UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

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

Plaintiffs

v.

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

Defendants

Civil No. 09-1775 (DWF/FLN)

Independent Consultant and Monitor

STATUS REPORT ON COMPLIANCE

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Independent Consultant and Monitor

June 11, 2013

TABLE OF CONTENTS

Exhibits

Ex. 1. *FY 2013 Budget for MSHS-Cambridge*, DHS.

Ex. 2. Bulletin No. 12-76-01, *MSHS-Cambridge: Admission and Discharge Criteria, Crisis Stabilization Services, and Transition Planning,* Dec. 31, 2012.

Ex. 3. Defendants' May 1, 2013 memo to David Ferleger.

Ex. 4. Plaintiffs' May 9, 2013 email to David Ferleger with attached memo from Ombudsman Roberta Opheim.

Ex. 5. Dr. Edwin Mikkelsen *curriculum vitae.*

Ex. 6. Dr. Fredda Brown *curriculum vitae.*

Ex. 7. Dr. Linda Bambara *curriculum vitae.*

Ex. 8. Evaluation Criteria Keyed to Settlement Section.

Ex. 9. *Program Data Sheet.*

Ex. 10. *MSHS-Cambridge, Guidelines for Psychotropic PRN Use.*

Ex. 11. *Psychotropic Med Usage*, received May, 2013.

Ex. 12. Minnesota Department of Human Services, DHS Licensing, Correction Order, Cambridge, October 26, 2012.

Ex. 13. *Client Care – Visitor Procedure*, Procedure No. 15899, eff. September 15, 2009.

Ex. 14. *Client Care: Involvement with Family, Guardian and Friends*, Procedure No. 15899, eff. October 8, 2012.

Ex. 15. Office of the Ombudsman for Mental Health and Developmental Disabilities, May 2, 2013 letter to Commissioner Lucinda Jessen. Cover letter for attached report, "In the Review of: Minnesota

Specialty Health Systems (MSHS) – Cambridge, Replacement program for the former METO program").

Acknowledgements

The Monitor thanks the Cambridge clients and direct care staff, professionals and administrators for their cooperation and assistance with this review, and for their personal good will. Director Steve Jensen, with the support of Deputy Commissioner Anne Barry and others in the DHS Central Office, opened the facility for scrutiny without reservation. Michael Tessneer has led the Department's efforts in this litigation with aplomb.

It is my hope that those identified above are among the "few people" of whom Francois de La Rochefoucauld speaks: "Few people have the wisdom to prefer the criticism that would do them good, to the praise that deceives them."

The wisdom, experience and commitment of Roberta Opheim, Office of Ombudsman for Mental Health and Developmental Disabilities, and Dr. Colleen Wieck, Executive Director, Governor's Council on Developmental Disabilities, have been of incalculable assistance to the Defendants, Plaintiffs and the Monitor.

The Monitor also expresses his appreciation for the diligent work of his assistant, Elizabeth McElroy, M.S.Ed.

This report responds to the Order of April 25, 2013, Dkt. 212, requiring the Court's independent consultant and monitor ("Monitor") to "independently investigate, verify, and report on compliance with the Settlement Agreement and the policies set forth therein on a quarterly basis." The Court also directed that the report include "any related or collateral issues that directly affect the quality of life of individuals with developmental disabilities."

A draft was shared with the parties and consultants, Roberta Opheim, Ombudsman for Mental Health and Developmental Disabilities, and Dr. Colleen Wieck, Executive Director, Governor's Council on Developmental Disabilities. Their comments are appreciated and were considered.[1]

PRIORITIES FOR JUDICIAL ATTENTION

In the Monitor's view, five topics merit the Court's attention at its earliest convenient opportunity. Resolution of each will provide the parties with needed guidance and, it is expected, will facilitate compliance. The topics are:

I. The Olmstead Plan
II. Rule 40 Modernization
III. The Future of Cambridge
IV. Release from Active Judicial Oversight
V. Extension of the Court's Jurisdiction

These are in addition to any judicial response to the compliance findings and the recommendations in the remainder of this report.

I. THE OLMSTEAD PLAN

The *Olmstead* Plan is due November 1, 2013 although there is a good chance that it will be delayed again; the state has not yet retained consultation to assist in its development. The plan must then be implemented state-wide, for all people with disabilities -- a formidable task. Compliance must then be reviewed and verified.

[1] The parties' and consultants' comments are in the appendices to this report. Each is dated June 4, 2013 and is referenced, "[PARTY/WRITER's] 6/4/13 Letter."

Governor Dayton issued Executive Order 13-01[2] on January 28, 2013, which established an *Olmstead* Sub-cabinet to develop Minnesota's *Olmstead* Plan. That was a welcome and positive step. The Governor's Order acknowledges that it is essential to provide services and supports in the most integrated setting, and speaks to the importance of community services

The Court expressed concern about the Governor's Order in the Order of April 25, 2013 at 3 (Dkt. 212).[3] The Governor's Order appears to distance itself from this litigation. His Order is lacking in several respects.

- The Order does not mention this litigation.
- The Order does not acknowledge that there is a judicially mandated obligation that "the State and the Department shall develop and implement" the plan.
- The plan and its implementation are subject to Court approval, monitoring and enforcement.
- The Order does not direct the Sub-cabinet to submit the Plan to the Court for review and approval.

The above omissions, together with the *Olmstead* Planning Committee report having questioning whether there is a necessity for an *Olmstead* Plan, are cause for concern.

The Monitor respectfully suggests that the Court consider steps which might be taken on this issue.

II. RULE 40 MODERNIZATION

The Settlement Agreement requires "modernization" of Rule 40, which speaks to aversive and deprivation procedures for people with developmental disabilities. Reversing its focus, the modernization is 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,

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[2] Ex. 133 to Defendants' *Status Report to the Court* (March 18, 2012), Dkt. 202.

[3] The Court stated, "The Court notes that, although an Executive Order was filed four days after counsel met with the Court, there was no discussion of it with the Court by any of the parties prior to its entry, and *there has been no explanation since its entry as to its relationship to, or its impact on, the Settlement Agreement, if any*. The Executive Order purports to address *Olmstead* issues, ..." (emphasis added).

and development of an *Olmstead* Plan."[4]

The Rule 40 Advisory Committee, which first met on January 30, 2012, more than 16 months ago, has not yet issued its advice to DHS, and its work has been fraught with significant conflict. There have been heated clashes within the Committee and outside it over both the process for drafting and approving its product, and the content of some of its provisions. The work is not done.

The Omnibus DHS Bill before the Legislature has some relationship to Rule 40. Whether DHS contends that the Omnibus DHS Bill is, in any way, a product of the Rule 40 process or approved by the Rule 40 Committee, is unclear and should be clarified promptly. Plaintiff Class counsel strongly disagrees with some language in the Bill, which permits a so-called 'transitional' use of restraints which are forbidden by the settlement agreement. Plaintiffs believe this violates the Settlement Agreement.

The Department "anticipates" that the Committee will issue its final recommendations by June 30, 2013.[5] This seems unrealistic, given the continuing substantive disagreements on both the Committee's draft narrative and the relationship between the Omnibus DHS Bill and Rule 40

As with the *Olmstead* Plan, the Court's Order of April 25, 2013 expressed concern with the Rule 40-related Omnibus DHS Bill.[6]

The Monitor respectfully suggests that the Court consider steps which might be taken on this issue.

III. THE FUTURE OF CAMBRIDGE

The settlement agreement, adopted by the Court, prescribes "best practices" for serving people with developmental disabilities, together with compliance with the *Olmstead* principles favoring services in the "most integrated setting."

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[4] Settlement Agreement, §X.C. at 19.

[5] *Id.*

[6] Order of April 25, 2013 at 5 ("Finally, the Court has learned there is an omnibus DHS bill moving through the state legislature. Surprisingly to this Court, and without explanation or notice to the Court as to its relationship to the Settlement Agreement, it appears that DHS has proposed a ban on all restraint and seclusion, EXCEPT for individuals with developmental disabilities.").

Recognizing these imperatives, the Department has advised the Monitor that the Cambridge program services will be 100% community based and no longer on the Cambridge Campus. DHS will provide services in Cambridge successors in small community homes dispersed across the state. This shift to community services is supported by Plaintiffs, the Ombudsman and the Executive Director of the Governor's Council on Intellectual and Developmental Disabilities.[7]

This planful change is a continuation of the process set in motion by the settlement agreement. METO had served dozens of clients under very restrictive conditions. Cambridge's census hovers at about 8 to 10 clients. Already, the Cambridge transitional home a few blocks from Cambridge serves three clients in a typical house in a residential neighborhood.

The Monitor respectfully suggests that the Court consider steps which might be taken on this issue.

IV. RELEASE FROM ACTIVE JUDICIAL OVERSIGHT

It is not in disregard of the non-compliance findings in this report that the Monitor acknowledges the Defendants' success in complying with dozens of evaluation criteria. Cambridge staff and DHS officials have expended significant effort to make that possible. That effort and its results are commended.

It would further the overall goals of the settlement agreement for Defendants' compliance enumerated in this report to be acknowledged by removing those requirements from active judicial oversight. Compliance must, of course, be

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[7] These "METO successors" will continue to be protected under the Settlement Agreement. This shift to community services is supported by Settlement Class Counsel, the Ombudsman and the Executive Director of the Minnesota Governor's Council on Developmental Disabilities, provided that it complies in all respects with the Settlement Agreement, the *Olmstead* decision and serves people with developmental disabilities in the most integrated setting with adequate and appropriate transition plans, protections, supports, and services consistent with each person's individualized needs and goals. sufficient in number to meet the State's need to ensure that all clients who meet the current criteria will have access in at timely manner and shall not be diverted to a less integrated program due to a lack of placement.

The Monitor's independent experts also questioned the need for the existence of Cambridge's restrictive institutional model of services.

sustained and Monitor review must be available. Backsliding in compliance would result in renewed judicial attention to those requirements, and the Court would retain jurisdiction over them.

Release from active judicial oversight would permit the parties and Monitor to focus attention on the most challenging settlement agreement requirements, including many which promise systemic changes. This would advance Defendants' efforts to remedy non-compliance with outstanding Quality of Life issues.

The Monitor respectfully suggests that he be authorized to submit a proposed order recommending certain settlement requirements for release from active judicial oversight.

V. EXTENSION OF THE COURT'S JURISDICTION

There can be no reasonable dispute that compliance with all of the settlement agreement will not be achieved by December 4, 2013.[8] For example, implementation of three major hallmarks (appropriate treatment at Cambridge, implementation of the in-development Olmstead Plan, and the Rule 40 modernization), and compliance verification, will likely not occur for months after that date.

Non-compliance with a settlement agreement is grounds for a Court extending its jurisdiction over a settlement.[9] The Court's Independent Consultant and Monitor was appointed, in part, due to deficiencies in Defendants' compliance and their reporting. In addition to uncontested reports of non-compliance in Monitor reports, and Defendants' self-reporting, over the past year, Defendants agree with nearly all of the Monitor's non-compliance findings in this report.[10]

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[8] With regard to receiving reports, resolving disputes, and "as the Court deems just and equitable," the Settlement Agreement provides that the Court's jurisdiction over this matter extends until December 4, 2013, two years after the settlement's approval. § XVIII.B. With certain exceptions – including the External Reviewer -- the Settlement Agreement terminates at the same time. § XVIII.E The External Reviewer terminates June 30, 2015.

