serious maltreatment" means sexual abuse, maltreatment resulting in death, neglect resulting in serious injury which reasonably requires the care of a physician whether or not the care of a physician was sought, or abuse resulting in serious injury. For purposes of this definition, "care of a physician" is treatment received or ordered by a physician, physician assistant, or nurse practitioner, but does not include diagnostic testing, assessment, or observation; the application of, recommendation to use, or prescription solely for a remedy that is available over the counter without a prescription; or a prescription solely for a topical antibiotic to treat burns when there is no follow-up appointment. For purposes of this definition, "abuse resulting in serious injury" means: bruises, bites, skin laceration, or tissue damage; fractures; dislocations; evidence of internal injuries; head injuries with loss of consciousness; extensive second-degree or third-degree burns and other burns for which complications are present; extensive second-degree or third-degree frostbite and other frostbite for which complications are present; irreversible mobility or avulsion of teeth; injuries to the eyes; ingestion of foreign substances and objects that are harmful; near drowning; and heat exhaustion or sunstroke. Serious maltreatment includes neglect when it results in criminal sexual conduct against a child or vulnerable adult.

It was determined that the substantiated maltreatment for which SP1 was responsible did not meet statutory criteria to be determined as recurring or serious because although SP2 was responsible for both neglect and abuse, this was considered a single incident.

It was determined that the substantiated maltreatment for which SP2 was responsible did not meet statutory criteria to be determined as recurring or serious because this was considered a single incident.

Action Taken by Facility:

The facility completed an *Internal Review of an Alleged Maltreatment Report* and determined that policies and procedures were adequate but were not followed. SP1 and SP2 were retrained on related facility policies. SP1 and SP2 were suspended until retraining was completed and then reassigned to work at other facility sites.

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

SP1 was not disqualified from providing direct care services as a result of the maltreatment determination in this report. However, SP1 was notified by the Office of Inspector General that any further substantiated act of maltreatment, whether or not the act meets the criteria for "serious," will automatically meet the criteria for "recurring" and will result in the disqualification of SP1. The determination that SP1 was responsible for maltreatment is subject to appeal.

SP2 was not disqualified from providing direct care services as a result of the maltreatment determination in this report. However, SP2 was notified by the Office of Inspector General that any further substantiated act of maltreatment, whether or not the act meets the criteria for "serious," will automatically meet the criteria for "recurring" and will result in the disqualification of SP2. The determination that SP2 was responsible for maltreatment is subject to appeal.

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: 20172511

Date Issued: June 20, 2017

Name and Address of Facility Investigated:

Crow's Nest Programs, Inc. #2
717 S Swift Ave
Litchfield, MN 55355

Crow's Nest Programs, Inc.
344 Atlantic Ave
P.O. Box 143
Kandiyohi, MN 56251

Disposition: Substantiated as to the neglect of a vulnerable adult by a staff person.

License Number and Program Type:

1068088-H_CRS (Home and Community Based Services-Community Residential Setting)
1068085-HCBS (Home and Community-Based Services)

Investigator(s):

Carla Harvieux
Minnesota Department of Human Services
Office of Inspector General
Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
651-431-6616

Suspected Maltreatment Reported:

It was reported that a staff person (SP) forgot to lock away a knife after use which permitted a vulnerable adult (VA) to obtain the knife and cut his/her wrists and abdomen. During the incident, the VA also broke a plastic hanger and attempted to swallow pieces of it, and attempted to open and ingest a bottle of liquid laundry detergent that was in the living room.

Date of Incident(s): April 18, 2017

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 17, paragraph (a):

The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited

EXHIBIT C

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 May 3, 2017; from documentation at the facility; and through interviews conducted with facility staff persons (the SP, P1, P2, and P3), the VA's case manager (CM), and the VA's guardian (G). This investigator met the VA, but the VA declined to provide information regarding the incident to this investigator.

Facility documentation showed the following information:

- The VA was diagnosed with "mild" developmental disabilities, adjustment disorder, and borderline personality disorder with anxiety. The VA's *Coordinated Services and Support Plan Addendum* (*CSSP Addendum*) stated that the VA had a history of self-injurious behaviors (cutting him/herself and swallowing inedible objects), was often "anxious," and found it "difficult to relax."

- The VA's team compiled a list of items which were "deemed to be unsafe" for the VA or the environment in which s/he lived. The list included soft drink cans and bottles; items with small caps, lip balm, cutlery, food serving utensils, anything sharp, cigarettes, lighters, matches, compact discs, digital video discs, and items that belonged to other persons. The VA's team restricted his/her rights to have "free access" to cupboards, cabinets, and drawers. The VA's plans of care did not state whether the VA had a history of ingesting cleaning supplies and/or chemicals, but staff persons were to ensure that all cleaning supplies and chemicals were stored in locked areas of the facility to prevent the VA from ingesting them.

- The VA might become agitated easily without "observable" reasons, and might become "aggressive" when s/he was upset. When the VA became aggressive or tried to harm him/herself, staff persons were to verbally redirect the VA to an activity that s/he enjoyed. If the VA tried to harm him/herself with an item, staff persons were to block the VA's arms using their arms or hold the VA's wrists at the VA's sides. If staff persons were unable to redirect the VA from harming him/herself with an item, staff persons were to remove the item from the VA, and remain within an "arm's length" of the VA until the VA calmed. The VA sometimes declined to take/her prescribed medications, but when the VA declined to take medications, staff persons were to verbally redirect the VA by explaining the importance of the medications to the VA's health, and to contact a facility health care professional for assistance if the VA continued to decline to take his/her medications. The VA enjoyed watching movies, meeting people, and community outings.

Interviews with this investigator, facility documentation, and the facility's *Internal Review* provided the following information regarding the April 18, 2017, incident.

- Information was consistent from the SP, P1 (a supervisory staff person), and P2, that prior to the incident, staff persons washed the facility's laundry at a laundromat because the facility's washing machine was broken. The laundry detergent was normally kept in a locked storage area at the facility along with other chemicals and cleaning supplies. On the date of the incident, P3 and another staff person (P5) washed the residents' clothing at the laundromat and then returned to the facility with the clean clothing and laundry detergent. P3 and P5 placed the clean clothing and laundry detergent on the floor near the coat closet in the living room. P3 and P5 began completing other tasks, and did not lock the laundry detergent away.

- At approximately 7 p.m., the VA exited his/her bedroom and declined to take his/her medications that were to be administered at 8 p.m. The SP, P1, and P2, did not respond to the VA, and the VA returned to his/her bedroom. At approximately 7:30 p.m., the VA asked for his/her medications, but the SP, P1, and P2, redirected the VA by saying that the VA would receive his/her medications at 8 p.m. The VA became upset and made a telephone call to a family member, but the SP, P1, and P2 were uncertain which family member the VA called. P1 then began cutting up strawberries for an evening snack, while P2 was sitting at the kitchen table completing documentation. Three residents (R1, R2, and R3) were also sitting at the table, the VA was sitting in the living room, and the SP was washing the dishes at the kitchen sink. The SP placed the clean dishes and cutlery (including a knife with a serrated blade approximately five to six inches long that P1 used to cut up strawberries), in a drying rack in the kitchen. At approximately 7:50 p.m., the SP went to R3's bedroom to get a cleansing wipe for R3's eyeglasses.

- The SP said that when s/he began walking back to the kitchen after getting the cleansing wipe, s/he saw the VA standing between the kitchen and the living room. The VA was looking into the kitchen and began walking toward the drying rack. The SP realized that the knife was still in the drying rack and also walked toward the drying rack to "see if [s/he] could get [the knife] before [the VA did]." The SP reached the drying rack and observed that the serrated edge of the knife was facing up. The SP "did not know what to do" and "did not want to be injured," so s/he "backed away." The VA "grabbed" the knife and "sliced at" his/her neck and "jabbed" his/her chest "a couple" of times. At this time, the SP and P2 directed R2 to go to his/her bedroom downstairs, while the SP assisted R3 to his/her bedroom, and P2 assisted R1 to his/her bedroom. P1 attempted to obtain the knife from the VA.

- P1 said that s/he asked the VA to stop and put the knife down, but the VA began "slashing at" his/her neck and left wrist, and cut two "gashes" in his/her wrist. The VA then lifted his/her shirt and began "poking" him/herself in the upper abdomen which "scraped" the VA's skin, but did not "break" it. P1 continued to redirect the VA to put the knife down, and asked the VA to talk about what "was wrong." The VA walked around the partial wall that divided the kitchen and the living room several times while P1 followed him/her. The VA went to stand by the kitchen counter and began crying. P1 approached the VA, told the VA that s/he would get the VA help, and asked the VA to put the knife down. The VA told P1 that s/he needed help and needed an ambulance, and then placed the knife on the countertop. P1 picked up the knife and quickly locked it away. P1 observed that the VA's left wrist was bleeding, but had begun to clot. The VA's neck and abdomen were scraped, but were not bleeding. P1 believed that it was not necessary to call 9-1-1 since the VA had put the knife down, the VA's injuries were not severe, and a hospital was three blocks from the facility. P1 called P4 (an administrative staff person) and P3 (another supervisory staff person). P4 did not answer, but P3 answered and came to the facility to assist P1.

- P1 said that P3 arrived within five minutes, and they prepared to take the VA to the hospital's emergency department. The SP and P2 returned to the living room/kitchen, but did not have additional interactions with the VA that day. P1 and P3 provided consistent information that when they prompted the VA to put his/her jacket on, the VA removed his/her jacket from its hanger and then broke the plastic hanger into pieces, which the VA attempted to swallow. P3 obtained the broken pieces of plastic from the VA before the VA could swallow them. The VA then "grabbed" the liquid laundry detergent and attempted to remove its cap, but was unable to do so. P1 said that s/he took the laundry detergent from the VA and "held onto it." At approximately 8:15 p.m., P1 and P3 assisted the VA into the facility van and transported the VA to the hospital's emergency department. The VA was evaluated by a physician in the emergency department and admitted to the hospital, but it was unknown whether the VA was admitted due to his/her injuries or to be evaluated by a mental health care professional.

- The SP stated that s/he was assigned to be the VA's primary staff person on the date of the incident, but was unsure whether s/he followed the facility's policies, procedures, and training when s/he did not put the knife away immediately after washing it. The SP thought that it was "never stated anywhere" that staff persons were to lock knives away, but s/he usually put knives and other sharp items away immediately after they were used. This time, the SP "just slipped."

- Information was consistent from P1, P2, and P3 that it was facility policy and procedure that knives and sharp objects were to be locked away after their use, and that the VA was not to have access to knives or other sharp objects. However, P1 and P2 each stated that it was routine to allow knives to dry in the drying rack before returning them to the locked drawer where they were stored. P3 said that s/he trained staff persons to lock away knives and other sharp objects after each use, and "made it clear" to staff persons which drawers and cabinets were to be kept locked at all times. P1, P2, and P3 each said that they believed that the facility's *Program Abuse Prevention Plan* (*PAPP)* specified that knives were to be locked away after use, but the *PAPP* did not say how quickly knives were to be locked away after use.

The VA's April 18, 2017, medical records stated that s/he was evaluated at the hospital emergency department by a physician for "self-mutilating behavior and suicide threats." The VA was "uncooperative" and stated "over and over again" that s/he "did not want to go back home," but did not "appear to be in any physical distress." The VA had two "large lacerations noted over the volar aspect of the left wrist" that were approximately 16 centimeters long, that were described as "gaping" though no tendons were exposed. The VA also had "superficial" lacerations on his/her upper abdomen and lower chest, and on the right side of his/her neck, none of which required "repair" and were more like "deep scratch[es]." The VA's affect was described as "depressed, agitated, and anxious," and s/he was "fixated in [his/her] thinking." The VA was determined that s/he did not want to return to the facility and his/her judgement was "absent." The VA stated that it was his/her intention to kill him/herself if s/he was returned to the facility. The VA's "wounds" were "dressed" with telfa, kling, and ace wrap, and s/he was advised to keep the dressing on the wounds until the morning of April 20, 2017. Hospital health care professionals (HCPs) attempted to locate an appropriate placement for the VA, but were unable to locate an alternative placement for the VA. The VA was observed and found to be "stable" after evaluation and through the overnight period. The HCPs discussed the VA's situation with the G and the CM and made the decision to return the VA to the facility pending "further assessment of [his/her] case and the possibility that [s/he] might be sent to a different group home." The VA continued to do well and was in good spirits when s/he was discharged from the hospital's emergency department on April 19, 2017, at approximately 6 p.m.