[9] A federal court has the authority to continue oversight of a consent decree where there is non-compliance and the decree's purposes have been frustrated. *E.g., United States v. Connecticut*, 931 F. Supp. 974, 984 (D. Conn. 1996) (appointing special master; citing cases).

[10] Defendants' 6/4/13 Letter.

The Ombudsman explains a basis for an extension:

> In summary, the Ombudsman remains concerned the major accomplishments envisioned in the *Jensen* Settlement Agreement has not resulted in the improved quality of life envisioned for persons with developmental disabilities in the 17 months the agreement has been in effect. While efforts continue, I remain concerned that insufficient progress has been made or will be made by the time the court is scheduled to discontinue its' oversight. *I would respectfully request that the monitor request the court to extend the length of time the court retains its oversight authority if we are to see true transformation that was the promise of the agreement.*[11] (emphasis added).

The Monitor urges the parties to agree to a one to two year extension. Absent agreement by the parties, the Court may desire to act under its inherent and other authority. The Monitor respectfully suggests that the Court extend its jurisdiction over this case for one to two years, subject to further extension if Defendants have not achieved substantial compliance at that point.[12]

PART ONE

EXECUTIVE SUMMARY

On June 30, 2011, as a result of this litigation, the institution called Minnesota Extended Treatment Option ("METO") was closed. It is now called Minnesota Specialty Health Services – Cambridge.

Average Length of Stay Under MSHS-Cambridge Auspice (months)

Since Settlement Approval	Since Jan. 1, 2013
5.2	5.3

This fiscal year, Cambridge served an average daily census of 10 clients. The

[11] Ombudsman's Comments, June 4, 2013, at 3. Plaintiffs' Letter of June 4, 2013 at 19. Plaintiffs suggest to the Monitor a one year extension for "implementation and enforcement."

[12] The Monitor also suggests that he report to the Court no later than February 2013 whether it would be advantageous to compliance to call upon the enforcement assistance of the United States Department of Justice, Civil Rights Division.

Fiscal Year 2013 Budget for MSHS-Cambridge is $4,123,678. Its FY 2013 *per diem* rate *per* client is $1,264 per day per client. Unlike other state-operated institutions, Minnesota does not receive any federal reimbursement for MSHS-Cambridge.

Since the Court's adoption of the Settlement Agreement, the average length of stay, including clients already at the facility when METO closed, was 11 months; that average for clients discharged in 2013 was 12 months. Excluding clients who had been at METO, the length of stay is much shorter, as shown in the table on the prior page..

I. OVERALL COMPLIANCE

The Settlement Agreement is the backbone of the report and, for compliance review "shorthand" purposes, the Monitor and parties have utilized the evaluation criteria ("EC") which were mined from the settlement text. In this report, the ECs are divided into three categories: Quality of Life, Instrumental and Administrative. "Instrumental" criteria are those which are the foundation or precursors to achieving the Quality of Life indicators.[13]

The results are mixed.

- DHS does fairly well complying with administrative requirements.
- DHS does relatively poorly complying with quality of life requirements.
- Follow-through is often missing.[14]

These results are consistent with the conclusion elsewhere in this report that DHS management of implementation requires additional professional personnel with resources and *authority* to move compliance forward.

The chart below aggregates the compliance ratings per each evaluation criterion, without weighting the importance of the specific requirements. Of course, the percentages in such a chart overstate compliance in a significant respect. The chart weights Administrative requirements the same as Quality of Life requirements.[15]

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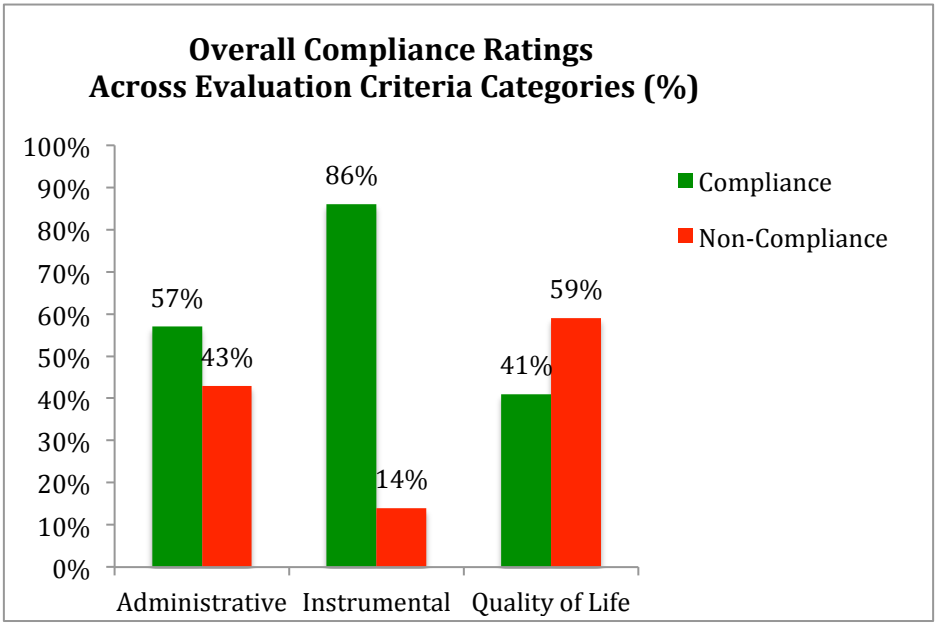
[13] One must keep in mind that, for items found in compliance as a result of this review, there will need to be a determination of what duration of compliance will merit the confidence of the Court that compliance will be sustained beyond the Court's jurisdiction over the case.

[14] A detailed grid is at the end of this Executive Summary.

[15] See Ombudsman's Comments, June 4, 2013 at 2 (making this point).



The very high rate of compliance with instrumental requirements (86%) compared to that for quality of life requirements (59%) raises this serious question posed by the Ombudsman:

> . . . I am concerned that if items classified as Instrumental are a precedent to or foundational to the quality of life, how the monitor could conclude they are in compliance when those foundational issues have not resulted in an improved quality of life for the individual served by the Department of Human Services?

The question merits an answer. Defendants in many instances have performed the "foundational" (or "instrumental") settlement requirements, but have failed to achieve compliance with the Quality of Life requirements. That failure may be due to a variety of reasons, and the reasons may differ for various requirements:

- An absence of prioritization of settlement agreement requirements.
- The instrumental requirements may not be fully beneficial to achieving the desired ends (for example, one wonders whether the mandated person centered training is resulting in improved quality of life within the facility).
- There may be a lack of follow through, either from an absence of skilled staff or administrators, gaps in policy, or insufficient knowledge or resources.
- Some requirements appear to have been ignored.

As we move forward, all concerned parties would be well advised to examine

compliance deficiencies to determine their root, so that fundamental causes can be addressed.

II. MAJOR FINDINGS REGARDING CAMBRIDGE

- Cambridge has been in successful in eliminating nearly all restraints of any sort. There are rare instances of brief personal (manual) restraint.[16] Staff treat clients with respect and client-staff interactions appear positive and supportive. Monitoring/reporting on restraints is sometimes problematic.
- Active treatment and habilitative services are not currently in place for the clients of Cambridge. Clients are often idle and do not have a structured day. There are no established individualized daily schedules. One staff member, questioning the practice of allowing clients to refuse to attend treatment groups, stated that treatment at Cambridge "is ineffective. We're just housing people."
- Person centered planning and positive behavior support, lynchpins of the settlement agreement, are not present.
- Treatment is not meaningful. Behavior Support Plans do not meet professional standards. They do not include interventions directed toward improving an individual's quality of life. Functional Behavioral Assessments ("FBA") are the basis of appropriate behavioral support. There is a complete absence of FBAs in all behavior support plans.
- Behavior specialists have insufficient qualifications and training in person-centered planning and positive behavioral supports.
- The environment is institutional. Individual bedrooms are relatively bare and not personalized.
- Adequate psychiatric care is not provided.
- Clients are often admitted on multiple medications from prior placements. Cambridge does not appear to make aggressive efforts to decrease these medications when the individual is stable.
- Some administrative obligations, such as timely notice of restraint, and posting notices of rights, are not met.
- Administrative procedures are sometimes in confusion, with "official" documents not the same as those which are reported.
- Some reporting to the Court has been incorrect and misleading.
- Clients wait for weeks or months for community placement after Cambridge deems them ready for placement.

[16] Unfortunately, the decrease in restraint has been accompanied by an increase in 911 calls to the police.

- The clients at Cambridge could be served in small community placements.

III. OVERARCHING ISSUES

The following topics overhang the prospects for Defendants' successfully complying with the Court's order and, for some items, the credibility of DHS and the level of trust with the Plaintiff Class.[17]

In response to the May 22, 2013 draft of this report, DHS states that it plans to provide a "detailed action plan" to address the overarching issues identified below.

Defendants' June 4, 2013 Letter to the Monitor
"On or before June 30, 2013, the Department will provide the Court Monitor, Settlement Class Counsel, Ombudsman Opheim, and Dr. Wieck with a detailed action plan explaining how the Department will address these overarching issues, findings and recommendations. This action plan will include a list of specific tasks and deadlines, and will identify the person(s) responsible for addressing each recommendation."

The Future of Cambridge. The settlement agreement, adopted by the Court, prescribes "best practices" in serving people with developmental disabilities, together with compliance with the *Olmstead* principles favoring services in the "most integrated setting." Recognizing these imperatives, the Department has advised the Monitor that the Cambridge program services will be 100% community based and no longer on the Cambridge Campus. DHS will provide services in Cambridge successors in small community homes dispersed across the state. This shift to community services is supported by Plaintiffs, the Ombudsman and the Executive Director of the Governor's Council on Intellectual and Developmental Disabilities.[18]

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[17] Plaintiffs characterize DHS as taking a "dangerous, cavalier approach" and declare:

> This has led to a near complete breakdown of trust involving DHS stated positions, later found to be untrue, or partially false, or never conveyed, or subsequently, and secretly, contradicted by others within DHS or other State agencies.

Plaintiffs' Letter to the Monitor, June 4, 2013 at 2 ("Plaintiffs' 6/4/13 Letter"). The letter is an appendix to this report.

[18] These "METO successors" will continue to be protected under the Settlement Agreement. This shift to community services is supported by Settlement Class Counsel, the Ombudsman and the Executive Director of the Minnesota Governor's Council on Developmental Disabilities, provided that it

This planful change is a continuation of the process set in motion by the settlement agreement. METO had served dozens of clients under very restrictive conditions. Cambridge's census hovers at about 8 to 10 clients. Already, the Cambridge transitional home a few blocks from Cambridge serves three clients in a typical house in a residential neighborhood.

- **Olmstead Plan**. The Governor issued an Executive Order establishing a sub-cabinet to develop Minnesota's first *Olmstead* Plan. That was a positive step. The Order acknowledges the imperative to provide services and supports in the most integrated setting, and speaks to the importance of community services. The Order is, however, lacking in several respects:
  - ✓ The Order does not mention this litigation.
  - ✓ The Order does not acknowledge that, under the court's decree in this case, "the State and the Department shall develop and implement" the plan.
  - ✓ The plan and its implementation are subject to Court approval, monitoring and enforcement.
  - ✓ The Order does not direct the Sub-cabinet to submit the Plan to the Court for review and approval.

  These omissions, together the *Olmstead* Planning Committee report having questioning whether there is even an obligation for an Olmstead Plan, are cause for concern.

Implementation Plan and Implementation Management. DHS has no roadmap for implementation of the settlement agreement. The Court has several times urged the parties to develop an implementation plan. Whether the newly promised "action plan" will be sufficient remains to be seen. Compliance with the Settlement Agreement is not likely to be achieved without intensified and sufficiently staffed professional teams with *authority* to ensure compliance. Defendants agree that there has been insufficient

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complies in all respects with the Settlement Agreement, the *Olmstead* decision and serves people with developmental disabilities in the most integrated setting with adequate and appropriate transition plans, protections, supports, and services consistent with each person's individualized needs and goals. sufficient in number to meet the State's need to ensure that all clients who meet the current criteria will have access in at timely manner and shall not be diverted to a less integrated program due to a lack of placement.

The Monitor's independent experts also questioned the need for the existence of Cambridge's restrictive institutional model of services.

monitoring, tracking and implementation staffing to advance implementation of the statewide settlement agreement.[19] Plaintiffs concur.[20]

Defendants' June 4, 2013 Letter to the Monitor

In response to the Monitor's draft report, DHS found it imperative that it increase the resources it dedicates to" compliance and planning." Accordingly, the Department has formed a formal Jensen Implementation Team. The Team will focus on formalizing the Department's Jensen Settlement Agreement implementation plan and implementation management system. Specifically, the Team will ensure that the Department fulfills its obligations under the Settlement Agreement, fully honors and implements the *Olmstead* principles, and consistently adopts and implements best practices."

- **Rule 40 Committee**. The modernization of Rule 40, like the *Olmstead* Plan, was to have been a centerpiece of the state-wide impact of the settlement. The Rule 40 Committee work has been beset by internal disagreements and unresolved debate, and by claims of miscommunication and exclusion from decision-making. In recent weeks, legislation submitted in the Omnibus DHS Bill related to Rule 40 was reportedly not first vetted by the Rule 40 Committee and its import is in serious dispute with the Plaintiffs. The Rule 40 Committee should get its house in order, be required to resolve all issues under the guidance of an expert consultant-facilitator, and meet a fixed date for submitting its product to the Court.

- **Integration with County Case Management**. There is a pressing need for resolution of inadequacies in community services which result in a) referrals and commitments to MSHS-Cambridge which may not be necessary, and b) additional time in residence at Cambridge after Cambridge staff refer the client for community placement. Clients should not be fit into beds which happen to be empty at the moment. Presently, counties benefit financially during clients' stays at the facility. The incentives should operate differently; maintaining their clients in the community should benefit the counties. With the re-purposing of the Cambridge facility, strengthening the counties' involvement in the person-centered *Olmstead* compliance efforts is essential.

- **Rule 20 Commitments.** About a third of MSHS-Cambridge residents are committed under Criminal Rule 20 for evaluation of their competence or to determine whether they can become competent with regard to pending criminal charges. Cambridge has no authority to discharge these clients to

[19] Defendants' Letter to the Monitor, June 4, 2013 at 1-2.

[20] Plaintiffs' 6/4/13 Letter at 3 ("incredibly understaffed effort" and "absence of priority").

home or a placement. Clients committed under Rule 20 pose particular security challenges. The admission and discharge criteria for MSHS-Cambridge are inconsistent with admission of Rule 20 clients. It would be useful for DHS to consider and resolve this apparent contradiction.

- **The Court Was Not Informed that MSHS-Cambridge Operated Without a Department of Health License for 10 Months**. A facility serving people with disabilities cannot legally operate without licensure. MSHS-Cambridge requires a license issued by DHS and also by the Minnesota Department of Health ("MDH"). Cambridge operated in violation of the law for *10 months* from its establishment July 1, 2011 until it was licensed by the Minnesota Department of Health April 24, 2012. DHS later called its lapse "inexcusable." The Court and Plaintiffs were not informed that Cambridge was not licensed. The settlement requires licensure. The recent revelation of this licensing/notice lapse has sharpened Plaintiffs' wariness of DHS' representations on other matters.

- **Overview of Conditions.** The Settlement Agreement requires that care and planning for class members, and staff training, be based on person-centered planning and person-centered thinking, on a foundation of positive behavior supports. Active treatment and meaningful living, together with protection from harm, are expected as well. The State of Minnesota "declares, as a top concern, the safety and quality of life of the Residents of the Facility. The State agrees that its goal is to provide these residents with a safe and humane living environment free from abuse and neglect." Settlement Agreement at 3, Recital 7.

    - **Idleness and Failure to Provide Adequate Habilitation**. Many staff members are demoralized by their feeling that they are unable to provide the clients with active treatment. Clients are often idle at Cambridge. A client may play video games or watch television or play cards all or most of a day. Mid-day awakening is typical. There are no established individualized daily schedules. One staff member, questioning the practice of allowing clients to refuse to attend treatment groups, stated that treatment at Cambridge "is ineffective. We're just housing people."

    - **Environment.** Cambridge clients live in two one-story buildings with exterior architecture is similar to houses in development's nearby. Inside, the buildings have an institutional structure and appearance. A building's Homes are connected by small hall spaces with an intricate system of locked doors between them. There is a large "nursing station" office behind glass windows. Client bedrooms (all single rooms) generally have no personalization,

nothing on the walls, and little furniture.

- **Client and Staff Interaction.** Both direct care and professional staff were uniformly observed interacting with clients supportively and with caring words and actions. Staff were seen to serve home cooked food to clients, and to respond encouragingly to client comments and requests for assistance.

- **Fabricated, Inaccurate and Useless Information.** A major element of data collection instrument, used daily and the basis for reporting which affects treatment decisions, often contains fabricated information on client/staff interactions. Supervisory and Behavior Analyst staff confirmed that the data is useless, not used and ignored. When asked why the data continue to be collected and entered, a Behavior Analyst said, "I'm too embarrassed to tell my staff that the information they are entering is not used by anyone." Treatment plans were also found to be inaccurate.

- **Vocational and Day Services.** When METO was replaced by MSHS-Cambridge, the entire vocational program for clients was abruptly shut down. Since Fall, 2012, Cambridge has begun (it is still in early stages) movement (it is still in early stages) toward vocational opportunities. However, the work assessment activity does not fill a person's day with meaningful, valued activity. From staff report, there is no effort to develop a person-centered description or plan regarding a quality day time, or night time, experience.

- **Positive Behavior Supports.** A Functional Behavior Analysis ("FBA") is a foundation for a Positive Behavior Support Plan. Such supports are required by the settlement. FBAs do not exist. Cambridge has failed – for months – to implement accepted recommendations by DHS' Internal Reviewer to develop FBAs and for other improvements to behavioral services to clients. Behavioral Support Plans fail to meet minimal professional standards.

IV. Compliance Grid

A compliance grid is presented on the following two pages. This presents the compliance ratings for each evaluation criterion (individually or grouped).

The grid may be considered a visual summary of the findings in Part Four of this report, as well as a gateway into the detailed discussion in Part Four.

Compliance Determinations for Evaluation Criteria

EC#	Evaluation Criteria Short Name	Compliance Determination
ADMINISTRATIVE CRITERIA		
32 - 38	TIMELY NOTICE OF RESTRAINT	Non-Compliance
40	INTERNAL REVIEWER DESIGNATED	Compliance
41	TIMELY NOTICE TO INTERNAL REVIEWER	Non-Compliance
69	MARKETING, RECRUITMENT & PUBLICITY	Compliance
88	OLMSTEAD - COMMITTEE MEMBERS	Compliance
99	REPLACE "MENTAL RETARDATION" - DHS	Non-Compliance
100	REPLACE "MENTAL RETARDATION" - STATUTES	Compliance
INSTRUMENTAL CRITERIA		
1	METO CLOSED	Compliance
5	GUARDIAN COMMENT OPPORTUNITY	Compliance
16	PROTOCOL TO CONTACT THIRD PARTY EXPERT	Not Rated
17	LIST OF 5 EXPERTS	Not Rated
18	EXPERTS ARE PAID	Not Rated
19	3RD PARTY - CONTACT AFTER RESTRAINT	Compliance
20	CONSULTATION WITHIN 30 MINUTES	Compliance
22	CONSULTATION TO OBTAIN ASSISTANCE	Compliance
23	MEDICAL OFFICER CONTACTED	Compliance
24	MEDICAL OFFICER ASSESSED SITUATION	Compliance
25	MEDICAL OFFICER REVIEW DOCUMENTED	Compliance
27	ABUSE/NEGLECT - DISCIPLINE	Not Rated
28	ABUSE/NEGLECT - PROSECUTION REFFERAL	Not Rated
29	RESTRAINT FORM COMPLETED	Compliance
30	RESTRAINT FORM TIMELY	Compliance
31	FORM STATES NO PROHIBITED RESTRAINT	Compliance
39	NOT REPLACE OTHER REPORTING	Compliance
42	INTERNAL REVIEWER CONSULTATION	Compliance
43 - 51	EXTERNAL REVIEWER	Compliance
52 - 53	ADVOCATE REVIEWERS ACCESS TO FACILITY	Compliance
61	STAFF TRAINING - PERSON CENTERED	Compliance
62	STAFF TRAINING - BEST PRACTICES	Compliance
63	SPECIFIED TRAINING BEFORE 12/31/11	Compliance
64	TRAINING BEFORE RESTRAINT INVOLVEMENT	Compliance
65	SPECIFIED TRAINING BEFORE 3/31/12	Compliance
71	PUBLICITY AND MISSION ARE CONSISTENT	Compliance
72	POSTING RIGHTS	Non-Compliance
73	RIGHTS POSTING UNDERSTANDABLE	Non-Compliance
83	COMMUNITY SERVICES - HIRING	Compliance
84	COMMUNITY SERVICES - NO VACANCY	Compliance
84A	BEHAVIOR ANALYST QUALIFICATIONS MET	Non-Compliance
85	OLMSTEAD COMMITTEE ESTABLISHED	Compliance
86	OLMSTEAD RECOMMENDATIONS ISSUED TIMELY	Non-Compliance
87	OLMSTEAD PLAN IS DEVELOPED AND IMPLEMENTED	Not Rated
89	RULE 40 - CONVENE COMMITTEE	Compliance
90	RULE 40 - FUNCTION AND PRODUCT	Non-Compliance
91	RULE 40 BEST PRACTICES REVIEW	Compliance
92	RULE 40 NOTICE OF RULE MAKING	Compliance
93	NO WAIVER OF RULE 40 FOR FACILITY	Compliance
94	MSH - NO DD PLACEMENTS	Compliance
95	MSH - INITIAL PERIOD NO DD PLACEMENTS	Compliance
96	MSH - NO CHANGE IN COMMITMENT WITHOUT HEARING	Compliance