The facility's January 20, 2016, *PAPP* (which was in place at the time of the incident) stated that staff persons were to be aware of each resident's plans of care and were to follow them, but did not specifically address locking up knives in the facility.

The facility's personnel and training records showed that staff persons were trained on the Reporting of Maltreatment of Vulnerable Adults Act prior to the incident. On an unspecified date, the SP was also trained on "kitchen safety" (which stated that staff persons were not to leave knives "loose in a drawer" that could be accessed by facility residents), and trained on the specific needs of each resident on December 30, 2016.

Conclusion:

A. Maltreatment:

On April 18, 2017, at approximately 7:30 p.m., the SP washed dishes (including a knife with a five to six inch serrated blade) at the facility. The SP placed the knife in the drying rack in the kitchen and left it to dry while s/he retrieved an item from R3's bedroom. The VA subsequently obtained the knife and used it to cut his/her left wrist,

poke his/her abdomen, and scrape his/her neck, before placing the knife on the counter. Staff persons intervened appropriately once the VA had the knife to deescalate him/her and remove the knife. P1 locked the knife away after the VA lay the knife on the counter. While getting ready to go to the hospital, the VA obtained a plastic hanger which s/he broke into pieces that s/he attempted to swallow, and a bottle of liquid laundry detergent that s/he attempted to open. P3 obtained the broken pieces of the hanger from the VA and P2 took the laundry detergent from the VA before the VA was able to ingest them or harm him/herself with the items. P1 and P3 then transported the VA to the hospital emergency department. The VA was admitted to the hospital, but it was unknown whether s/he was admitted due to his/her injuries or for other reasons.

The VA had a history of engaging in self-injurious behaviors of cutting him/herself and swallowing inedible objects. The VA's plans stated that s/he was not to have access to knives or other sharp objects," and that all cleaning supplies and chemicals were to be stored in locked areas of the facility to prevent the VA from ingesting them.

The laundry detergent was normally kept in a locked storage area at the facility along with other chemicals and cleaning supplies. On the date of the incident, P3 and P5 washed the residents' clothing at the laundromat and then returned to the facility with the clean clothing and laundry detergent. P3 and P5 placed the clean clothing and laundry detergent on the floor near the coat closet in the living room, and left them there. Although the VA obtained the laundry detergent (which should have been locked away when not in use according to the facility's policies and procedures) and attempted to open it, given that no information showed that the VA had a specific history of ingesting laundry detergent and that P2 was able to take the laundry detergent from the VA before the VA could open it, there was not a preponderance of the evidence whether there was a failure to provide the VA with care or supervision which is reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety.

However, regarding the knife, given that the facility had a specific list of items that the VA should not be permitted to access which included knives, that the VA had a history of cutting him/herself, and that the VA accessed the knife when it was left open in the drying rack to cut him/herself, there was a preponderance of the evidence that there was a failure to provide the VA with care or supervision which is reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety.

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:
>
> (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.

Although P1 and P2 each stated that staff persons routinely allowed knives to dry in the drying rack before locking them away, P3 said that s/he trained staff persons to lock away all sharp objects after each use and the SP said that s/he usually locked away knives and sharp items after each use, but s/he forgot to do so on the date of the incident. Given this, and that prior to the incident the SP was trained on the VA's individual plans of care and the Reporting of Maltreatment of Vulnerable Adults Act the SP was responsible for the maltreatment of the VA.

C. Recurring and/or Serious Maltreatment:

The Office of Inspector General is required to evaluate whether substantiated maltreatment by an individual meets the statutory criteria to be determined as "recurring or serious." Individuals determined to be responsible for recurring or serious maltreatment are disqualified from providing direct contact services. Minnesota Statutes, section 245C.02, subdivision 16, states:

> "Recurring maltreatment" means more than one incident of maltreatment for which there is a preponderance of evidence that maltreatment occurred and that the subject was responsible for the maltreatment.

Minnesota Statutes, section 245C.02, subdivision 18, states:

> "Serious maltreatment" means sexual abuse, maltreatment resulting in death, neglect resulting in serious injury which reasonably requires the care of a physician whether or not the care of a physician was sought, or abuse resulting in serious injury. For purposes of this definition, "care of a physician" is treatment received or ordered by a physician, physician assistant, or nurse practitioner, but does not include diagnostic testing, assessment, or observation; the application of, recommendation to use, or prescription solely for a remedy that is available over the counter without a prescription; or a prescription solely for a topical antibiotic to treat burns when there is no follow-up appointment. For purposes of this definition, "abuse resulting in serious injury" means: bruises, bites, skin laceration, or tissue damage; fractures; dislocations; evidence of internal injuries; head injuries with loss of consciousness; extensive second-degree or third-degree burns and other burns for which complications are present; extensive second-degree or third-degree frostbite and other frostbite for which complications are present; irreversible mobility or avulsion of teeth; injuries to the eyes; ingestion of foreign substances and objects that are harmful; near drowning; and heat exhaustion or sunstroke. Serious maltreatment includes neglect when it results in criminal sexual conduct against a child or vulnerable adult.

It was determined that the substantiated maltreatment for which the SP was responsible did not meet statutory criteria to be determined as recurring because it was a single incident and was not serious because though the VA was admitted to the hospital for observation overnight, the treatment s/he received for his/her injuries was available over the counter treatment.

Action Taken by Facility:

The facility completed an *Internal Review* which stated that their policies and procedures were adequate but were not followed. Staff persons were retrained on the facility's policies and procedures. The VA no longer lived at the facility.

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

The SP was not disqualified from providing direct care services as a result of the maltreatment determination in this report. However, the SP was notified by the Office of Inspector General that any further substantiated act of maltreatment, whether or not the act meets the criteria for "serious," will automatically meet the criteria for "recurring" and will result in the disqualification of the SP. The determination that the SP was responsible for maltreatment is subject to appeal.

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: 20173097

Date Issued: June 30, 2017

Name and Address of Facility Investigated:

Bridges MN 6th Avenue
526 6th Avenue South
South St. Paul, MN 55075

Bridges MN
203 Little Canada Road East #250
Little Canada, MN 55117

Disposition: Substantiated as to neglect of a vulnerable adult by a staff person.

License Number and Program Type:

1084656-H_CRS (Home and Community Based Services-Community Residential Setting)
1079030-HCBS (Home and Community-Based Services)

Investigator(s):

Sarah Schumacher
Minnesota Department of Human Services
Office of Inspector General
Licensing Division
PO Box 64242
Saint Paul, Minnesota 55164-0242
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Suspected Maltreatment Reported:

It was reported that a staff person (SP) dropped off a vulnerable adult (VA) at a community place and left. The VA was supposed to have staff supervision at all times. The VA was unsupervised for approximately four hours.

Date of Incident(s): May 14, 2017.

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 17, paragraph (a):

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.

EXHIBIT D

Summary of Findings:

Pertinent information was obtained during a site visit conducted on June 6, 2017, and June 15, 2017; from documentation at the facility; and through five interviews conducted with the VA, facility staff persons (P1 and P2), the SP, and the VA's guardian (G).

The VA was diagnosed with bipolar, schizoaffective disorder, depression, post-traumatic stress disorder, and reactive attachment disorder. The VA's *Individual Abuse Prevention Plan* stated that the VA was sexually vulnerable, had a history of sexual abuse toward minors, and was "likely to violate those that are more sexually vulnerable than [him/her]." The VA would "probably avoid dangerous situations" but might place him/herself in danger. Facility documentation showed that the VA was naturally social and friendly, was impulsive, and had poor boundaries which could put the VA at risk without staff person supervision. Staff persons were to be with the VA at all times. For the VA's "health and safety," the VA had one to one staff person supervision 24 hours a day, including one to one awake supervision overnight. The VA enjoyed socializing, dancing, music, playing the harmonica, writing music, and playing basketball.

The VA stated:

- The SP dropped off the VA at the YMCA around 1 p.m. The SP told the VA that s/he would pick up the VA at 5 p.m. and then the SP left. The VA saw that the YMCA was closed but the SP had already driven away. The VA and the SP did not have cell phones.

- The VA walked to a nearby gas station, about six blocks away but they did not have a phone the VA could use. Then the VA walked to another community location, but they did not have a phone either. The VA walked another six blocks to Walgreens and was able to use the phone. The VA said that was around 2:30 or 3 p.m. The VA called the G and left a message.

- Then the VA walked to a grocery store and then back to Walgreens where there was a security guard. The VA got a ride from a police officer back to the YMCA. The SP arrived back at the YMCA around 5 p.m. to pick up the VA. Another staff person also arrived at the YMCA and told the SP that the VA could not go with him/her so the other staff person took the VA back to the facility.

- The VA did not think the SP would put him/her in "harm's way" but stated that there should have been more communication between the VA and the SP. The VA stated that s/he should have told the SP that the VA should not be left by him/herself.

- The VA stated that the SP was "only trying to give [the VA] a privilege to be by [his/herself] and make [the VA] independent."

- While the VA was walking, a community person approached the VA and asked the VA what "gang" the VA was in because of the color of the VA's clothes. The VA stated the person "chased" him/her for a block and said the VA was wearing the "wrong colors." The VA did not know if the person wanted to fight the VA or not. The VA stated that nothing else happened to him while s/he was unsupervised.

P1 stated:

- The G called P1 around 2 p.m. and said that the VA called the G and was without supervision in the community. The G called P1 back shortly after the first call and told P1 that the VA called the G again and

had been with a security guard at Walgreens for about one and a half hours. P1 called the security guard and said a staff person was on their way to pick up the VA. The security guard's shift was ending so s/he called the police and told P1 that the VA was being brought back to the YMCA. P1 found a staff person to go to the YMCA and pick up the VA.

- The VA needed 24 hour supervision. Staff persons receive multiple trainings on the VA including training that the VA was not to be without staff person's supervision. Staff persons signed a training sheet that said that staff person would not ever leave the VA without supervision. P1 stated that s/he trained the SP on the VA's supervision requirements. The SP did not have a history of not following the VA's plans.

- The VA was not supposed to be around minors. The VA needed staff person supervision in the community because s/he needed staff persons to help him/her avoid "triggers" that caused the VA to become angry.

P2 stated that the VA was not supposed to be out of staff persons' sight in the community. The VA was not supposed to be around minors and someone could easily make the VA upset or angry. The VA told P2 that the SP had left the VA in the community other times. P2 stated that when s/he went to the YMCA with the VA, P2 stayed near the VA and kept him/her in eye sight. P2 stated that s/he would never leave the VA in the community without supervision.

The SP stated:

- The SP assumed that the YMCA was open when s/he dropped off the VA around 2:30 p.m. The SP told the VA that s/he would be back to pick up the VA at 5 p.m.

- The SP stated that the VA had 24 hour supervision at the facility and that they did not go into the community much other than the YMCA and the library.

- The SP felt "confident" that the VA would be safe while at the YMCA. The SP did not like "standing over" the VA when in the community and wanted to VA to have some independence.

The G stated:

- The VA had a "high risk of offending" especially with children when in the community. The VA had an offense with a minor eleven years ago so the VA was no longer a registered sex offender.

- If someone were to approach the VA and ask the VA to go with them or have sex with them, the VA likely would.

- The past three to four months, the VA had several outbursts and had some arrests for property destruction and threatening language resulting in an arrest.

- The G did not have any concerns about the VA's care at the facility and thought the facility provided adequate training to staff persons.

- The G did not know why the SP thought it was a good idea to drop off the VA without supervision given the VA's risks.