QUALITY OF LIFE CRITERIA		
2	OLMSTEAD COMPLIANCE	Non-Compliance
1A	CAMBRIDGE HAS BEEN LICENSED	Non-Compliance
3	CAMBRIDGE COMPLIES WITH OLMSTEAD	Non-Compliance
4	ONLY ELIGIBLE CLIENTS SERVED	Compliance
6	DISCONTINUE PROHIBITED RESTRAINTS	Compliance
7	NO USE OF PROHIBITED RESTRAINTS	Compliance
8	MEDICAL RESTRAINT NOT USED	See EC 14 - 15
9, 21	RESTRAINTS USED ONLY IN EMERGENCY	Compliance
10	RESTRAINT POLICY IS FOLLOWED	Compliance
11	NO PRONE, CHEMICAL, SECLUSION, TIME OUT	Compliance
12	ZERO SECLUSION	Compliance
13	ZERO TIME OUT	Compliance
14	ZERO PRN CHEMICAL RESTRAINT	Non-Compliance
15	ZERO PRN FOR BEHAVIOR CONTROL	Non-Compliance
26	ALL ABUSE/NEGLECT ALLEGATIONS INVESTIGATED	Non-Compliance
54	ENSURE MOST INTEGRATED SETTING	Non-Compliance
55	ACTIVELY PURSUE DISCHARGE WITH TRANSITION PLANS	Non-Compliance
56	FAMILY ACTIVELY INVOLVED	Non-Compliance
57	PERSON CENTERED PLANNING AT EACH STAGE	Non-Compliance
58	RESIDENT CHOICE	Non-Compliance
59	BEST EFFORTS FOR PLACEMENT ALTERNATIVES	Non-Compliance
60	IMPLEMENT IN ACCORD WITH *OLMSTEAD*	Non-Compliance
66	VISITORS PERMITTED	Non-Compliance
67	VISITOR FULL ACCESS	Compliance
68	PRIVATE VISITATION	Non-Compliance
70	MISSION CONSISTENT WITH SETTLEMENT	Compliance
97	MSH - ALL TRANSFERS PER *OLMSTEAD*	Non-Compliance
98	ANOKA - TRANSFERS PER *OLMSTEAD*	Compliance

PART TWO

CAMBRIDGE: PAST AND PRESENT

I. HISTORY

The recent name change of the facility at Cambridge is the fifth since its establishment. Just as the name has changed, conditions have changed. Similarly, the solutions to the challenges of the conditions in the facility have evolved. Since 1925, the remedies have moved from growing the facility to diminishing its size, and from custodial care to transition to community care. This section provides a bird's-eye perspective on this evolution.

The State of Minnesota opened a new institutional facility outside the town of Cambridge, Minnesota in June of 1925. It was originally named the Minnesota Colony for Epileptics and consisted of an administration building and one cottage.[21] By 1931, the census was 460 and it was "filled to capacity" with 343 acres of land, 100 of which were under cultivation.[22]

Interesting by today's standards is this description in a 1975 official history of the principles for care at Cambridge from 1945 to 1955:[23]

> Through these many years, the hospital had operated under some very fundamental principles of that day, such as:
>
> Every patient sent to this Institution is expected to receive the greatest possible benefit therefrom, physically, morally and mentally.

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[21] Blanche La Du, Char, State Board of Control, Quarterly Conference of the Executive Officers of the State Institutions (Oct. 6. 1931). http://www.mnddc.org/past/pdf/30s/31/31-CDC-BLD.pdf. Some of the history in the following paragraphs is also from: http://www.kentandersonphoto.com/a-brief-history/.

[22] H.L. Paine, *Report of Personal Inspection*, Cambridge State School and Hospital, Dept. of Public Welfare (Nov. 1954). http://www.mnddc.org/past/pdf/50s/54/54-RPI-Paine.pdf.

[23] Norman Synstelien, Public Relations Officer, A History of Cambridge (1975). http://www.mnddc.org/past/pdf/70s/75/75-Cambridge-History.pdf.

> Under no circumstances is rudeness or harshness permitted. The spirit of kindness must everywhere prevail.
> Let the educational spirit predominate. Teach, teach and then teach again. Most of the patients are eager to learn such things as they understand.

By 1949, the name was changed to the Cambridge State School and Hospital, and housed individuals with developmental disabilities and other "mental deficiencies." The orientation was long-term and custodial.

During the 1950s, new buildings were constructed; the population in 1954 was 1,098.[24] Residents attended school five days per week from 8:30 AM to 3:30 PM (two periods of academic classes, one period handicraft, and a short music period).[25] In 1962, the peak population of 2,008 was reached.[26] In 1965, a formal report on Cambridge State School and Hospital data stated,[27]

> The level of care which now is provided is more custodial than developmental in nature. It is composed of a helter-skelter kind of need - meeting which varies from shift to shift and day to day. Stated simply: There are not enough staff to provide anything more than a "herd-type" care for our residents.

The institution became Cambridge State Hospital in 1967. In 1985, the name was again changed during a statewide attempt to regionalize institutional care. It became the Cambridge Regional Human Services Center, with a goal to move residents to the community.

In 1972, the *Welsch v. Likins* class action was filed in federal court by six named plaintiffs including two Cambridge residents. In 1974, the court held that residents had a right to adequate least restrictive treatment, and protection against seclusion, restraints and excessive use of medication to control behavior.[28] A 1977 Consent Decree targeted Cambridge for improvements in staffing, care and treatment and other conditions. [29] A 1980

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[24] Harlan L. Paine, Report of Personal Inspection, Department of Public Welfare (1957). http://www.mnddc.org/past/pdf/50s/54/54-RPI-Paine.pdf

[25] *Id.*

[26] Norman Synstelien, Public Relations Officer, A History of Cambridge (1975). http://www.mnddc.org/past/pdf/70s/75/75-Cambridge-History.pdf

[27] John Stocking, *Cambridge State School and Hospital Data* (1965). http://www.mnddc.org/past/pdf/60s/65/65-CSH-JHS.pdf

[28] *Welsch v. Likins*, 373 F.Supp. 487 (D. Minn. 1974).

[29] *Welsch v. Dirkswager*, Consent Decree (December, 1977).

decree set strict population restrictions state-wide and the institutional populations were reduced by half over seven years. Eventually, the parties agreed to terms for ending the lawsuit in what they titled, "Negotiated Settlement," filed in 1987.[30] There had been a court monitor in *Welsch.* The 1987 settlement required a legislatively-authorized replacement appointed by the Governor. This let to the creation of the current Ombudsman office.

In 1998, Cambridge became the Minnesota Extended Treatment Options (or METO), with its new facilities built behind the old institutional buildings, since demolished. In 2009, the Legislature prohibited DHS from laying off METO staff as a result of program "restructuring" (without defining the word). DHS responded by establishing priorities for job openings elsewhere, and "enhanced separation benefits" for METO employees from two bargaining units."[31]

As the Court knows, a 2008 report by the state Ombudsman for Mental Health and Developmental Disabilities found METO staff using restraints "as a routine treatment modality in far too many cases" and other deficiencies.[32] That report prompted this lawsuit. The Settlement Agreement was approved by the Court December 5, 2011.

As more fully referenced within this Report, the Office of the Legislative Auditor recently observed that DHS Licensing, the settlement did not fully remedy problems with the use of restraint:

> DHS's Licensing Division determined that the new Cambridge facility also had problems with use of restraints in emergency situations. In February 2012, DHS conducted its first licensing review and issued a correction order because the facility did not adhere to its policy that required reporting the use of restraints within 24 hours. In July 2012, the department issued two more correction orders within a week of each other for similar violations. In October 2012, licensing staff cited the facility for using restraints in inappropriate circumstances. A day later, licensing staff issued another correction order—the facility's

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http://www.mnddc.org/past/pdf/70s/77/77-WELSCH-10.pdf

[30] *Welsch v. Gardebring*, *Negotiated Settlement*, No. 4-72 Civ. 451 (Apr. 1, 1987). http://www.mnddc.org/past/pdf/80s/87/87-Welsch-35.pdf.

[31] Office of the Legislative Auditor, *Evaluation Report: State-Operated Human Services* at 4 (February 2013).

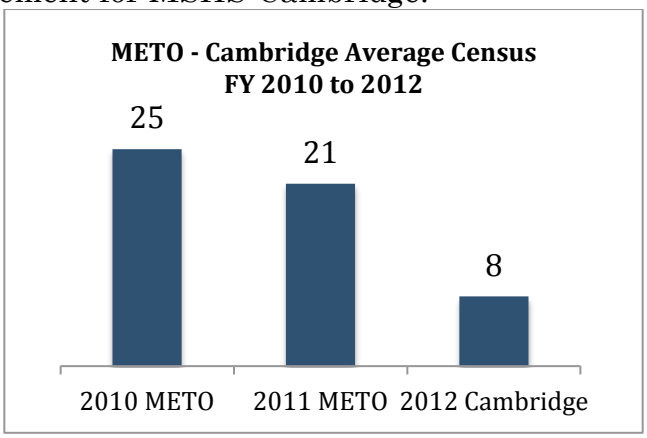
[32] Ombudsman for Mental Health and Developmental Disabilities, *Just Plain Wrong* (2008),

fourth since mid-February for not adhering to facility policy regarding the review and reporting of the use of restraints.[33]

II. CENSUS AND LENGTH OF STAY[34]

On June 30, 2011, as a result of this litigation, METO was closed. In its most recent name change -- the fifth since its establishment -- the facility was renamed Minnesota Specialty Health Services – Cambridge.

The average daily census at the facility has decreased significantly since METO closed. This fiscal year, Cambridge served an average daily census of 10 clients. The Fiscal Year 2013 Budget for MSHS-Cambridge is $4,123,678, with the rate stated by DHS for FY 2013 of $1,264 *per* day *per* client.[35] Unlike other state-operated institutions, Minnesota does not receive any federal reimbursement for MSHS-Cambridge.



[33] Office of the Legislative Auditor, *Evaluation Report: State-Operated Human Services* at 16 (February 2013).

[34] These data are as of May 9, 2013. The length of stay includes time at METO.

[35] Ex. 1 (*FY 2013 Budget for MSHS-Cambridge*, DHS). Arithmetically, the DHS stated *per diem* is based on an average census of 8.9 clients.

The relatively high cost of DHS state-operated human services institutions was noted by the Office of the Legislative Auditor recently. Office of the Legislative Auditor, *Evaluation Report: State-Operated Human Services* (Feb. 2013) at 23-24.

Average Length of Stay Under METO and Cambridge (months)	
Since Settlement Approval	Since Jan. 1, 2013
11	12

27 clients have been discharged from Cambridge since the Court's December 5, 2011 approval of the settlement, most recently on April 26, 2013. *Their average length of stay was 11 months, including METO time. Under the MSHS-Cambridge auspice, the average is 5.2 months.* 5 of the 27 clients had been at Cambridge for years (respectively, 4 years, 1.8 years, 3.8 years, 4 years, 4.2 years). Since January 1 , 2013, there were 7 discharges. One of the "very lengthy-stay" clients (4.2 years), who originally was at METO. was discharged during this time.. For the balance of the 2013 discharges, the *average length of stay was 5.3 months*.

DHS policy is that Cambridge is a short-term transitional facility, with an expected length of stay of no more than 90 days (3 months).[36]

Some observations may be made based on this data:

- Clients remaining at the facility who had been admitted when it was METO, had been institutionalized for years.

- The change to the MSHS Cambridge auspice is associated with reduced lengths of stay.