P1, P2, and the SP were each trained on the Reporting of Maltreatment of Vulnerable Adults Act.

The SP was trained on the VA's plans and on March 6, 2017, signed a document outlining the VA's risks that stated the SP acknowledged responsibility or having the VA in view except when in the bathroom, the VA's bedroom, or doing laundry at the facility.

Conclusion:

A. Maltreatment:

Consistent information shows that on May 14, 2017, the SP dropped off the VA at the YMCA and left. The VA saw that the YMCA was closed but the SP was already gone so the VA walked to several community locations to access a phone. The VA called the G who called P1. P1 arranged for a staff person to pick up the VA.

The VA's plans stated that s/he was sexually vulnerable and had a history of sexual abuse toward a minor. The VA was impulsive and had poor boundaries and was also friendly and social. The VA was to have one to one staff person supervision 24 hours a day. Staff persons were to be with the VA at all times. The G stated that the VA was at a "high risk of offending" especially if s/he was around minors. If someone approached the VA and asked the VA to go with them and or have sex with them the VA would. The VA had recent incidents of property destruction and threatening language resulting in an arrest.

The VA said the SP dropped him/her off at 1 p.m. but the SP said it was around 2:30 p.m. However, P1 said that the G called about 2 p.m. after the VA called the G. Regardless of the exact time of drop off, the VA was without supervision for at least two and a half to three hours. The VA was with the Walgreen's security office and a police office for some of that time, but was without a facility staff person.

Given the above, there was a preponderance of the evidence that the SP did not follow the VA's plan and left the VA in the community without supervision.

Although the VA was not injured or harmed, and that once the VA accessed a phone and called the G, the VA stayed with the security office and police officer until s/he was picked up, according to staff persons and the G the VA had substantial risk being in the community unsupervised. Given the aforementioned and that P1 and P2 each stated it was clear in training that the VA was never to be left without staff person supervision, there was a preponderance of the evidence that there was a failure to provide the VA with reasonable and necessary care and services.

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:

(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.

Documentation and interviews showed that the facility provided training regarding the VA's supervision. Despite training, the SP decided to leave the VA in the community unsupervised. Therefore the SP was responsible for maltreatment of the VA.

C. Recurring and/or Serious Maltreatment:

The Office of Inspector General is required to evaluate whether substantiated maltreatment by an individual meets the statutory criteria to be determined as "recurring or serious." Individuals determined to be responsible for recurring or serious maltreatment are disqualified from providing direct contact services. Minnesota Statutes, section 245C.02, subdivision 16, states:

> "Recurring maltreatment" means more than one incident of maltreatment for which there is a preponderance of evidence that maltreatment occurred and that the subject was responsible for the maltreatment.

Minnesota Statutes, section 245C.02, subdivision 18, states:

> "Serious maltreatment" means sexual abuse, maltreatment resulting in death, neglect resulting in serious injury which reasonably requires the care of a physician whether or not the care of a physician was sought, or abuse resulting in serious injury. For purposes of this definition, "care of a physician" is treatment received or ordered by a physician, physician assistant, or nurse practitioner, but does not include diagnostic testing, assessment, or observation; the application of, recommendation to use, or prescription solely for a remedy that is available over the counter without a prescription; or a prescription solely for a topical antibiotic to treat burns when there is no follow-up appointment. For purposes of this definition, "abuse resulting in serious injury" means: bruises, bites, skin laceration, or tissue damage; fractures; dislocations; evidence of internal injuries; head injuries with loss of consciousness; extensive second-degree or third-degree burns and other burns for which complications are present; extensive second-degree or third-degree frostbite and other frostbite for which complications are present; irreversible mobility or avulsion of teeth; injuries to the eyes; ingestion of foreign substances and objects that are harmful; near drowning; and heat exhaustion or sunstroke. Serious maltreatment includes neglect when it results in criminal sexual conduct against a child or vulnerable adult.

It was determined that the substantiated maltreatment for which the SP was responsible did not meet statutory criteria to be determined as recurring or serious because the VA was not harmed or injured while unsupervised and this was a single incident.

Action Taken by Facility:

The facility completed an *Internal Review* and determined that policies and procedures were adequate but were not followed. The SP was no longer working with the VA.

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

The SP was not disqualified from providing direct care services as a result of the maltreatment determination in this report. However, the SP was notified by the Office of Inspector General that any further substantiated act of maltreatment, whether or not the act meets the criteria for "serious," will automatically meet the criteria for "recurring" and will result in the disqualification of the SP. The determination that the SP was responsible for maltreatment is subject to appeal.

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: 20175045

Date Issued: October 11, 2017

Name and Address of Facility Investigated:

Bridges MN 6th Ave
526 6th Ave S,
South St. Paul, MN 55075

Bridges MN
203 Little Canada Rd E, #250,
Little Canada, MN 55117

Disposition: Substantiated as to abuse of a vulnerable adult (VA) by a staff person (SP).

License Number and Program Type:

1084656-H_CRS (Home and Community Based Services-Community Residential Setting)
1079030-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

Suspected Maltreatment Reported:

It was reported that a staff person (SP) sprayed a vulnerable adult (VA) with mace after the VA physically aggressed toward the SP.

Date of Incident(s): August 1, 2017

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 (1), (3), and (4):

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:

- Hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult.

EXHIBIT E

- 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

- Use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825.

Summary of Findings:

Pertinent information was obtained during a site visit conducted on August 19, 2017; from documentation at the facility and law enforcement records; and through seven interviews conducted with the SP, one staff person (P2), three supervisory staff persons (P3, P4, and P5), the VA's guardian (G), and the VA's case manager (CM). This investigator met the VA, but s/he was unable to provide additional information regarding the incident. This investigator made several attempts to make arrangements to interview a supervisory staff person (P1), but the attempts were unsuccessful.

According to the VA's *Functional Behavior Assessment & Support Recommendations*, s/he was diagnosed with an intellectual disability, autistic disorder, schizoaffective disorder, and impulse control disorder. The VA's "behaviors" included, but were not limited to "aggressions." The VA's aggression included punching, hitting, and hair pulling, and kicking others. The VA's *Intensive Support Self-Management Assessment* stated that s/he did not like to be told "No," and did best when given alternatives. The VA enjoyed fishing, watching television, and spending time with his/her family.

The following information was obtained from the VA's *Health & Safety Protocols* and *Individual Abuse Prevention Plan (IAPP):*

- Staff persons were not to use an emergency use of manual restraint (EUMR) with the VA, but no reason was listed. (Note: Minnesota statues, section 245D.02, subdivision 8a, stated that an EUMR was used when an individual presented an "imminent" risk of physical harm to themselves or others and was the "least restrictive" intervention.)

- The VA's *Health & Safety Protocols* stated that when the VA had a "behavior," staff persons were to remain calm, grab a telephone, and "get out of [the VA's] way." A staff person could lock themselves in a room while allowing the VA to de-escalate for five to ten minutes. Staff persons were to call the rapid response team if assistance was needed.

- The VA's *IAPP* stated that when the VA had a "behavior," staff persons were to verbally redirect the VA to "Stop," move to safety with access to a telephone, and "put a door between" themselves and the VA. Staff persons were to call the rapid response team or 9-1-1 depending on the severity of the VA's aggression.

The "rapid response team" was a group of staff persons within Bridges that could be called when additional support was needed.

The VA lived alone and received a staff ratio of 1:1 for 24 hours daily. The VA moved into the facility on December 28, 2016.

According to http://www.mace.com, mace, or pepper spray, was used for personal defense. Upon direct contact of mace, the individual's eyes will "slam" shut, they will cough, and there will be an "intense burning" sensation on their skin. These symptoms should disappear in less than an hour. According to https://www.pepper-spray-store.com pepper spray caused an "intense, temporary debilitating burning sensation" resulting in "non-lethal" inflammation of all "mucous membranes" in the eyes, nose, mouth, and lungs.

The following information was obtained from the VA's *Incident and Emergency Report* completed by a supervisory staff person (P1) who was also a rapid response team member:

- On August 1, 2017, at 9:30 p.m., the VA wanted to go to the store to get some tea. The SP told the VA that they were not going to go because someone left fishing bait in the vehicle causing the vehicle to smell. The VA stated that s/he would clean the vehicle and the SP then stated it was "too late" and that they would not be going.

- The VA became "angry," the SP went into the office, and closed the door. The VA kicked a hole in the center of the door. The SP reached in his/her bag for mace and sprayed the VA with mace.

- The SP exited the facility and called 9-1-1 and P1. Law enforcement was at the facility with the VA and the SP before P1 arrived. The VA declined to seek medical attention so the VA was "medically cleared" at the facility.

- The SP was "immediately removed" from providing direct care. P1 remained at the facility with the VA until another staff person (P2) arrived to cover the rest of the SP's shift.

The following additional information was obtained through an interview with the SP:

- After the SP told the VA that they would not be leaving to get the VA's tea, the SP walked into the staff office and tried to close the door, but the VA proceeded to bang on the door. The SP told the VA that they could not go get his/her tea and offered to make tea for the VA at the facility. The VA reminded the SP that s/he offered to help clean the vehicle, but the SP told the VA "No" again and the VA continued to bang on the door. The SP told the VA that s/he was going to have "some time" to him/herself and the VA continued to bang on the door.

- The VA walked away from the staff office and the SP locked the door. The VA brought a cellular telephone to the SP and banged on the door. The SP stated that s/he needed "some time," but the VA kept talking about the cellular telephone and had a "hissy fit." The SP opened the office door to grab the cellular telephone and the VA proceeded to push on the door. The SP put the back of his/her foot on the door to prevent it from opening and the VA kept banging on the door. The SP used the cellular telephone to call the VA's guardian (G) and a supervisory staff person (P3), but neither one answered. The SP then called another supervisory staff person (P4) who instructed the SP to call the rapid response team.

- The telephone list with the rapid response team's telephone number was hanging on the wall, but the SP could not reach the list while holding the door closed. At this point, the door was "cracking open." The SP then called his/her family member. By this point, the VA had been banging on the door for 30 minutes so the SP called law enforcement. The VA kicked the door in and "grabbed" the SP. The SP told the VA that if s/he did not stop, the SP would "mace" the VA. The VA did not stop so the SP reached in his/her bag and maced the VA. The SP added that s/he did not spray the VA "a lot." The SP added that s/he "fricken

got the worst of it," because the mace came down the bottle and the SP got it into his/her eyes. The VA did not have any effects from the mace.

- The VA "chased" the SP out of the facility and continued chasing the SP until four law enforcement vehicles and two paramedic vehicles showed up. Law enforcement had to "hold" the VA because the VA "charged" at the SP again. The SP called P1 after law enforcement arrived. (Note: In the facility's *Internal Review*, a supervisory staff person interviewed the SP and the SP stated that s/he called P1 prior to law enforcement and that P1 stated s/he would be at the facility in an hour because s/he was dealing with another issue.)

- The SP could usually calm the VA down, but nothing worked on the date of the incident and the SP added that the VA had never "acted out" like this before. The SP stated that if s/he knew the VA was going to "escalate that high," s/he would have "plugged his/her nose" and taken the VA to get his/her tea.

- The SP added that s/he did not know if s/he could use mace or not while at the facility. The SP had been in the field for over 10 years and worked with other residents with aggression, but had never felt "terror" like s/he felt at that moment with the VA.

- The SP added that s/he thought something was wrong with the VA since the VA had not slept for three days in a row, had not taken his/her medications, and was not acting like him/herself.

- The SP stated that s/he "felt really bad," was "sorry," and would "never" do it again. The SP added that in the future, s/he would pay more attention to the "signs", but added that s/he was a "human first" and "felt" that s/he had "no other alternative."

The following additional information was obtained through interviews with P1, P2, and three supervisory staff persons (P3, P5, and P5) about the incident:

- P3 stated that s/he had been at the gym for one and a half hours and had received a call and a text message from the SP and a message from another supervisory staff person (P5). P5 provided P3 with a summary of the incident.