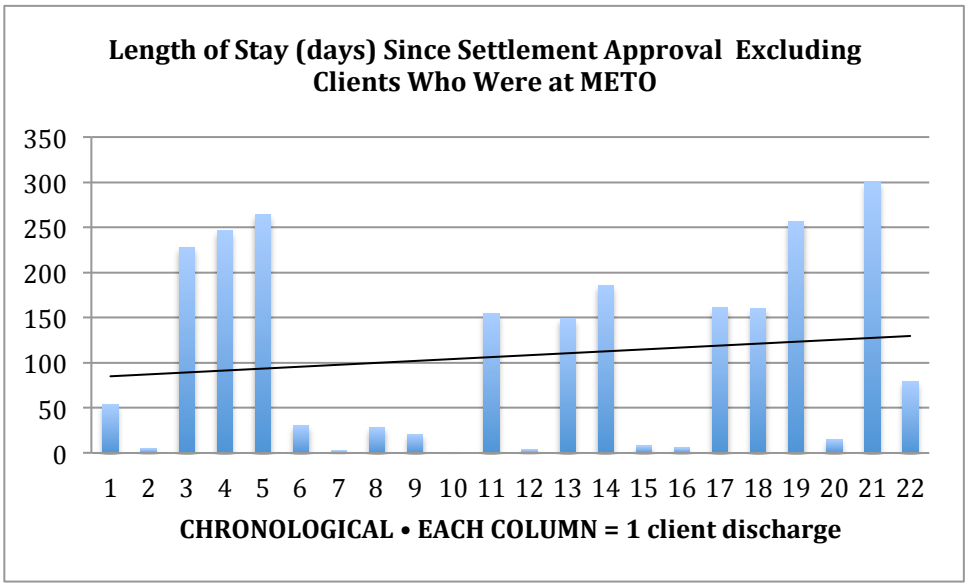
- The average 5 months length of stay, as of now, is on a slight upward trend since the settlement approval.

- Overall, DHS is having mixed success in meeting its goal of a 90 to 180 day client stay. The chart below shows the actual length of stay for all clients discharged since settlement approval, excluding any who had been under the METO auspice. The black line shows that the linear trend is a slight increase

Average Length of Stay Under MSHS-Cambridge Auspice (months)	
Since Settlement Approval	Since Jan. 1, 2013
5.2	5.3

[36] Ex. 2. (Bulletin No. 12-76-01, *MSHS-Cambridge: Admission and Discharge Criteria, Crisis Stabilization Services, and Transition Planning* (Dec. 31, 2012).

in length of stay. As noted later, a dearth of community services is resulting in clients being held at Cambridge for weeks or months longer than Cambridge deems them ready for community placement.



PART THREE

THE NATURE OF THIS REPORT

I. THE COURT'S CHARGE

This report responds to the Order of April 25, 2013, Dkt. 212, requiring the Court's independent consultant and monitor ("Monitor") to "independently investigate, verify, and report on compliance with the Settlement Agreement and the policies set forth therein on a quarterly basis." The Court also directed that the report include "any related or collateral issues that directly affect the quality of life of individuals with developmental disabilities.[37]

The Court explained:

> It is obvious by this Order and Memorandum that the Court continues to be extremely concerned that a large number of individuals with developmental disabilities, their families, friends, and loved ones will soon be before this Court proclaiming that nothing has changed significantly since December 1, 2011. The Court remains hopeful that the parties are still willing to carry out the intent of the Settlement Agreement, which was to benefit a large number of individuals with disabilities in a truly meaningful and significant way. Whether that is happening, or will happen, remains to be seen.[38]

Since the Monitor's appointment July 17, 2013, the Department has submitted four bi-monthly self-reports on the status of compliance, beginning September 17, 2012. These were not subject to a review and comment period.

The Monitor's several prior reports examined selected aspects of Defendants' performance under the settlement agreement. This is the most comprehensive and the first report to make findings regarding overall compliance.

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[37] *Op cit*., n. 19, at 7.

[38] *Op cit*., n. 19, at 10.

II. METHODOLOGY AND SCOPE

This Status Report results from consideration of information from a variety of sources, including:

- Department of Human Services bi-monthly reports filed with the Court, and exhibits to those reports.
- Documents received from Defendants and others since the Monitor's appointment.
- The parties' submissions to the Monitor pursuant to the Court's Order of April 25, 2013 mandating this review. These are attached to this report.
- DHS responses to the Monitor's review-related multiple requests.
- Visits to MSHS-Cambridge by the Monitor and/or his assistant May 3 to 5, and May 8 to 10, 2013.
- Review of material provided by Cambridge and DHS during site visits.
- Review of other documents previously provided by DHS and Plaintiffs Class Counsel.
- Visit to the successor transitional group home by the Monitor May 9, 2013.
- Interviews with Cambridge clients, administrators and staff.
- Interview with DHS Medical Director, and Quality Assurance staff responsible for Cambridge.
- Reports of independent experts
- The parties' and consultants' comments on the Monitor's draft report.

This report examines compliance with the settlement agreement with regard to the Cambridge facility. This focus on the METO successor is most responsive to concerns raised recently in several quarters regarding conditions at Cambridge.[39]

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[39] The report does not cover:

- the three-person group home established as a METO successor; this is a single-family house in the town of Cambridge in a residential neighborhood;
- the state-wide community services provisions in the settlement. Some of these are specifically stated *not* to be requirements; review of these and related provisions would have required a state-wide systemic analysis. In addition, these requirements are most logically reviewed in conjunction with implementation of the *Olmstead* Plan.
- provisions regarding other institutions; a full review of these requirements most logically would in conjunction with implementation of the *Olmstead* Plan.

This report does not rely on Defendants' or Plaintiffs' submissions, although they are considered. Also, this report does not rely on Defendants' "updates" or promises of "next steps" in prior reports.

Many settlement requirements have a "history," that is, a backdrop of efforts towards compliance, including such things as discussions between the parties, internal DHS development of plans and approaches, target dates kept or not kept, including some starts and re-starts. This report does not attend to such history. Instead, it draws conclusions on the current state of compliance and, where have been major lapses over the months in question, those lapses may prompt or contribute to a non-compliance finding or other conclusion.

III. INDEPENDENT EXPERT REVIEWS

The Monitor retained three independent experts to assist in this compliance review: Dr. Edwin Mikkelsen, Dr. Fredda Brown, and Dr. Linda Bambara. Dr. Brown and Dr. Bambara provided a joint report. The reports are included in the Appendix to this report, and incorporated by reference. The experts' *curricula vitae* are exhibits to this report.[40]

The experts were charged to concentrate their reviews on quality of life questions, each of which were tied to identified evaluation criteria. The general themes are:

- Who is served at Cambridge? Do Cambridge meet the basic service requirements?
- Are habilitative/treatment services at Cambridge appropriate?
- Are residents served in the most integrated setting appropriate?
- Is use of medication appropriate?
- Were restraints used only in an emergency?
- Is transition planning properly accomplished?

Dr. Edwin Mikkelsen attended undergraduate and Medical School at the University of Nebraska, an internship at the Mayo Clinic was followed by an adult psychiatry residency at the Massachusetts Mental Health Center-Harvard Medical School, a research fellowship at the National Institute of Mental Health and child psychiatry training at the Yale Child Study Center. He became Director of the Division of Child Psychiatry at the Massachusetts Mental Health Center, a teaching Hospital for Harvard Medical School. Dr. Mikkelsen has authored or coauthored over 100 professional publications

[40] Dr. Mikkelsen's *curriculum vitae* is Ex. 5, Dr. Brown's is Ex. 6, and Dr. Bambara's is Ex. 7.

including three books. One of his books is *Criminal offenders with mental retardation: Risk assessment and the continuum of community-based treatment programs.* NADD Press (National Association of Dual Diagnosis), Kingston, NY, 1999 (co-author). In 1990 he became a consultant to the MENTOR Network and has served as the Medical Director for that organization since 1992. Dr. Mikkelsen has also been a consultant for the Massachusetts Department of Developmental Services since 1980. During that time he has provided both clinical Psychiatric Consultation to the individuals who are served by the Department as well as Consultation to the Executive Office. Dr. Mikkelsen is certified by the American Board of Psychiatry in both Adult and Child Psychiatry and has served as an examiner at the oral exams for both of these Boards.

Dr. Fredda Brown is Professor in the Programs in Special Education at Queens College, City University of New York, and director of the Queens College Regional Center on Autism Spectrum Disorders. She has spent many years providing educational and behavioral consultation to individuals with severe disabilities and their families. She is the editor of five books, and author of numerous journal articles and book chapters relating to the education of individuals with severe disabilities. Most recently her work focuses on the relationship between problem behavior, communication, and self-determination, and professional attitudes regarding behavioral treatment acceptability. Dr. Brown is past Editor-in-Chief of *Research and Practice for Persons with Severe Disabilities (RPSD),* and currently serves on several Editorial Boards, including the *Journal of Positive Behavior Interventions* (JPBI), and *RPSD.* She has sat on the National Board of Directors of the Association for Positive Behavior Supports (APBS) and TASH.

Dr. Linda Bambara is Professor of Special Education, Department of Education and Human Services, Lehigh University. Her work, which blends research, advocacy, and service for the inclusion of individuals with developmental disabilities, spans over 30 years. Presently, she is Executive Director and Co-Executive Director of two university-based service programs that provide employment training and post-secondary education and community living supports to adults and high school age youth with developmental disabilities. She has served as Primary Investigator or Co-Primary Investigator on grants from the U. S. Department of Education and Autism Speaks, and served as Co-Primary Investigator of a state funded regional center that provided education and training to families and providers of children and adults with autism. Dr. Bambara has served on numerous national and state committees focused on promoting the human rights of individuals who present behavioral challenges.. Dr. Bambara is co-author of over 75 publications including journal articles, chapters, and 4 books, is the former editor-in-chief of the journal *Research and Practice for*

Individuals with Severe Disabilities (formerly *JASH),* and is on the editorial board four academic journals, including the J*ournal of Positive Interventions.*

A. Dr. Edwin Mikkelsen's Conclusions

Dr. Mikkelsen's conclusions include, for example:

- Active treatment and habilitative services are not currently in place for the residents of MSHS-Cambridge.
    - Clients are aware of discharge planning and participate in the process. (p. 33).
    - Daily activities are "unstructured", unless the client shows interest in the programming offered. Staff are "demoralized by their feeling that they were unable to provide the individuals with active treatment." In addition, they feel they are "unable to provide any direction or structure to the individuals' daily activities, for fear that this might provoke an aggressive response by the individual, and that responding to such a response would incur the risk that they would be in violation of the Settlement terms of the lawsuit and related Court ruling."
    - The Risk Assessment does not include a thorough historical context of the client's behaviors. Inclusion of this background information can make behaviors more understandable and potentially responsive to treatment. This omission can also affect community programs' willingness to serve these clients.
    - The frequency of psychiatric visits is similar to the standard used in regional treatment centers for ID/DD, but considering the level of psychiatric illness present with those admitted at MSHS, increasing the frequency might be considered. This might also help to reduce noted polypharmacy at the facility.
    - Individuals could benefit from a "thorough Functional Analysis" to inform the Behavior Plan.
- [At the time of Dr. Mikkelsen's visit], there is no indication that emergency restraints are used at MSHS – Cambridge. However, 911 calls have been made to local police for assistance. "It is not clear if having the police arrive in response to a 911 Call is less intrusive than an emergency restraint applied in the facility."
- Residents at MSHS-Cambridge are often admitted on multiple medications from prior placements. MSHS-Cambridge "does not appear to make aggressive efforts to decrease these medications when the individual is stable."