- P3 added that the VA had no issues with eating, sleeping, or not taking his/her medications and had not been acting differently prior to the incident.

- P4 stated that s/he received a call from the SP around 9 p.m. stating that s/he needed assistance at the facility, but was unable to reach the G or P3. P4 added that s/he could hear the VA "yelling" in the background, but was unable to hear what the VA was saying. P4 asked the SP if s/he had tried to talk to the VA in a calm voice and the SP stated that s/he had tried "everything" and "nothing" worked. P4 instructed the VA to contact the rapid response team.

- P2 stated that s/he arrived at the facility to relieve the SP at 10:45 p.m. P2 added that s/he did not notice a "strong mace smell" and that there were no "fumes" in the office from the mace. P2 stated that the VA had no effects from the mace.

- P2 and P3 each stated that the office door was very thin and added that it would not be hard to break through.

- P3 stated that s/he thought the SP was trained appropriately, but did not put his/her training to good use. P3 added that the SP did not go about "anything the right way" on the date of the incident. Other staff persons drove the vehicle on that same day, so the SP should have driven the VA to get his/her tea instead of declining the VA's request. When the VA offered to clean the vehicle, the SP should have accepted and taken the VA to get his/her tea. The VA did not have a curfew and the store was open 24 hours a day, so it was not "too late" to take the VA to get his/her tea. The VA did not like being told "No," so the SP should have found other ways to word it to so as not to upset the VA. All of the telephone numbers the SP needed were posted on the wall in the office and the SP could have called other supervisors, a staff person from a nearby facility, or 9-1-1 before thinking of using mace. P3 added that the SP could have called the rapid response team to have them take the VA to get tea.

Additional information:

- P3 stated that the vehicle smelled because someone left worms in the truck so s/he removed the worms. On the date of the incident, s/he and another staff person both used the vehicle to take the VA fishing and the vehicle smelled, but the vehicle was drivable. P2 and P3 each stated that even if the vehicle smelled, that was no reason to deny the VA's request to get tea especially since the VA offered to clean the vehicle.

- P2 and P3 each stated that if the VA wanted to go for tea, the staff persons were there to help and should have taken the VA to get tea. P3 added that since the VA was retired and had nothing to do "bright and early" in the morning, that the store was only five minutes away, that the facility was not in a "bad part" of town, and that the VA had his/her own money, the SP should have taken the VA to get his/her tea.

- P3 stated that "months ago" at another facility a vulnerable adult saw mace in a staff person's bag and "told" management. After that (but prior to this incident), the SP asked P3 about it. P3 stated that no staff person was to have mace at the facility. P3 did not why a staff person would have mace especially since the facility's policy stated not to and since the facility provided services to vulnerable adults.

- P2 stated that no weapons of any kind were allowed.

- P4 added that s/he did not "think" that mace could be used at the facilities.

The *Cross Training Checklist* for the VA involved staff persons signing that they "reviewed and received instruction" on the VA's "CSSP Addendum and "understood" how to "implement" the VA's plans.

The following information was obtained from the facility's *Emergency use of Manual Restraint (EUMR) Policy:*

- The use of a "chemical restraint" and "any aversive or deprivation" were listed as a prohibited procedures.

- "Within 60 calendar days" of hire, staff persons were trained on the use of manual restraints in an emergency. Staff persons "must" receive this training prior to implementing a restraint.

- Using "any aversive" procedure as a "behavioral or therapeutic program" to "reduce or eliminate a behavior" or as "punishment" was "prohibited."

The facility's personnel records showed that the SP, P1, P2, P3, P4, and P5 each received training on the Reporting of the Maltreatment of Vulnerable Adults Act, *Emergency use of Manual Restraint Policy*, and the needs of the VA.

Relevant Rules and/or Statutes:

Minnesota Chapter, 9544.0060, subparts 1 and 2 states that the actions or procedures in this section are prohibited from use as a substitute for adequate staffing, for a behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for staff convenience. Prohibited procedures included, "using noxious smell, taste, substance, or spray, including water mist."

Minnesota statutes, section 245D.06, subdivision 5, stated that it was "prohibited" to use an aversive procedure as "punishment" or as a substitute for behavioral programming to reduce or eliminate a behavior.

Conclusion:

A. Maltreatment:

On August 1, 2017, the VA wanted to go to the store to get some tea. The SP told the VA that they would not be getting tea since the vehicle smelled and because it was too late. The VA became angry. The SP went into the staff office and closed the door. The VA banged on the staff office door for 30 minutes. During that time, the SP called the G, P3, P4, a family member of the SP, and then 9-1-1. The VA broke through the office door and grabbed the SP. The SP told the VA that if the VA did not stop, the SP would spray mace at the VA. The SP sprayed mace at the VA and exited the facility. Law enforcement and paramedics showed up and medically cleared the VA. The SP called P1 for additional assistance.

According to https://www.pepper-spray-store.com, mace, or pepper spray, caused an "intense, temporary debilitating burning sensation" resulting in "non-lethal" inflammation of all "mucous membranes" in the eyes, nose, mouth, and lungs.

The SP stated that s/he could not take the VA to buy tea since the facility vehicle smelled and it was too late. P2 and P3 each stated that the VA's request should not have been denied as the vehicle could have been driven. P3 added it was not too late for the VA since the VA did not need to be up early in the morning, the store was only five minutes away, the facility was not in a "bad part" of town, and the VA had his/her own money.

Although the SP stated that s/he tried everything to redirect the VA, his/her account of the events did not include any therapeutic or redirection techniques. In addition to calling the G, P3, and P4 for assistance, s/he also called a family member instead of calling 9-1-1 immediately when s/he felt "terror" during the incident. The SP's actions of using mace were in violation of Minnesota statues, section 245D.06, subdivision 5, which stated that it was "prohibited" to use an aversive procedure as "punishment" or as a substitute for behavioral programming to reduce or eliminate a behavior.

There was a preponderance of the evidence that using mace to redirect the VA's behaviors was an aversive procedure that was not therapeutic and produced or could reasonably be expected to produce physical pain or 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 Hitting, slapping, kicking, pinching, biting, or corporal punishment of a vulnerable adult; 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 use of any aversive or deprivation procedures for persons with developmental disabilities or related conditions not authorized under section 245.825).

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.

Although the SP stated that s/he did not know that s/he could not use mace on the VA, the facility's *Emergency use of Manual Restraint (EUMR) Policy*, which the SP received training on, stated that chemical restraints and aversive procedures were prohibited. In addition, the SP was trained on the VA's plans and stated that if s/he has known the VA would have "escalate[ed] that high," s/he would have "plugged his/her nose" and taken the VA to get his/her tea. Given this, and that the SP received training on the Reporting of the Maltreatment of Vulnerable Adults Act, the SP was responsible for maltreatment of the VA.

C. Recurring and/or Serious Maltreatment:

The Office of Inspector General is required to evaluate whether substantiated maltreatment by an individual meets the statutory criteria to be determined as "recurring or serious." Individuals determined to be responsible for recurring or serious maltreatment are disqualified from providing direct contact services. Minnesota Statutes, section 245C.02, subdivision 16, states:

> "Recurring maltreatment" means more than one incident of maltreatment for which there is a preponderance of evidence that maltreatment occurred and that the subject was responsible for the maltreatment.

Minnesota Statutes, section 245C.02, subdivision 18, states:

> "Serious maltreatment" means sexual abuse, maltreatment resulting in death, neglect resulting in serious injury which reasonably requires the care of a physician whether or not the care of a physician was sought, or abuse resulting in serious injury. For purposes of this definition, "care of a physician" is treatment received or ordered by a physician, physician assistant, or nurse practitioner, but does not include diagnostic testing, assessment, or observation; the application of,

> recommendation to use, or prescription solely for a remedy that is available over the counter without a prescription; or a prescription solely for a topical antibiotic to treat burns when there is no follow-up appointment. For purposes of this definition, "abuse resulting in serious injury" means: bruises, bites, skin laceration, or tissue damage; fractures; dislocations; evidence of internal injuries; head injuries with loss of consciousness; extensive second-degree or third-degree burns and other burns for which complications are present; extensive second-degree or third-degree frostbite and other frostbite for which complications are present; irreversible mobility or avulsion of teeth; injuries to the eyes; ingestion of foreign substances and objects that are harmful; near drowning; and heat exhaustion or sunstroke. Serious maltreatment includes neglect when it results in criminal sexual conduct against a child or vulnerable adult.

It was determined that the substantiated maltreatment for which the SP was responsible did not meet statutory criteria to be determined as recurring or serious since this was a single incident and the VA did not have any effects from the mace that required the care of a physician.

Action Taken by Facility:

The facility completed an *Internal Review* and determined that policies and procedures were adequate, but were not followed. The SP was "immediately removed" from direct care at the time of the incident and will no longer work with the VA. All staff persons were retained on the VA's "person specific items" and crisis prevention intervention techniques. The facility's *Handbook* was updated to reflect clarifying language prohibiting possession and use of weapons.

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

The SP was not disqualified from providing direct care services as a result of the maltreatment determination in this report. However, the SP was notified by the Office of Inspector General that any further substantiated act of maltreatment, whether or not the act meets the criteria for "serious," will automatically meet the criteria for "recurring" and will result in the disqualification of the SP. The determination that the SP was responsible for maltreatment is subject to appeal.

The facility was issued corrective action for the violation in this report in combination with DHS Report number 20174280.

Internal file management notations redacted

From: Shamus O'Meara
Sent: Friday, January 21, 2011 1:28 PM
To: Colleen.Wieck@state.mn.us
Subject: FW: AGO_DOCS-#2758324-v1-METO_Jensen_Settlement_Agreement_1-21-11

Colleen, FYI, just in.

Shamus

Shamus P. O'Meara
Johnson & Condon, P.A.
7401 Metro Blvd. Suite 600
Minneapolis, MN 55439
spo@johnson-condon.com
direct: 952.806.0438

From: Kohnstamm, Kenneth [mailto:Kenneth.Kohnstamm@state.mn.us]
Sent: Friday, January 21, 2011 1:10 PM
To: Shamus O'Meara
Cc: Alpert, Steve
Subject: AGO_DOCS-#2758324-v1-METO_Jensen_Settlement_Agreement_1-21-11

Here's our revision of your proposal of January 6. This is only for sections I-XII and XIX. This should be in a redline version that makes it easy for you to see our changes and permits you to make changes of your own.

We'll get you the balance early next week. Ken

EXHIBIT F

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

James and Lorie Jensen, as parents, guardians and next friends of Bradley J. Jensen; James Brinker and Darren Allen, as parents, guardians and next friends of Thomas M. Allbrink; Elizabeth Jacobs, as parent, guardian and next friend of Jason R. Jacobs; and others similarly situated, Plaintiffs, vs. Minnesota Department of Human Services, an agency of the State of Minnesota; Director, Minnesota Extended Treatment Options, a program of the Minnesota Department of Human Services, an agency of the State of Minnesota; Clinical Director, the Minnesota Extended Treatment Options, a program of the Minnesota Department of Human Services, an agency of the State of Minnesota; Douglas Bratvold, individually, and as Director of the Minnesota Extended Treatment Options, a program of the Minnesota Department of Human Services, an agency of the State of Minnesota; Scott TenNapel, individually and as Clinical Director of the Minnesota Extended Treatment Options, a program of the Minnesota Department of Human Services, an agency of the State of Minnesota; and State of Minnesota, Defendants.	Court File No.: 09-CV-1775 DWF/FLN **STIPULATED CLASS ACTION SETTLEMENT AGREEMENT AND ORDER ON STIPULATED CLASS ACTION SETTLEMENT**

This Stipulated Class Action Settlement Agreement ("Agreement") is entered into by and between Plaintiffs James and Lorie Jensen, as parents, guardians and next friends of Bradley J. Jensen, James Brinker and Darren Allen, as parents, guardians and next friends of Thomas M. Allbrink, Elizabeth Jacobs, as parent, guardian and next friend of Jason R. Jacobs and Defendants Minnesota Department of Human Services, an agency of the State of Minnesota

("DHS" or "Department") and the State of Minnesota ("State"); collectively, and Scott TenNapel, individually and in his former official capacity ("Defendant TenNapel"), the "Settling Parties."

RECITALS

1. The State developed and operates Minnesota Extended Treatment Options ("METO") to provide treatment and care for persons with developmental disabilities.

2. Plaintiffs Bradley J. Jensen, Thomas M. Allbrink, Jason R. Jacobs and others similarly situated were residents of METO.

3. In their Amended Complaint, Plaintiffs contend *inter alia* the State and DHS unlawfully and unconstitutionally permitted METO to routinely impose seclusion and mechanical restraints upon residents, including Plaintiffs and others similarly situated, for which Plaintiffs claim damages and injunctive relief, including attorney's fees and costs, resulting from Defendants' alleged conduct.

4. Defendants have denied Plaintiffs' allegations in their entirety.

5. In order to avoid the burdens of litigation and resolve the claims in the above referenced lawsuit in a mutually agreeable manner, it is the intent and desire of the Settling Parties to enter into this Agreement, contingent upon approval by the Court, which the parties jointly request.

6. Plaintiffs' counsel have conducted substantial investigations and negotiations and, considering the benefits of the settlement and the risks of litigation, have concluded that it is in the best interest of the Plaintiffs and the Class Members to enter into this Agreement. The Plaintiffs and counsel agree that this settlement is fair, reasonable and adequate with respect to

the interests of the Plaintiffs and the Class Members, and should be approved by the Court pursuant to Federal Rule of Civil Procedure 23.

7. The State engaged the services of Defendant TenNapel in various capacities at METO either by employing him directly or by contracting with his employers, Provide Care, Inc. and Karcher Foster Services, Inc., for his services. The Settling Parties agree that Defendant TenNapel currently has no current official capacity with the State of Minnesota. As such, the provisions of this Agreement which call for commitments and modifications regarding either the operations of METO, including closure and transfers, or commitments to modify the rules governing aversive and deprivation procedures in Minnesota, bind the State, DHS and the Plaintiffs, and the Settling Parties agree that upon final approval of this Agreement, the Agreement imposes no duty on Defendant TenNapel with respect to implementing or enforcing those terms.

NOW THEREFORE, in consideration of the above Recitals and the respective covenants, promises, agreements and releases contained herein, which the Settling Parties agree constitute good and valuable consideration, and on the joint motion of the Settling Parties for Court Approval of this Agreement, it is hereby STIPULATED AND AGREED as follows:

I. INCORPRATION OF RECITALS

Each and every Recital set forth above is incorporated herein by this reference as if set forth in their entirety.

II. JURISDICTION AND VENUE

A. The Court has federal question jurisdiction over this matter pursuant to 28 U.S.C. § 1331 and related law, and has original jurisdiction over this matter pursuant to 28 U.S.C. § 1343(a)(3). Plaintiffs have commenced this action pursuant to 42 U.S.C. § 1983, Title II of the

Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and related federal laws to recover damages, including the costs of this suit and reasonable attorney's fees, claimed by Plaintiffs and the Class Members ~~by~~ resulting from Defendants' alleged violations of federal law and for injunctive relief.

B. The Court has supplemental jurisdiction over the claims in this matter that arise under state law pursuant to 28 U.S.C. § 1367(a) because Plaintiffs' state law claims are so related to the federal claims that they form part of the same case or controversy and derive from a common nucleus of operative facts.

C. Venue in the District of Minnesota is appropriate pursuant to 28 U.S.C. § 1391, as the conduct alleged herein occurred in this District.

III. DEFINITIONS

A. *Agreement*: Agreement means this Stipulated Class Action Settlement Agreement herein.

B. *Facility*: Facility means the Minnesota Extended Treatment Options ("METO") program, its Cambridge, Minnesota successor~~s~~, and the two new adult foster care transitional homes to which residents of METO have been or may be transferred.

C. *Resident*: Resident means a person residing at ~~METO, its successors, or residing at any other state operated facility to which the resident of METO has been or may be transferred.~~the Facility.

D. *Plaintiffs*: Plaintiffs mean Plaintiffs James and Lorie Jensen, as parents, guardians and next friends of Bradley J. Jensen, James Brinker and Darren Allen, as parents, guardians and next friends of Thomas M. Allbrink, and Elizabeth Jacobs, as parent, guardian and next friend of Jason R. Jacobs.

E. *Defendants*: Defendants means the Minnesota Department of Human Services, an agency of the State of Minnesota; Director, Minnesota Extended Treatment Options, a program of the Minnesota Department of Human Services, an agency of the State of Minnesota; Clinical Director, the Minnesota Extended Treatment Options, a program of the Minnesota Department of Human Services, an agency of the State of Minnesota; Douglas Bratvold, individually, and as Director of the Minnesota Extended Treatment Options, a program of the Minnesota Department of Human Services, an agency of the State of Minnesota; Scott TenNapel, individually and in his official capacities including Clinical Director of the Minnesota Extended Treatment Options, a program of the Minnesota Department of Human Services, an agency of the State of Minnesota; and State of Minnesota.

F. *Settling Parties*: Settling Parties means Plaintiffs and the State of Minnesota ("State") the Minnesota Department of Human Services ("DHS" or "Department"), and Defendant TenNapel.

G. *Settled Claims*: Settled Claims means all claims alleged against the Settling Parties in Plaintiffs' Amended Complaint, and all claims against the Settling Parties relating to or arising from the allegations contained in Plaintiffs' Amended Complaint.

H. *Other Definitions:* Other definitions are set forth in this Agreement and its attachments A, B and C.

I. *Best Practices:* Best practices means generally accepted professional standards.

J. *Scope:* The provisions of this Agreement pertain only to the residents of the Facility, with the exception of the provisions of Paragraph XI, "Systemwide Improvements."

IV. DECLARATION OF TOP CONCERN

The State of Minnesota declares, as a top concern, the safety and quality of ~~the~~ life of ~~its~~ the residents. ~~with developmental disabilities.~~ The State agrees that its goal is to provide the residents ~~of Minnesota Extended Treatment Options and its successor(s) and people with developmental disabilities residing in state operated programs~~ with a safe and humane living environment free from abuse and neglect.

V. CLOSURE OF THE METO PROGRAM

The State and DHS agree the METO program will be closed by June 30, 2011. Any successor to METO shall: (1) comply with the U.S. Supreme Court decision in *Olmstead v. L.C.*, 527 U.S. 582 (1999); (2) utilize person centered planning principles and positive behavioral supports consistent with applicable best practices including, but not limited to the Association of Positive Behavior Supports, *Standards of Practice for Positive Behavior Supports* (http://apbs.org) (February, 2007); (3) be licensed to serve people with developmental disabilities; (4) only serve "Minnesotans who have developmental disabilities and exhibit severe behaviors which present a risk to public safety" pursuant to METO's original statutory charge under Minnesota Statutes 252.025, subd. 7; and (5) ~~substantively consult with~~notify parents and guardians of residents, at least annually, ~~parents and guardians residents with developmental disabilities and allow them meaningful participation in the design, development, implementation and evaluation of any successor to METO.~~of their opportunity to comment in writing, by e-mail, and in person, on the operation of the Facility.

VI. PROHIBITED TECHNIQUES

A. Except as provided in subpart VI.-B., below, the State and DHS shall immediately and permanently discontinue the use of mechanical restraint (including metal law enforcement-type handcuffs and leg hobbles, cable tie cuffs, PlastiCuffs, FlexiCuffs, soft cuffs, posey cuffs,

and any other mechanical means to restrain), manual restraint, prone restraint, chemical restraint, seclusion, ~~individual isolation, electroconvulsive therapy,~~ and the use of painful techniques to induce changes in behavior through punishment on residents with developmental disabilities~~.~~. Medical restraint, and psychotropic and/or neuroleptic medications shall not be administered to residents for punishment, in lieu of adequate and appropriate habilitation, skills training and behavior supports plans, for the convenience of staff and/or as a form of behavior modification.

B. **Policy.** The Facility's policy, "Therapeutic Interventions and Emergency Use of Personal Safety Techniques," Attachment A, is incorporated by reference. This policy defines manual restraint, mechanical restraint, and emergency, and provides that certain specified manual and mechanical restraints shall only be used in the event of an emergency. This policy also prohibits the use of prone restraint, chemical restraint, seclusion and time out.

C. **Seclusion and Time Out from Positive Reinforcement.**

1. The Facility's use of seclusion is prohibited.

2. Seclusion means the placement of a person alone in a room from which egress is:

a. noncontingent on the person's behavior; or

b. prohibited by a mechanism such as a lock or by a device or object positioned to hold the door closed or otherwise prevent the person from leaving the room.

3. The Facility's use of Room Time out from positive reinforcement is prohibited.

4. Time out means removing a person from the opportunity to gain positive reinforcement and is employed when a person demonstrates a behavior identified in the

individual program plan for reduction or elimination. Room time out means removing a person from an ongoing activity to a room (either locked or unlocked).

D. **Chemical Restraint.** The Facility shall not use chemical restraint.

1. A chemical restraint is the administration of a drug or medication when it is used as a restriction to manage the resident's behavior or restrict the resident's freedom of movement and is not a standard treatment or dosage for the resident's condition.

2. Orders or prescriptions for the administration of medications to be used as a restriction to manage the resident's behavior or restrict the resident's freedom of movement shall not be written as a standing order or on an as-needed basis (PRN).

~~E. The Department shall include a protocol to contact a qualified Third Party Expert, pre-approved by Plaintiffs and Defendants and the costs for the Third Party Expert paid by the Department, as soon as possible but no later than thirty (30) minutes upon the emergency presenting to consult with Facility staff and provide professional assistance to abate the emergency condition, including the use of positive behavioral supports techniques, safety techniques, and other best practices.~~

E. **Medical Officer Review.** The Department's policy, Attachment A, provides that in the event of an emergency, restraint may be used. As soon as the situation is stabilized, but no later than 30 minutes after the emergency begins, the responsible supervisor shall contact the Department's medical officer on call in order that the medical officer may assess the situation, suggest strategies for de-escalating the situation, and approve of or discontinue the use of restraint. The consultation with the medical officer shall be documented in the resident's medical record.

F. **Zero Tolerance for Abuse and Neglect** ~~The State shall take effective steps to ensure that residents are free from abuse and neglect. The State shall announce or re-affirm, as applicable, a policy of "zero tolerance" for abuse (including verbal, mental, sexual, or physical abuse) and neglect, whether from other residents or from staff. To the fullest extent available under applicable law, the State shall pursue the termination, criminal prosecution and conviction of any staff member violating the zero tolerance policy. The State shall further announce or re-affirm, as applicable, its commitment to compliance with the reporting requirements relating to abuse of vulnerable persons per Minnesota Statutes, Section 626.557 *et seq*. The State shall immediately remove any staff member suspected of staff on resident abuse or neglect from direct resident contact until the conclusion of the investigation and submission of the written investigation report about the incident. The State shall impose appropriate disciplinary and/or corrective personnel action where a staff person is determined to have caused or been responsible for abuse and/or neglect, and against any staff person who fails to report a significant incident to supervisory or other appropriate personnel in a timely or accurate manner.~~The State affirms its commitment to comply with the reporting requirements relating to abuse of vulnerable persons pursuant to Minn. Stat. § 626.557 *et seq*. The State's goal is to achieve "zero tolerance" for abuse (including verbal, mental, sexual, or physical abuse) and neglect, whether from other residents or from staff. Any staff member suspected of staff on resident abuse or neglect shall be disciplined pursuant to DHS policies and the collective bargaining agreement, if applicable. Where appropriate, the State shall refer matters of suspected abuse or neglect to the county attorney for criminal prosecution.

VII. RESTRAINT REPORTING AND MANAGEMENT

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A. METO Form 31032 (Attachment C "Documentation of Implementation of Controlled Procedures") shall be completed by the end of the shift during which use is made of manual or mechanical restraint.