- There is no indication that psychotropic medications are used to overtly manage behavior or restrain freedom of movement, or that PRNs are used for punishment, for the convenience of staff, or as a behavior modification technique.
- Clients are deemed ready for community placement several weeks to months prior to the identification of a community placement that will accept them.
- The "function of the MSHS-Cambridge could be carried out in more community residences that have security enhancement, such as door and window alarms." "Mr. Jensen indicated that there are state- and vendor-operated programs that do have these security measures in place."

B. Dr. Fredda Brown and Dr. Linda Bambara's Conclusions

Dr. Brown and Dr. Bambara's conclusions include, for example:

- Current organizational structure, procedural requirements, and therapeutic orientation may compete with implementing best practices in positive behavior support and person-centered planning.
- It is questionable whether Cambridge can identify individuals' support needs following best practices in the field.
- There is a complete absence of functional behavioral assessments in all clients' Positive Behavior Support plans. The context of exhibited target behaviors occurring during baseline is not included, thus omitting important information,
- Behavior Support Plans are not linked to hypotheses regarding the function of environmental determinants of problem behaviors.
- There is no evidence that person centered orientation drives the support plan.
- The extent of family or individual involvement in developing support plans is unclear.
- There is no evidence of collaboration or teaming in development of behavior support plans.
- There are no objectives in support plans that relate to age-appropriate forms of self-determination (for example, house governance, individualized job development).
- Behavioral data are not analyzed professionally.
- Support plans are not evaluated and modified professionally.
- Behavior specialists have insufficient qualifications/training in positive behavior support and person centered planning.

IV. COMPLIANCE STANDARD

A. Substantial Compliance

Settlement agreements "have many of the attributes of ordinary contracts, [and so] they should be construed basically as contracts." *United States v. ITT Cont'l Baking Co.*, 420 U.S. 223, 236, 238 (1975). However, a settlement agreement embodied in a court's decree has an additional characteristic; it "is a strange hybrid in the law."[41] It is both a "voluntary settlement agreement which could be fully effective without judicial intervention" and a final judicial order "placing the power and prestige of the court behind the compromise struck by the parties" and is "subject to continued judicial policing.'"[42]

In its Order of April 25, 2013, the Court charged the Monitor to use a "substantial compliance" standard. Other courts also evaluate a defendant's performance based on a "substantial compliance" or "substantial performance" standard. In the well-known formulation by not-yet Justice Cardozo, a deviation from a settlement is a violation "if it is so dominant or pervasive as in any real or substantial measure to frustrate the purpose of the contract." *Jacob & Youngs, Inc. v. Kent,* 230 N.Y. 239, 243 (1921). "There is no general license to install whatever, in the [defendant's] judgment, may be regarded as "just as good." *Id.*

The touchstones for determining substantial compliance are the dominant or fundamental purposes of the agreement. *See Cody v. Hillard*, 139 F.3d 1197, 1199-1200 (8th Cir. 1998) (prison case) (relevant to consider "whether [district court] ignored the evidence of past and present violations or whether he considered any violations inconsequential in the context of substantial compliance" and "the district court must exercise its discretion in determining whether those violations were serious enough to constitute substantial noncompliance and to cast doubt on defendants' future compliance with the Constitution."); *Jeff D. v. Otter,* 643 F.3d 278, 288 (9th Cir. 2011) ("there can be no 'substantial performance' where the part unperformed touches the fundamental purpose of the contract and defeats the object of the parties entering into the contract." (citation omitted); *R.C. ex rel. the Ala. Disabilities Advocacy Program v. Walley*, 475 F.Supp.2d 1118, 1126 (M.D. Ala. 2007) *aff'd sub nom.*, 270 F. App'x 989 (11th Cir. 2008)

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[41] *Vanguards of Cleveland v. City of Cleveland*, 23 F.3d 1013, 1018 (6th Cir. 1994).

[42] *Id.*

(where settlement agreement requires services be delivered according to a set of principles, "substantial compliance" means that the system is "operating functionally in the manner intended by the practice principles").

Compliance alone is not sufficient to free a defendant from judicial supervision. Once compliance is achieved, the next question is whether the compliance is durable. *Horne v. Flores*, 557 U.S. 433, 450 (2009)(if a durable remedy has been implemented, continued enforcement of the order is not only unnecessary, but improper). At that point, the court determines "whether the State would continue that compliance in the absence of continued judicial supervision." J*ohn B. v. Emkes*, 710 F.3d 394, 412 (6th Cir. 2013).

B. Fundamental Purposes and Principles

We turn now to the settlement's fundamental purposes and principles which will inform compliance determinations.

In this case, the State of Minnesota "declares, as a top concern, the safety and quality of life of the Residents of the Facility. The State agrees that its goal is to provide these residents with a safe and humane living environment free from abuse and neglect." Settlement Agreement at 3, Recital 7. The State further agreed that its goal is to extend the benefits of the settlement state-wide:

> The State also agrees that its goal is to utilize the Rule 40 Committee and *Olmstead* Committee process described in this Agreement to extend the application of the provisions in this Agreement to all state operated locations serving people with developmental disabilities with severe behavioral problems or other conditions that would qualify for admission to METO, its Cambridge, Minnesota successor, or the two new adult foster care transitional homes.

Id. See Settlement Agreement, Section III.F. ("Scope") (scope of obligations are limited to the Facility, except Recital 7 and "System wide Improvements" at Section X).

Finally, the settlement emphasizes multiple times the centrality of "person centered planning" and "positive behavioral supports" to both individual service planning and delivery, and to the systemic underpinnings of services.

Thus, it is fair to say that the fundamental purposes of the settlement agreement are:

- A safe and humane living environment free from abuse and neglect,

Enhancement of Quality of Life through "person centered planning" and "positive behavioral supports,"

- System-wide community services and placements,
- Attention to the "most integrated setting" mandate, and implementation of an all-disabilities *Olmstead* Plan, and
- Modernization of Rule 40 in relationship to *Olmstead* and person-centered planning.

C. Application of Compliance Standard

As the Court and the parties know, the settlement text has been mined for distinct obligations to facilitate DHS' reporting and the Monitor's compliance review. These are termed the "Evaluation Criteria" ("EC").[43] With the purposes of the settlement in mind, the Monitor further refined the Evaluation Criteria to categorize each as:

- *Administrative* (constituting notices, constitution of committees, and the like),

- *Instrumental* (actions required as precedent to, or a foundation for, Quality of Life requirements), and

- *Quality of Life* (actions and outcomes which are basic to the purposes and principles of the decree, and which directly impact the lives of the clients.).

In the balance of this report, findings of "Compliance" or "Non-Compliance" are applied where merited.

Keeping in mind the Eighth Circuit Court of Appeals' distinction between less essential violations and "those violations were serious enough to constitute substantial noncompliance," *Cody v. Hillard, supra*, the Monitor reports as follows:

- ***SUBSTANTIAL NON-COMPLIANCE is non-compliance with Quality of Life or Instrumental evaluation criteria.*** Achievement of the Quality of Life criteria are enabled (though not guaranteed) by compliance with the Instrumental. Therefore, failure to meet instrumental criteria is rated on the same standard as failure to meet

[43] The Evaluation Criteria are listed in Ex. 8 ("Evaluation Criteria Keyed to Settlement Section") as well as shown in prior monitor reports to the Court. They are also listed in Defendants' first three *Status Reports*.

quality of life criteria.

- ***The several instances of non-compliance with Administrative requirements would not result in a finding of "substantial non-compliance."***

This report does not address the Horne issue of whether compliance with settlement obligations has been maintained for a sufficient duration to merit an end to the Court's oversight. This report also does not address whether sanctions are appropriate, or what those sanctions might be.

PART FOUR

FINDINGS AND RECOMMENDATIONS

Part Four presents the findings and recommendations of the Court's Independent Consultant and Monitor, preceded by observations on several overarching issues which are vital to successful implementation.

I. FORMAT

The format of the findings and recommendations consists of five sections:

1. Identification of the settlement agreement section, with its language quoted verbatim.

2. A statement of facts relevant to compliance with the requirement. Sufficient facts are stated to fairly provide the compliance status, and to serve as the basis for discussion and compliance determinations. There is no intention to state all facts relevant to the issue.

3. A discussion.

4. Compliance findings ("Compliance" or "Non-compliance."). Here, it is noted whether the requirement is Administrative, Instrumental, or Quality of Life. *See* explanation of these categories in Part Two, Section V.C. above.

5. The Monitor's recommendations, if any. An Appendix lists all recommendations together.

In a few instances, a requirement is not rated because of a lack of information or because, an event has not yet occurred.

II. OVERARCHING ISSUES

These observations include matters affecting the quality of life of individuals with developmental disabilities in Minnesota, as well as matters which vitally affect DHS' compliance with the Settlement Agreement. None of these topics is new to DHS.

A. The Future of Cambridge

The settlement agreement, adopted by the Court, prescribes "best practices" in serving people with developmental disabilities, together with compliance with the *Olmstead* principles favoring services in the "most integrated setting." The Department intends the Cambridge program services will be 100% community based and no longer on the Cambridge Campus.

Recognizing these imperatives, the Department will provide services in these Cambridge successors in small community homes dispersed across the state. This shift to community services is supported by Plaintiffs, the Ombudsman and the Executive Director of the Governor's Council on Intellectual and Developmental Disabilities, subject to a caution that this be accomplished well and in accordance with client need and with the settlement agreement. In addition, the Monitor's independent experts also questioned the need for the existence of a restrictive institutional model of services.

The deinstitutionalization of Cambridge is a continuation of the process set in motion by the settlement agreement. METO had served dozens of clients under very restrictive conditions. Cambridge's census hovers at about 10 or 11 clients. Already, the Cambridge "transitional home" a few blocks from Cambridge serves three clients in a typical house in a residential neighborhood.

As Defendants proceed with their plan for dispersed community homes to serve those under the settlement agreement, the Monitor notes that it is essential that all safeguards to ensure person centered planning, positive behavioral supports, quality and security must be in place. This major change should be in accordance with a written plan, shared with Plaintiffs, the consultants and the Monitor, and subject to monitoring under the Court's orders.[44]

[44] Clients served by these new "METO successors" will, of course, continue to be protected under the Settlement Agreement.

B. Olmstead Plan

The Governor issued an Executive Order establishing a sub-cabinet to develop Minnesota's first *Olmstead* Plan. That was a positive step. The Order acknowledges the imperative to provide services and supports in the most integrated setting, and speaks to the importance of community services.

The Order is, however, lacking in several respects:

- ✓ It does not mention this litigation.
- ✓ It does not acknowledge that, under the court's decree in this case, "the State and the Department shall develop and implement" the plan.
- ✓ The plan and its implementation are subject to Court approval, monitoring and enforcement.
- ✓ The Governor's Order does not direct the Sub-cabinet to submit the Plan to the Court for review and approval.