B. Within 24 hours, the completed METO Form 31032 shall be submitted electronically, by fax or personally delivered, to the following:

a. Office of Health Facility Complaints;

b. Ombudsman for Mental Health and Developmental Disabilities;

c. DHS Licensing;

d. DHS Internal Reviewer;

e. Client's family and/or legal representative;

f. Case manager;

g. Other licensed care giver, if any;

h. Plaintiffs' counsel.

~~C. For any use of Prohibited Techniques set forth in section VIA. DHS shall use the incident reporting, investigation, analysis and follow up set forth in Minnesota Statute § 256B.096, subd. 4, and shall also use DHS Division of Licensing Self Monitoring Checklist, Emergency and Incident Response & Reporting, Attachment C to this Agreement, amended to include the use of Prohibited Techniques.~~

VIII. INTERNAL AND EXTERNAL REVIEW OF THE USE OF RESTRAINTS

In order to monitor the Facility's use of manual and mechanical restraints, the Department will utilize one of its qualified employees as an internal reviewer and shall fund the costs of the external reviewer within the Office of Health Facility Complaints.

A. **Internal Reviewer.**

1. The Department shall designate one employee with responsibility for monitoring the Facility's use of restraints ("internal reviewer"). Presently this is Richard S. Amado, Ph.D., Director of the Department's Office for Innovation in Clinical and Person Centered Excellence, whose duties include a focus on the elimination of restraints.

2. The Facility shall complete METO Form 31032 and provide it to the internal reviewer, and all others listed in section VII.–B., above, within 24 hours of the use of manual or mechanical restraint.

3 The internal reviewer shall consult with staff at the Facility in order to assist eliminating the use of manual and mechanical restraints.

B. **External Reviewer**.

1. The external reviewer will be approved by Plaintiffs and Defendants before hire and will be an employee of the Office of Health Facility Complaints, Minnesota Department of Health and shall have full enforcement authority consistent with the Office of Health Facility Complaints, as ~~including but not limited to the authority~~ set forth in Minnesota Statute § 144.53, *et. seq*.

2. DHS will fund the costs of the external reviewer.

3. The external reviewer will have the following credentials:

   a. Ph.D. in psychology, education, clinical social work, or a related field;

   b. Certification or eligible for certification as a Board certified Behavior Analyst at the Doctoral level;

   c. Experience in person centered planning;

d. Experience using the integration of diagnostic findings, assessment results and intervention recommendations across disciplines in order to create an individual program plan;

e. Experience and demonstrated competence in the empirical evaluation of mood and behavior altering medications.

4. Every three months, the external reviewer shall issue a written report informing the Department whether the Facility is in substantial compliance with this Agreement and the policies incorporated hereto. The report shall enumerate the factual basis for its conclusion and may make recommendations and offer technical assistance. The external reviewer shall provide Plaintiffs and Defendants with a draft report. The parties will have 15 business days to provide written comment. The external reviewer's final report shall be issued to the parties thereafter.

5. The external reviewer shall issue quarterly reports to the Court ~~during~~ for the ~~first 24 months upon Order approving~~ duration of this Agreement~~,~~. ~~and at least annually thereafter, which~~ The reports shall describe whether the Facility is operating consistent with best practices, and with this Agreement. The external reviewer's reports shall be filed on the Court's public electronic court filing system, or any successor system, with appropriate redaction of the identities of residents or other personal data information that is statutorily protected from public disclosure.

6. The external reviewer shall not be a "Special Master" nor "Court Appointed Monitor." The external reviewer shall have full enforcement authority consistent with the Office of Health Facility ~~Compliance~~ Complaints' ~~including but not limited to the~~ authority set forth in Minnesota Statute § 144.53, *et. seq*.

7. ~~The State shall allow oversight of the Facility, including unimpeded access to staff, residents, records, Facility residential locations and community services.~~

~~Oversight shall be permitted by the Office of the Ombudsman for Mental Health and Developmental Disabilities, the Disability Law Center and/or any specially created Independent Advisory Committee, and, upon notice to, and coordination with, the Minnesota Attorney General's Office, Plaintiffs' counsel.~~In addition to the external reviewer's authority described above, the following shall have access to the facility and its records, including the medical records of residents for the purpose of ascertaining whether the facility is complying with this Agreement:

a. The Office of Ombudsman for Mental Health and Developmental Disabilities, consistent with its authority under Minn. Stat. § 245.94. This Settlement Agreement shall be deemed adequate basis for the Office of Ombudsman to exercise its powers under Minn. Stat. § 245.94, subd. 1.

b. The Disability Law Center, consistent with its authority under 42 U.S.C. § 15043. This Settlement Agreement shall be deemed adequate basis for the Disability Law Center, as the designated Protection and Advocacy organization in Minnesota, to exercise its authority under 42 U.S.C. § 15043.

c. Plaintiffs' counsel, upon notice to and coordination with, the Minnesota Attorney General's Office.

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IX. ~~TRANSFERS~~ TRANSITION PLANNING

The State shall undertake best efforts to ensure that each resident is served in the most integrated setting appropriate to meet such person's individualized needs, including home or community settings. The State shall actively pursue the appropriate discharge of residents and provide them with adequate and appropriate transition plans, protections, supports, and services consistent with such persons' individualized needs, in the most integrated setting and where the individual does not object. Each resident and the resident's family and/or legal representative shall be involved in the team evaluation, decision making, and planning process to the greatest extent practicable, using whatever communication method he or she prefers. To foster each resident's self-determination and independence, the State shall use *person-centered* planning

principles at each stage of the process to facilitate the identification of the resident's specific interests, goals, likes and dislikes, abilities and strengths, as well as support needs. Each resident shall be given the opportunity to express a choice regarding preferred activities that contribute to a quality life. The State shall undertake best efforts to provide each resident with reasonable ~~viable~~ placement alternatives.~~.~~ ~~It is the State's determination that all residents meet the essential eligibility requirements for placement and habilitation in integrated community settings.~~ It is the State's goal that ~~A~~all residents ~~can~~ be served in integrated community settings ~~when~~ with adequate protections, supports, and other necessary resources are identified as available by service coordination. ~~The State shall ensure that this requirement is clearly set forth in each resident's plan. The provisions in this subpart C shall be consistent and~~ This paragraph shall be implemented in accord with the U.S. Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 582 (1999).

X. OTHER PRACTICES AT THE FACILITY.

A. The Facility treatment staff shall receive training in positive behavioral supports, person centered approaches, therapeutic interventions, personal safety techniques, crisis intervention, and post crisis evaluation. The training is explained more fully in Attachment B which is incorporated by reference hereto. All training shall be consistent with applicable best practices and standards, including but not limited to the Association of Positive Behavior Supports, *Standards of Practice for Positive Behavior Supports* (http://apbs.org) (February, 2007).

B. 1. Staff at the Facility shall receive the specified number of hours of training subsequent to September 1, 2010 and prior to ~~June 30~~December 31, 2011:

Therapeutic interventions	8

Personal safety techniques	8
Medically monitoring restraint	1

Staff at the Facility shall not be eligible to impose restraint until the above specified training has been completed, and then only certain restraints in an emergency as set forth in Attachment A to this Agreement, Therapeutic Interventions And Emergency Use Of Personal Safety Techniques." ~~All training shall be consistent with applicable best practices and standards, including but not limited to the Association of Positive Behavior Supports, *Standards of Practice for Positive Behavior Supports*~~

2. Staff at the Facility shall receive the specified number of hours of training subsequent to September 1, 2010 and prior to ~~December~~ March 31, 201~~1~~2:

Person centered planning and positive behavior supports (at least 16 hours on person centered thinking/planning)	40
Post Crisis Evaluation and Assessment	4

C. **Visitor Policy.** The State and DHS shall permit residents unscheduled and scheduled visits with immediate family and/or guardians~~.~~, unless the Interdisciplinary Team (IDT) determines the visit is contraindicated. Visitors shall be allowed full and unrestricted access to the resident's living areas, including kitchen, living room, social and common areas, bedroom and bathrooms~~.~~, consistent with all residents' rights to privacy. Residents shall be allowed to visit with immediate family members and/or guardians in private without staff supervision~~.~~, unless the IDT determines this is contraindicated.

D. Upon Court approval of this Agreement, the State and DHS will discontinue any marketing~~, publicity or description~~ of, or recruitment for the Facility.

~~E. The State shall post a brief and easily understood statement of individual rights in every state-operated living unit and program area where people with developmental disabilities~~

~~reside . This information must include how to exercise such rights and how to report violations of such rights.~~

E. Pursuant to Minn. Stat. § 144.652, subd. 1, the Facility shall continue to post the Health Care Bill of Rights, the name and phone number of the person within the Facility to whom inquiries about care and treatment may be directed, and a brief statement describing how to file a complaint with the Office of Health Facility Complaints, including the address and phone number of that office.

XI. SYSTEM WIDE IMPROVEMENTS.

A. **Expansion of Community Support Services**.

1. *Goals and objectives*. State Operated Community Support Services ("CSS") will be expanded in an effort to deliver the right care at the right time in the most integrated setting for individuals with developmental disabilities. The expansion of this service will allow for the provision of assessment, triage, and care coordination to assure persons with developmental disabilities receive the appropriate level of care at the right time, in the right place in the most integrated setting ~~as needed and~~ in accordance with the U.S. Supreme Court decision in *Olmstead v. L.C*, 527 U.S. 582 (1999).

a. **Long term monitoring**. CSS will identify and provide long term monitoring of individuals with clinical and situational complexities in order to help avert crisis reactions, provide strategies for service entry changing needs, and prevent multiple transfers within the system. Approximately 75 individuals will be targeted for long term monitoring.

b. **Crisis management**. Intervention and technical assistance will be provided where the consumer lives, strengthening the capacity for the clinic to serve clinically complex individuals in their homes. CSS mobile wrap-around response teams will be located

across the state for proactive response to maintain living arrangements. The maximum time for CSS to arrange a crisis intervention will be 3 hours~~.~~ from the time the parent or legal guardian authorizes CSS' involvement. CSS will partner with Community Crisis Intervention Services to maximize support, complement strengths, and avoid duplication. CSS will provide augmentative training, mentoring and coaching.

c. **Training**. CSS will provide staff at community based facilities and homes state of the art training encompassing person centered thinking, multi-modal assessment, positive behavior supports, consultation and facilitator skills, and creative thinking. Mentoring and coaching as methodologies ~~are~~ will be targeted to prepare for increased community capacity to support individuals in their community.

2. Expansion of CSS will begin in ~~November~~ February of 201~~0~~1 with an estimated completion date of ~~February 28~~June 30, 2011. This increase will be an additional 14 full time equivalent positions which will equate to 15 people. The proposed positions are as follows:

2 Behavior Analyst 3 positions,

1 Behavior Analyst 2,

2 Behavior Analyst 1

4 Social Worker Specialist positions, and

5 Behavior Management Assistants.

Total cost of salaries for these staff is estimated by DHS to be $823,000. The estimated cost of equipment and space is estimated by DHS to be $107,800.

The term 'behavior analyst' refers to individuals with requisite educational background experience and credentials recognized by national associations such as the Association of Professional Behavior Analysts.

B. ***Olmstead* Plan**

1. Within sixty (60) days of the Court's approval of this Agreement, the Department will establish an *Olmstead* Planning Committee which will issue its public ~~report~~ recommendations within ~~six~~ ten ~~(6)~~(10) months of the Court's Order approving this Agreement. Within ~~one year~~ eighteen months of the Court's approval of this Agreement, the State and the Department shall develop and implement a comprehensive *Olmstead* plan that uses measurable goals to increase the number of people with disabilities receiving services that best meet their individual needs and in the "Most Integrated Setting," and is consistent and in accord with the U.S. Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 582 (1999).

2. The Olmstead Planning Committee must be comprised of no less than fifteen (15) members with demonstrated understanding of the spirit and intent of the *Olmstead* decision, best practices in the field of disabilities, and a longstanding commitment to systemic change that respects the human and civil rights of people with disabilities. The Committee must be comprised of stakeholders, including parents, independent experts, representatives of the Department, the Ombudsman Office for Mental Health and Developmental Disabilities, Minnesota Governor's Council on Developmental Disabilities, Minnesota Disability Law Center, Plaintiff's counsel, and others as agreed upon by the parties.

C. **Rule 40.**

1. Within 60 days from the date of the Order approving this Agreement , the Department shall organize and convene a Rule 40 (Minn. R. 9525.2700-.2810) Committee ("Committee") comprised of stakeholders, including parents, independent experts, DHS representatives, the Ombudsman for Mental Health and Developmental Disabilities, the Minnesota Governor's Council on Developmental Disabilities, Minnesota Disability Law Center,

Plaintiffs' counsel and others as agreed upon by the parties, to study, review and modernize Rule 40 to reflect current best practices, including, but not limited to the use of positive and social behavioral supports, and the development of placement plans consistent with the principle of the "most integrated setting" and "person centered planning, and development of an '*Olmstead* Plan'" consistent with the U.S. Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 582 (1999). The Committee's review of best practices shall include the Arizona Department of Economic Security, Division of Developmental Disabilities, Policy and Procedures Manual, Policy 1600 Managing Inappropriate Behaviors.

2. Within 60 days from the date of the Court's approval of this Agreement, a public notice of intent to undertake administrative rule making will be issued.

3. DHS will not seek a waiver of Rule 40 for the Facility.

~~A~~D. **Minnesota Security Hospital.**

1. Within sixty (60) days upon Court approval of this Agreement, the State shall undertake best efforts to ensure that there are no transfers to or placements at the Minnesota Security Hospital of persons committed solely as a person with a developmental disability. No later than July 1, 2011, there shall be no transfers or placements of persons committed solely as a person with a developmental disability to the Minnesota Security Hospital. This prohibition does not apply to persons with other forms of commitment, such as mentally ill and dangerous, mentally ill, chemically dependent, sexual psychopathic personality and sexually dangerous persons. Nor does this prohibition pertain to persons who have been required to register as a predatory offender under Minn. Stat. § 243.166 or 243.167 or to persons who have been assigned a risk level as a predatory offender under Minn. Stat. § 244.052.

2. There shall be no ~~re-diagnosis~~ change in commitment status of any ~~resident~~ person originally committed solely as a person with a developmental disability without proper notice to that ~~resident's~~ person's parent and/or guardian and a full hearing before the appropriate adjudicative body.

3. No later than ~~thirty (30) days after Court approval of this Agreement,~~ 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 ~~subpart C, below.~~*Olmstead v. L.C.*, 527 U.S. 581 (1999).

~~B~~E. **Anoka Metro Regional Treatment Center.**

Persons committed solely as a person with a developmental disability may be transferred to AMRTC only if they have an acute psychiatric condition. Within 30 days of the Court's approval of this Agreement, any AMRTC resident committed solely as a person with a developmental disability who does not have an acute psychiatric condition will be transferred ~~to another facility.~~from AMRTC. The transfer shall be to the most integrated setting consistent with *Olmstead v. L.C.*, 527 U.S. 581 (1999). ~~Pursuant to Minnesota Statute §253B.02, subd. 6, the Commissioner of Human Services will fully exercise his/her authority to transfer or move any resident committed to Commissioner's care as a person with developmental disability, to a program or service deemed the most appropriate to meet the needs of the individual in the most integrated setting and consistent with the U.S. Supreme Court's decision in *Olmstead v. L.C.*, 527 U.S. 582 (1999).~~

XII. OTHER

A. It is understood that by agreeing to this settlement, the State, Department and Defendant TenNapel in no way admit fault or liability of any kind to Plaintiffs. Nothing in this Agreement shall be construed as an acknowledgement, admission or evidence of liability of the State, Department or Defendant TenNapel and nothing in this Agreement may be used as evidence of liability in any administrative, civil or criminal proceeding.

B. This Agreement is intended by the parties to effectuate a complete release by the Plaintiffs of all claims against the State, Defendant TenNapel, Defendant Bratvold, and the Department, as well as its present and former employees and agents, which agents include Defendant TenNapel's employers Provide Care, Inc. and Karcher Foster Services, Inc .

C. Within five (5) days upon the date of final approval of this Agreement, as set forth in section XVI, Dismissal of the Lawsuit, Plaintiffs shall execute voluntary dismissals with prejudice of individually named defendants Douglas Bratvold and Scott TenNapel. The date of final approval shall be the date after which no further appeal can be taken of an order giving final approval of this settlement.

D. ~~Pursuant to Minnesota Statutes, section 15.001 and current industry standards and practices, t~~The ~~State~~ Department shall terminate its use or publication of the pejorative term "mental retardation," in the manner specified by Minn. Stat. § 15.001.~~in all aspects of its services.~~

XIII. CLASS CERTIFICATION

A. The parties agree that the above-entitled action may be certified as a Class Action pursuant to Rule 23 of the Federal Rules of Civil Procedure, and that Plaintiffs counsel shall serve as Class Counsel upon Court approval of this Agreement. The Parties agree to recommend approval of this Agreement by the Court and to recommend participation in the settlement by Class Members. The Parties agree to undertake their best efforts, including all steps and efforts that may become necessary by order of the Court or otherwise, to effectuate the terms and purposes of this Agreement and to secure the Court's approval.

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B. The Class shall be defined as follows:

> Individuals who were subjected to the use of restraints of any kind for any reason and/or any type of seclusion method while a resident at the Minnesota Extended Treatment Options program from the inception of the program through the Court's approval of this Agreement as found in the records of METO residents, electronic verification of which has been provided to Plaintiffs' counsel.

C. The Class Period is the date of METO's inception, through the date of the Court's Order approving this Agreement.

D. The Class is so numerous that joinder of all Class Members is impractical.

E. The Class is ascertainable, as the names of all Class Members can be identified in resident records maintained by METO and DHS.

F. Plaintiffs will fairly and adequately protect the interests of the Class and have no interests adverse to or which directly and irrevocably conflict with the interests of other Class Members.

G. Plaintiffs are represented by counsel competent in the litigation of claims of the type asserted herein.

H. Questions of law and fact common to the Class predominate over questions affecting only individual Class Members, including but not limited to alleged violations of rights granted pursuant to the Eighth and Fourteenth Amendments to the United States Constitution; whether Minnesota Statutes, section 245.825 and Minnesota Rules 9525.2700 - .2810 violate the United States Constitution and the Constitution of the State of Minnesota; alleged violations of Title II of the Americans with Disabilities Act; alleged violations of Section 504 of the Rehabilitation Act; alleged violations of rights granted under the Constitution of the State of Minnesota; alleged violations of the Minnesota Human Rights Act; and alleged violations of Minnesota Statutes, sections 245.825, 144.651, 353B.03, and Minnesota Rules 9525.2700 - .2810; alleged violations of 42 C.F.R. 482.13; and other allegations.

I. Plaintiffs' claims are typical, identical or substantially similar to the claims of the Class Members because they originate from the same alleged policies and practices of Defendants, and because Defendants allegedly acted in the same way toward Plaintiffs.

J. Plaintiffs will fairly and adequately protect the interests of the Class Members. Plaintiffs are committed to the vigorous prosecution of this action, have retained competent counsel, and have no interests antagonistic to or in conflict with those of the Class. As such, Plaintiffs are adequate Class Representatives.

K. A class action is superior to other available methods for the fair and efficient adjudication of this controversy. Class treatment will permit a large number of similarly situated persons to prosecute their claims in a single forum simultaneously and without unnecessary duplication and effort that would result from numerous individual actions. Individual litigation of the facts of all the individual cases would unduly burden the Courts. Individual litigation would further present a potential for inconsistent or contradictory judgments, and would increase

the delay and expense to all parties and the Court system. Further, the expense and burden of individual litigation make it impossible for Class Members to individually redress the wrongs alleged in Plaintiffs' Amended Complaint. In contrast, a class action presents far fewer management difficulties and provides the benefit of single adjudication under the comprehensive supervision of a single court. Notice of pendency of the action and any resolution thereof can be provided to proposed Class Members by publication and/or other means.

L. This action is maintainable as a class action under Rule 23(b)(2) since the alleged actions of Defendants have been taken on grounds equally applicable to all members of the Class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the Class as a whole. This action is also maintainable as a class action under Rule 23(b)(3), as common questions of law and fact described above predominate over any questions affecting only individual members, the desirability of concentrating the claims in one forum, and a class action is superior to other available methods for the fair and efficient adjudication of the controversy.

M. If any Settling Party reasonably determines that the exercise of any right to opt out from this Class Action by one or more putative class members materially and adversely affects that Settling Party, then that party may propose modifications thereto by giving written notice to the counsel for all other Settling Parties. The written notice must be given within ten (10) business days from the final deadline for exercising the right to opt out. If the Settling Parties do not reach agreement on any reasonable proposed modifications within twenty (20) days from receipt of the written notice of intent to void or modify, then the Agreement shall remain in full force and effect. At its option, the affected Settling Party may, within ten (30)

days thereafter, file a motion with the Court consistent with the local rules for non-dispositive motions for adjudication of the disputed proposed modification.

XIV. NOTICE OF PROPOSED SETTLEMENT

Upon Court approval of this Agreement, DHS agrees to provide and pay for all notice, publication and administration of the proposed settlement to the Class Members, in a form approved by the Court, as required by Federal Rule of Civil Procedure 23(e). The Parties will recommend to the Court that notice of the proposed settlement will be provided by sending written notice by first-class mail, postage prepaid, to all Class Members at the addresses found on the individual Class Members' resident records in the possession of METO and DHS, electronic verification of which has been provided to Plaintiffs' Counsel, or other address provided by the Post Office, the Class Member, or otherwise as described in relevant records.

XV. FINAL COURT APPROVAL

A. After notice is provided to the Class as described above, and the time period for Class Member opt-outs, objections and comments has expired, the Settling Parties will jointly petition the Court for final approval of this Agreement, and will use their best efforts to obtain such approval. If any person objects to this Agreement, the Settling Parties will use their best efforts to meet such objection. If any person appeals the Court's order of final approval of the Agreement, the Settling Parties will use their best efforts to defeat the appeal.

B. The terms of this Agreement are subject to the Court's final approval and, in the event the Court's order granting final approval is appealed, the approval of all applicable appellate courts. If the Court or any appellate court enters an order altering this Agreement in a way that materially and adversely affects a named party in the lawsuit, that party may void the Agreement within three (3) business days from the date the trial court or appellate court enters

such an order by giving written notice of intent to void the settlement to the opposing parties' counsel.

XVI. DISMISSAL OF THE LAWSUIT

If no named party gives notice of intent to void the settlement as described in section XV B above, the Plaintiffs, individually and as representatives of the Class Members, shall execute and cause to be filed with the Court an agreed Order of Dismissal with Prejudice of all claims against the Defendants. The agreed Order of Dismissal shall be filed by Plaintiffs within five (5) business days after the date of final Court approval of this Agreement. The date of final approval shall be the date after which no further appeal can be taken of an order giving final approval of this settlement.

XVII. SETTLEMENT AMOUNT

A. As a compromise settlement of this lawsuit, and in exchange for the releases and covenants described in this Agreement, the State and DHS agree to pay a total of Three Million and No/100 Dollars ($3,000,000), including attorneys fees, costs, and disbursements in full settlement of all claims ("Settlement Amount"), except for costs of administration of the Class which is to be borne by the State Defendants. The Settlement Amount will paid as follows:

1. Subject to Court approval, Plaintiffs James and Lorie Jensen, collectively, as parents, guardians and next friends of Bradley J. Jensen shall be apportioned a minimum of Seventy-Five Thousand Dollars ($75,000.00) in total; James Brinker and Darren Allen, collectively, as parents, guardians and next friends of Thomas M. Allbrink shall be apportioned a minimum of Seventy-Five Thousand Dollars ($75,000.00) in total, and Elizabeth Jacobs, as parent, guardian and next friend of Jason R. Jacobs, shall be apportioned a minimum of Seventy-Five Thousand Dollars ($75,000.00) in total.