These omissions, together the *Olmstead* Planning Committee report having questioned whether there is even an obligation for an *Olmstead* Plan or compliance with one, are cause for concern.[45]

The Monitor notes that Defendants' response to this report's draft does not address the deficiencies in the Governor's Order. It is important that these issues be addressed promptly.

C. Implementation Management and Plan

There is no roadmap for implementation of the settlement agreement. The Court has several times "urged the parties to utilize their best efforts to develop an implementation plan that would include tasks, deadlines, persons responsible, and possible amendments to extend the jurisdiction of the Court for an additional period of time. There is no implementation plan.

There is no quality assurance or other mechanism in place for DHS to further compliance with the judicially-mandated standards for the facility, or for the system-wide requirements.

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[45] *See The Promise of Olmstead: Recommendations of the Olmstead Planning Committee* (Oct. 23, 2012) at 6 ("Finally, none of the conclusions in this report should be interpreted as agreement by state officials that the State of Minnesota is not in compliance with the integration provisions of the Americans with Disabilities Act.").

The multiple slippages described in this report should be sufficient to demonstrate that more needs to be done, and done quickly, to ensure compliance with the seventeen-month old Court's order.[46]

The three DHS entities to which one would turn for compliance management are not effectively performing necessary tasks:

- The *DHS Central Office* assigned Michael Tessneer as liaison and to coordinate Jensen compliance. For months, he had this role alone, and recently another staff person has joined him. Mr. Tessneer has no authority to direct compliance. For one or two staff, there is an overabundance of material to digest, communicate and track. Based on the Monitor's experience and knowledge of similar situations, this Central Office staffing is insufficient for the task.[47]

- *DHS Quality Assurance* has a single individual assigned to QA for Cambridge. Working alone, and making a circuit traveling the entire state, she is responsible for all the data collection for several institutions. She acknowledges the impossibility of this task and states that QA has "urgently" requested additional staffing, and that two new QA positions are in the works, but "the jobs have not yet been posted." In addition, and perhaps most telling, she has not been informed of the *Jensen* requirements and not been requested to track compliance.

- *MSHS-Cambridge* has a new Quality Assurance Plan (effective January 14, 2013), but no QA officer, minimal activity, and no focus on – and no mention of -- the settlement agreement in its 2012 minutes.[48] There is nobody in charge, no specific person responsible for coordination with the Central Office. The Cambridge Health

[46] Plaintiffs' counsel has been diligent in informally seeking information on compliance questions. From Plaintiffs' response to the draft report, it appears that their patience may be evaporating.

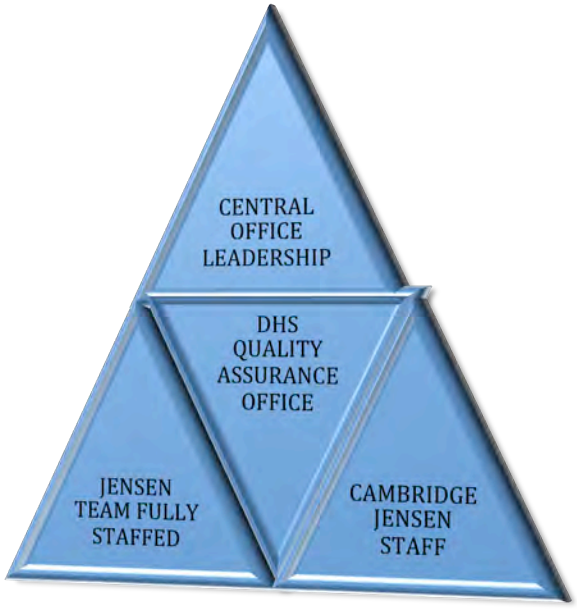
[47] The Monitor has repeatedly and quietly expressed this view to Mr. Tessneer and senior DHS officials virtually since his appointment.

[48] There is no one person on whose shoulders QA responsibility lies. The MSHS-Cambridge Quality Assurance Plan states that "Program Leadership" is responsible for its implementation; the many people identified as Program Leadership are: "Clinical Supervisor/Mental Health Professionals, supervisors, RN Consultant, Compliance Officer and Intake Coordinator." Quality Assurance Plan, Procedure No. 15002, eff. January 14, 2013.

Information Manager has a computer, but no copy machine, no printer and no fax machine in her office.[49]

Under leadership by the Commissioner and Deputy Commissioner, each of these entities could be an essential element of a solution, but none is fully doing the job now, either alone or in coordination with one another. It is therefore no wonder that some important *Jensen* elements have "slipped through the cracks," as reported below.

There is no need for time-consuming analysis of "what's wrong." The existing entities simply need to be provided the resources and authority to do what needs to be done, and to do so with precision and urgency.



Compliance with the Settlement Agreement's Cambridge-focused and state-wide requirements is not likely to be achieved without intensified and sufficiently staffed professional teams with authority to ensure compliance. One model would be three-pronged: a Central Office *Jensen* team of several professionals, coordinating with a Cambridge-based Jensen coordinator, and with DHS Quality Assurance staff assigned to assemble, manage and report data. In addition to its leader, the Central Office team might include one person devoted to Cambridge facility compliance, one to state-wide compliance, and a third to issues of maltreatment, restraints and the like.

[49] The closest devices are around a corner and down a hall the length of the building.

Defendants' June 4, 2013 Response to Draft Report

The Department of Human Services responded to the discussion above with a commitment both to establishing an implementation plan and the creation of a "formal Jensen Implementation Team," headed by a newly designated "Jensen Compliance Officer," Christina Baltes. It appears that the team consists of 14 individuals, including top leadership in DHS and at Cambridge, as well as others at Cambridge, and DHS' chief general counsel and another DHS attorney.

"The Team will focus on formalizing the Department's Jensen Settlement Agreement implementation plan and implementation management system. Specifically, the Team will ensure that the Department fulfills its obligations under the Settlement Agreement, fully honors and implements the Olmstead principles, and consistently adopts and implements best practices."

By June 30, 2013, the Department will submit "a detailed action plan explaining how the Department will address these overarching issues, findings and recommendations. This action plan will include a list of specific tasks and deadlines, and will identify the person(s) responsible for addressing each recommendation.

The Monitor commends DHS for its acceptance of the need for reorganized implementation oversight and an implementation plan. It will be important that this very large team ensure that it operates efficiently, and in a timely manner, and that it imbues appropriate authority in those team members "on the ground."

D. Integration with County Case Management

There is a pressing need for resolution of inadequacies in community services which result in a) referrals and commitments to MSHS-Cambridge which may not be necessary, and b) additional time in residence at Cambridge after Cambridge staff refer the client for community placement. This is not news to Cambridge or the DHS Central Office. County case management needs to be a partner in developing <u>new</u> person centered homes, vocational and other supports, rather than fitting clients into beds which happen to be empty at the moment.

The urgency has increased in light of the Department's decision to re-purpose the Cambridge facility, and to establish dispersed community successors for those to be served under the settlement agreement.

Cambridge is 100% state funded; it receives no federal match dollars. One Cambridge official noted that counties benefit financially during clients' stays at the facility. The incentives should operate differently; maintaining their clients in the community should benefit the counties.

Outreach to the judicial system to inform judges of possibilities for positive change in Cambridge clients' lives, and to explain the *Jensen* and *Olmstead* mandates, can occur now, and need not await an *Olmstead* Plan.

While the *Olmstead* Plan will surely address these issues state-wide, the Monitor urges DHS to begin now to consider how it will move on this proactively.

E. Rule 20 Commitments

About a third of MSHS-Cambridge residents are committed under Criminal Rule 20 for evaluation of their competence or to determine whether they can become competent with regard to pending criminal charges.

Cambridge does not control the next moves in these client's lives. Cambridge is not free to discharge Rule 20 clients to their homes or to a community placement. Due to security required for clients under control of the criminal courts, Cambridge is limited in the extent of free movement on or off-grounds for these clients.

In addition, some clients committed under Rule 20 can pose particular risks to other Cambridge clients who are not under criminal court control.

The admission and discharge criteria for MSHS-Cambridge (relatively short term crisis stabilization, with continuous community placement planning) is inconsistent with what Cambridge can do for individuals committed under Rule 20. It would be useful for DHS to consider and resolve this apparent contradiction.

F. The Court Was Not Informed that MSHS-Cambridge Operated Without a Department of Health License for 10 Months.

This issue is included because of its importance, and because it caused some consternation. Also, the recent revelation of this licensing/notice lapse has sharpened Plaintiffs' wariness of DHS' representations on other matters.

A facility serving people with disabilities cannot legally operate without a license, subject to a criminal law penalty.[50] MSHS-Cambridge requires both a license issued by DHS and also a license from the Minnesota Department of

[50] *See* Minn. Stat. 144.50 HOSPITALS, LICENSES; DEFINITIONS. (misdemeanor to operate without a license). Rule 4665.0300 FACILITY LICENSE

Health ("MDH"). Each agency licenses under different standards for different purposes.

MSHS-Cambridge operated in violation of the law for *10 months* from its establishment July 1, 2011 until it was licensed by the Minnesota Department of Health April 24, 2012. DHS later called its lapse "inexcusable."[51]

Cambridge was not licensed at the time of the settlement approval hearing. During the four and a half months following the Court's approval of the settlement (which requires licensure), the Court and Plaintiffs were not informed that MSHS-Cambridge was not licensed. During this time period, DHS was holding up admissions, and DHS was actively engaged with MDH seeking to secure a license.

METO closed June 30, 2011 but DHS did not inform the Department of Health of the closure until February 27, 2012, eight months later.[52] MSHS-Cambridge was not licensed by the Minnesota Department of Health until April 24, 2012.

On February 27, 2012, DHS submitted a new application to the Department of Health requesting a license. The letter cited this litigation. Changes in the number of beds and renovations to the former METO triggered the Department of Health to initiate visits by engineering and health surveyors as well as verification of licensure by DHS.[53]

On March 7, DHS stated to the Department of Health that it was "inexcusable" that DHS had inadvertently violated the "10 day [notice] requirement outlined in Minnesota statutes" regarding the new Cambridge

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[51] This lapse was first made public by the Office of the Legislative Auditor in in February 2013. Office of the Legislative Auditor, *Evaluation Report: State-Operated Human Services* at 66 (February 2013).

[52] DHS wrote to MDH on February 27, 2012 with a new application and informing MDH that METO was closed June 30, 2011. February 27, 2012 letter f rom Mori Zook (DHS) to Sussan Leppke (MDH). Also see, March 5, 2012 email from Mary Henderson (MDH) to Alan Van Buskirk and others (DHS). March 14, 2012 email from Mary Henderson (MDH) to others (METO closed 6/30/11 and MDH was just notified. DHS is now requesting a new 16 bed SLF-B).

[53] March 5, 2012 email from Mary Henderson (MDH) to Alan Van Buskirk and others (DHS).

program, and "apologize[d] for the subsequent problems that have resulted from this error on our part."[54]

Internally, the Department of Health expressed concern on March 12, 2012 with DHS' license application:

A. There is no current license in place.
B. DHS license covers 16 persons.
C. METO was licensed for 48 SLF beds.
D. New application shows 40 beds.
E. New application shows license for treatment of mental illness not DD, but the settlement agreement states DD.
F. Engineering clearance for renovation of buildings and discrepancies in the number of beds between MDH & DHS.
G. "There are residents somewhere at this location."
H. There are many loose ends to be resolved.[55]

Within an hour, a Department of Health official responded, questioning whether there were clients living at the facility, and twenty minutes later, MDH staff were seeking to understand the location of Cambridge beds for MDH's survey.[56]

Over a March 16, 2012 email, DHS submitted a new application to the Department of Health. This one reduced the number of beds from 40 to 16.[57]

The Department of Health notified Cambridge on April 12, 2012 of a number of violations of licensing rules, embodied in a Correction Order.[58] Cambridge requested waivers which MDH approved April 17, 2012.[59] Other waivers were granted over the next week.