2. Subject to Court approval, the sum of one million dollars ($1,000,000) shall be paid to Plaintiffs' Counsel as combined fees and costs. From this amount Plaintiffs' Counsel, serving as Class Counsel, will pay all of the class costs, including the costs incurred in preparing and

adjudicating the lawsuit, including any appeals, the costs incurred in providing staff to answer inquiries from Class Members and interested parties, and the costs of disbursing the settlement proceeds to all persons making a claim. The attorneys' fees and costs herein is the total amount that will be paid by Defendants for all attorneys' fees and costs in connection with the above entitled lawsuit and this Agreement, regardless of whether any Class Member or other person engages separate or additional legal counsel or incurs separate or additional attorneys' fees or costs.

3. After payment as set forth in subparts 1 and 2, above, the Court shall apportion an amount from remaining settlement proceeds to the Class Members, taking into account the documented total number of times a resident has been restrained and/or secluded during their residency consistent with the following schedule:

Number of Documented Times Restrained/Secluded:	Apportioned Amount
1-50	$500 to $25,000
51-100	$7,500 to $50,000
101-150	$15,000 to $75,000
151-200	$25,000 to $100,000
201-250	$35,000 to $200,000
251 or more	$50,000 to $300,000

The Court may also utilize other factors for apportionment which in the interest of justice it believes should be considered.

4. To the extent any portion of the Settlement Amount, less amounts for attorneys fees, costs and disbursements, are not distributed to the Plaintiffs and the Class, such portion shall be distributed equally to three programs for people with developmental disabilities and their families, to be jointly recommended to the Court by Colleen Wieck, Executive Director, Minnesota Governor's Council on Developmental Disabilities, and Anne Barry, Interim Commissioner, DHS.

B. The settlement amount paid to Plaintiffs shall be structured so that Plaintiffs do not lose or jeopardize any disability benefits or related benefits or funding they are receiving or for which they may qualify.

C. There shall be no attempt to recover any settlement funds against Plaintiffs or Class Members through cost of care charges for residing at METO or participation in any other State program involving people with developmental disabilities.

XVIII. RELEASE

A. In consideration of the terms and conditions of this Agreement ,upon final approval of this Agreement, Plaintiffs hereby fully and forever release and discharge the State and Defendant TenNapel, and their predecessors, executors, successors, assigns, directors, administrators, officers, employees, agents, attorneys, employers, and insurers (collectively Releasees) from all claims, demands, damages, actions, rights of action of whatever kind or nature which Plaintiffs now have or may hereinafter have arising out of, in consequence of, or on account of the Settled Claims, defined in section IIIG., including any latent damages and all developments and results therefrom, all known and unknown damages, whether developed or undeveloped, and all anticipated and unanticipated consequences of all such damages.

B. This Agreement is not intended to, and shall not, affect, reduce, diminish or release any right that Plaintiffs may have or may assert against those who are not the Releasees.

C. This Agreement is not intended to, and shall not, affect, reduce, diminish or release any right that Plaintiffs may have or may assert for disability benefits or other benefits from the State of Minnesota.

XIX. DISMISSAL AND RETENTION OF JURISDICTION

A. Upon final approval of this Agreement, the Court may cause this action to be dismissed with prejudice. The Settling Parties agree that within thirty days (30) days of the final approval of this Agreement by the Court they shall execute and deliver such additional documents as are necessary to effectuate this Agreement.

B. The Court shall retain jurisdiction over this matter for two (2) years from its approval of this Agreement for the purposes of receiving reports and information required by this

Agreement, or resolving disputes between the parties to this Agreement, or as the Court deems just and equitable.

C. The August 2, 2010 Protective Order in the above-entitled action shall remain in effect ~~during the pendency of this Agreement.~~according to its terms.

D. Plaintiffs shall provide the Minnesota Attorney General's Office and Defendant TenNapel written notice at least 14 days prior to any filing or court hearing of any enforcement proceeding. The notice shall specify the section of the Agreement subject to the enforcement action, the factual basis for the action and the relief being sought. At least 7 days prior to any court hearing of an enforcement action, plaintiffs' counsel shall make a good faith effort to confer with defense counsel and resolve the matter without court action.

E.. This Agreement shall terminate two years from the date of final Court approval of the Agreement. ~~, provided, however, that all policies, procedures, protocol, reporting, training, committees, positions, and funding as set forth in the Agreement, shall remain in full force and effect after termination of this Agreement.~~

XX. REPRESENTATIONS, WARRANTIES AND AGREEMENTS

The Settling Parties represent and warrant as follows:

A. The terms of this Agreement are contractual, not a mere recital.

B The Settling Parties have each received independent legal advice from their respective attorneys with respect to the advisability of executing this Agreement.

C. Prior to the execution of this Agreement by the Settling Parties, each party or its attorneys reviewed the Agreement at length and made all desired changes.

D. This Agreement is the result of negotiations between the Settling Parties, each of which has participated in the negotiating and drafting of this Agreement through their respective

attorneys. The language of this Agreement shall not be presumptively construed in favor of or against any of the Settling Parties.

E. Except as expressly stated in this Agreement, the Settling Parties have not made any statement or representation to any other party to this Agreement regarding any fact relied upon by such other party in entering into this Agreement, and the Settling Parties specifically do not rely upon any statement, representation, or promise of any other party in executing this Agreement, except as expressly stated in this Agreement.

F. There are no other agreements or understandings between the Settling Parties relating in any way to the Settled Claims or this Agreement except as stated in this Agreement.

G. The Settling Parties, together with their attorneys, have made such investigation of the facts pertaining to this Agreement and its provisions as they deem necessary.

H. The Settling Parties have been represented by their respective attorneys during the negotiation, drafting and execution of this Agreement.

I. This Agreement has been carefully read by, the contents hereof are known and understood by, and it is signed freely and voluntarily, and without inducement, threat or promise, by each person executing this Agreement.

J. Each party to this Agreement has duly authorized the execution and performance of this Agreement by all appropriate and necessary action. Each signatory to this Agreement has the power and authority to enter into and perform this Agreement.

K. Each party to this Agreement agrees that such party will not take any action which would interfere with the performance of this Agreement by any other party to this Agreement or that would adversely affect any of the rights provided for in this Agreement.

XXI. SEVERABILITY

It is understood and agreed by the Settling Parties that if any of the provisions hereof should contravene applicable law, or be held void, voidable, unenforceable, or invalid, the remaining portions hereof shall remain in full force and effect, and shall be construed as if not containing the particular provision or provisions held to be in contravention of applicable law, or void, voidable, unenforceable or invalid, and the rights and obligations of the parties shall be construed and enforced accordingly.

XXII. GOVERNING LAW AND JURISDICTION

This Agreement shall be construed and enforced in accordance with applicable federal laws.

XXIII. INTEGRATION

This Agreement constitutes a single, integrated, written contract expressing the entire agreement of the Settling Parties relative to the subject matter hereof. No covenants, agreements, representations, or warranties of any kind whatsoever have been made by the Settling Parties, except as specifically set forth herein. All prior discussions and negotiations have been and are merged and integrated into, and are superseded by, this Decree.

XXIV. SUCCESSORS

This Agreement shall be binding and enforceable upon the successors and assigns of the Settling Parties.

XXV. EXECUTION IN COUNTERPARTS

A. Counterparts. This Decree may be executed and delivered in two or more counterparts, each of which, when so executed and delivered, shall be an original, but such counterparts shall together constitute but one and the same instrument and agreement.

B. Originals. The Settling Parties shall execute five (5) originals of this Agreement, with one fully executed and complete original being provided to each Plaintiff, the State and to the Court.

XXVI. SECTION HEADINGS

The section headings, titles, and subtitles herein are used solely for convenience, shall not be used in interpreting this Agreement, and shall not be construed in any way to limit, modify, or affect the terms of this Agreement.

XXVII. LANGUAGE OF THE AGREEMENT

The use of the singular in this Agreement includes the plural, and vice versa.

XXVIII. DISPUTE RESOLUTION

If a dispute arises out of or relates to this Agreement, or the breach thereof, the Settling Parties agree first to try in good faith to resolve the dispute by informal negotiation or mediation (without a mediator unless otherwise agreed) before resorting to litigation.

XXIX. ADMISSIONS

Nothing contained in this Agreement shall be deemed an admission of guilt or liability by or against any party to this Agreement.

XXX. MODIFICATION

This Agreement may only be modified with the written consent of the Settling Parties, such consent not to be unreasonably withheld.

XXXI. EFFECTIVE DATE

This Agreement shall become effective upon final approval by the Court.

XXXII. NOTICE TO U.S. DEPARTMENT OF JUSTICE

Within 10 days of final approval of this Agreement, Plaintiffs' counsel shall send a letter to the United State Department of Justice, Civil Rights Division, stating that a class action settlement has been reached in the above-entitled lawsuit, and providing a copy of the executed Agreement and Court Order(s) approving the Agreement.

IN WITNESS WHEREOF, the Settling Parties hereby stipulate and consent to the terms and conditions of this Agreement and Court approval of this Agreement, and have each approved and executed this Agreement on the dates set forth opposite their respective signatures.

Dated: _____ _____
James Jensen
Plaintiff

Dated: _____ _____
Lorie Jensen
Plaintiff

Dated: _____ _____
James Brinker
Plaintiff

Dated: _____ _____
Darren Allen
Plaintiff

Dated: _____ _____
Elizabeth Jacobs
Plaintiff

Defendants State of Minnesota

and Minnesota Department of
Human Services

Dated: _____ _____

Anne Barry
Interim Commissioner/Chief
Compliance Officer

Dated: _____ _____

Scott TenNapel
Defendant

UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

	Court File No.: 09-CV-1775 DWF/FLN
James and Lorie Jensen, as parents, guardians and next friends of Bradley J. Jensen; James Brinker and Darren Allen, as parents, guardians and next friends of Thomas M. Allbrink; Elizabeth Jacobs, as parent, guardian and next friend of Jason R. Jacobs; and others similarly situated, Plaintiffs, vs. Minnesota Department of Human Services, an agency of the State of Minnesota; Director, Minnesota Extended Treatment Options, a program of the Minnesota Department of Human Services, an agency of the State of Minnesota; Clinical Director, the Minnesota Extended Treatment Options, a program of the Minnesota Department of Human Services, an agency of the State of Minnesota; Douglas Bratvold, individually, and as Director of the Minnesota Extended Treatment Options, a program of the Minnesota Department of Human Services, an agency of the State of Minnesota; Scott TenNapel, individually and as Clinical Director of the Minnesota Extended Treatment Options, a program of the Minnesota Department of Human Services, an agency of the State of Minnesota; and State of Minnesota, Defendants.	**ORDER ON STIPULATED CLASS ACTION SETTLEMENT**

The Stipulated Class Action Settlement Agreement ("Settlement Agreement"), attached hereto as Exhibit A, the Court orders as follows:

1. The Settlement Agreement and all of its provisions are hereby expressly approved.

2. The Settlement Agreement is incorporated into and made part of this Order by reference as if fully stated herein.

3. This Court retains jurisdiction over this matter with respect to any dispute or controversy arising out of the Settlement Agreement, including enforcement thereof, as between the parties to the Settlement Agreement, for the purposes of receiving reports and information required by this Agreement, or as the Court deems just and equitable.

4. The Settling Parties shall proceed consistent with the terms of the Settlement Agreement, and shall comply with the terms of the Settlement Agreement. 5. Within thirty days of this Order the Plaintiffs and State Defendants shall provide a proposed Notice of Class Action Settlement and Class publication protocol for review and approval by the Court.

6. Within 30 days after the time period for Class Member opt-outs, objections and comments has expired following publication to the Class, Plaintiffs and DHS will schedule a hearing for final Court approval of the Settlement Agreement, advising the Court if there are any objections or opt-outs to the Settlement Agreement and shall.

Dated: _____ _____

Donovan W. Frank
Judge of United States District Court

AG: #2755457-v1