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[54] March 7, 2013 email from Alan Van Buskirk (DHS) to Mary Henderson (MDH)

[55] March 12, 2012, 12:18 PM, email from Mary Henderson(MDH) to Darcy Miner and others (MDH).

[56] March 12, 2013, 1:10 PM, email from Darcy Minder (MDH) to Mary Henderson and others (MDH); March 12, 2013, 1:36 email from Mary Henderson (MDH) to Benjamin Zwart and Jim Loveland (MDH).

[57] March 16, 2012 email from Alan Van Buskirk (DHS) to Mary Henderson (MDH).

[58] April 12, 2012 letter from Brenda Fisher (MDH) to Paula Halverson (Cambridge).

[59] April 17, 2012 letter from James Loveland (MDH) to Stephanie Larson (Cambridge).

On May 4, 2012, MDH informed DHS that on April 24, 2012, the Department of Health issued a license to Cambridge effective April 24, 2013 to December 31, 2012.[60] *THIS LICENSE WAS ISSUED 10 MONTHS AFTER CAMBRIDGE OPENED AND WAS SERVING CLIENTS*.[61]

Until the April 24, 2012 licensure, Cambridge held off admissions since it was not licensed ("The reason Paula [Halverson, Cambridge Director] is so anxious is because they have been holding off on admissions pending a license approval.").[62] The following month, May, admissions to Cambridge jumped to 6, from the 1 or 2 monthly for January through April, and then continued at the very low number for the balance of the year.

[60] May 4, 2012 letter to Paula Halverson (Cambridge) from Mary Henderson (MDH).

[61] Cambridge currently operates with a renewed license for January 1 to December 31, 2013.

[62] May 1 and 2, 2013 emails from Maria King (DHS) to MDH staff.

III. Findings and Recommendations

EC 1 - 4

IV. CLOSURE OF THE METO PROGRAM OLMSTEAD, BEST PRACTICES, LICENSURE, AND PARENT NOTIFICATION

SETTLEMENT LANGUAGE

> 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 Minn. Stat. § 252.025, subd. 7; and (5) notify parents and guardians of residents, at least annually, of their opportunity to comment in writing, bye-mail, and in person, on the operation of the Facility.

PERSON CENTERED PLANNING & POSITIVE BEHAVIORAL SUPPORTS
THE UNDERPINNINGS FOR CLIENT TREATMENT AND SUPPORTS

For these initial tone-setting requirements, EC 1-4, we present an introduction to the person centered and positive behavioral support practices which are fundamental to the decree's purposes. Also below is an overview of Cambridge conditions which relate to compliance with EC 1 to 4.

The first operative paragraph of the Settlement Agreement mandates that any "successor to METO" utilize both a) person centered planning and b) positive behavioral supports:

> (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).[63]

These essentials pervade the Settlement Agreement.[64] If these elements are present for class members at Cambridge,[65] then Defendants are in compliance with this and the related "person centered" provisions. If these elements are absent, Defendants are in substantial non-compliance.

A. Person-centered planning and thinking

The Settlement Agreement requires that care and planning for class members, and staff training, be based on person-centered planning and person-centered thinking, on a foundation of positive behavior supports.

> Person Centered Planning is a way of helping people to think about what they want now and in the future. It is about supporting people to plan their lives, work towards their goals and get the right support. It is a collection of tools and approaches based upon a set of shared values that can be used to plan with a person - not for them. Planning should build the person's circle of support and involve all the people who are important in that person's life.

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[63] Settlement Agreement, Par. IV at 6. (EC 1).

[64] In addition to Par. IV (EC 1), the settlement encompasses the person-centered principles in multiple locations: Par. VII.A. (the Internal Reviewer. Dr. Amado, is Director of the Department's Office for Innovation in Clinical and Person Centered Excellence; Par. VII.B.3.c. (the External Reviewer had to have experience in person centered planning); Par. VIII ("To foster each resident's self- determination and independence, the State shall use person centered planning principles at each stage of the process…."); Par. IX.A. & B. (facility staff to "receive training in positive behavioral supports, person centered approaches, . . ."); Par. X.A.1.c. (community based facilities and homes; staff to receive "state of the art training encompassing person centered thinking, multi-modal assessment, positive behavior supports, . . ."); X.C.1. (Rule 40 to require "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, . . .").

[65] We leave to one side for the moment the applicability of these requirements to the care of Class Members who moved from Cambridge since the December 5, 2012 approval of the Settlement Agreement.

> Person Centered Planning is built on the value of inclusion and looks at what support a person needs to be included and involved in their community. Person centered approaches offer an alternative to traditional types of planning which are based upon the medical model of disability and which are set up to assess need, allocate services and make decisions for people.[66]

There are a variety of person-centered tools, each of which follows these principles:

- the person is at the center,
- family and friends are partners in planning,
- the plan focuses on gifts and capacities and looks to the future,
- planning builds a shared commitment to action,
- planning is an on-going process.[67]

Person-centered thinking permits people who provide support to work in a more person-centered way:

- How to sort what is important to a person from what is important for them
- How to address issues of health, safety and risk whilst supporting choice
- How to identify what the core responsibilities are for those who provide paid support
- How to consider what makes sense and what does not make sense about a person's life.[68]
- How to ensure effective support by matching characteristics of support staff to the person's needs

B. Positive Behavior Supports

The Settlement Agreement also requires services founded on Positive Behavior Supports. PBS practitioners adhere to a number of basis assumptions about behavior:

- Problem behavior serves a function
- Positive strategies are effective in addressing the most challenging behavior

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[66] Handout on "Person Centered Planning," DHS Rule 40 Advisory Committee Meeting, June 3, 2012.

[67] *Id.*

[68] *Id.*

- When positive behavior intervention strategies fail, additional functional assessment strategies are required to develop more effective PBS strategies
- Features of the environmental context affect behavior
- Reduction of problem behavior is an important, but not the sole, outcome of successful intervention; effective PBS results in improvements in quality of life, acquisition of valued skills, and access to valued activities [69]

The development of Positive Behavioral Supports for an individual includes at least these elements:

- Collaborative team-based decision-making
- Person-centered decision-making
- Self-determination
- Functional assessment of behavior and functionally-derived interventions
- Identification of outcomes that enhance quality of life and are valued by the individual, their families and the community
- Strategies that are acceptable in inclusive community settings
- Strategies that teach useful and valued skills
- Strategies that are evidence-based, and socially and empirically valid to achieve desired outcomes that are at least as effective and efficient as the problem behavior
- Techniques that do not cause pain or humiliation or deprive the individual of basic needs
- Constructive and respectful multi-component intervention plans that emphasize antecedent interventions, instruction in prosocial behaviors, and environmental modification
- On-going measurement of impact.[70]

Overview of Conditions

Idleness and Failure to Provide Adequate Habilitation

Clients are often idle at Cambridge. Many staff members are demoralized by their feeling that they are unable to provide the clients with active treatment.

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[69] Association for Positive Behavior Supports [APBS], *PBS [Positive Behavior Supports] Standards of Practice: Individual Level* (February 2007, Iteration 1). One of the Monitor's experts in this review is Dr. Fredda Brown who was one of the Standards Committee Chairs, which produced these *Standards*.

[70] *Id*.

There is little active programming or treatment. A client may play video games or watch television or play cards all or most of a day. Also, clients are permitted to sleep through groups and activities. For example, on May 1, 2013, the two clients in one Home had just awakened about noon. In another home the next day, a client had just awakened at 1:15 PM. Such mid-day awakening was typical on other days and in other homes.[71]

There are no established individualized daily schedules. One staff member, questioning the practice of allowing clients to refuse to attend treatment groups, stated that treatment at Cambridge "is ineffective. We're just housing people."

The organized activities at Cambridge which are intended to be treatment are called "groups." The topics for the groups are: are Wellness, Health Education, START (addressing anger and aggressiveness), Skills Review, Recreation, and Mini-Cores.[72] Uniformly, the Monitor was told, clients can refuse to attend any group. The refusal is termed "the client's choice." Groups are cancelled when staff "can't get anyone to go," as occurred for example, on May 2, 2013, according to staff (a wellness group).

One staff member reported that he is deterred from forcing a client to go to a treatment group: "If we forced a client to go to group and caused a behavior, you'd have a federal judge upset."

The free choice refusal both denies clients potential meaningful activity but it violates Cambridge's own policy. MSHS Procedure No. 15021 (eff. 9/6/12), "Care of Clients Refusing Treatment" requires that, when treatment is deemed essential, the treatment team is consulted for a "plan to encourage compliance," among other actions. If not essential and the client continues to refuse, a discharge plan is developed.

Environment

Cambridge clients live in two one-story buildings, with each building separated into two of what are called "Homes." The Homes have kitchens and laundry facilities. The common areas are institutional with little decoration. They have a large meeting/meal table, sofa and chairs. There is a television. There is a glass-windowed staff "office" which is what might be called a

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[71] Clients are awakened early morning to take medication, are offered breakfast, and then go back to sleep.

[72] Some clients have one or two additional sessions. Three clients have one hour of school daily. "Mini-Cores" are check-in meetings between a client and staff, once in the morning and once at the end of the afternoon.

"nursing station" in another context; its doors are locked. The exterior architecture is similar to houses in development's nearby. A building's Homes are connected by small hall spaces with an intricate system of locked doors between them. The doors to the outside are locked.

Client bedrooms (all single rooms) generally have no personalization and nothing on the walls. One room, for example, has a small table but no chair, no clothes hangers, and some plastic bins. Beds do not have headboards and are low to the floor. There are no rugs. At least one observed room has neither a table nor a chair. Each room has a window. In one bedroom, the Monitor observed a client asleep on the floor about noon on a weekday; the bed mattress did not have a sheet on it.

Client and Staff Interaction

Both direct care and professional staff were uniformly observed interacting with clients supportively and with caring words and actions. Staff were seen to serve home cooked food to clients, and to respond encouragingly to client comments and requests for assistance. No client seemed fearful of staff.

The Monitor observed a treatment group on May 2, 2013. Five clients participated in the common area of the Home, with one staff facilitating. The clients recalled that the topic a week earlier had been "teasing. This week's discussion was on anger, with "hot," "cold" and "cool" ways to express anger, "Cool" being the most appropriate. Clients watched a video, sometimes with impatience and sometimes with laughter, and took turns reading captions illustrating drawings in a paper packet. For some clients, the reading level required was beyond their grasp. The group was a positive interaction.

Fabricated, Inaccurate and Useless Information

A major element of data collection instrument, used daily and the basis for reporting which affects treatment decisions, often contains fabricated information on client/staff interactions. Each day, for each client, direct care

staff fill out hourly information on what is called the "Program Data Sheet." ("PDS")[73] The middle of the sheet has large rectangles for the client's "goals." The exhibit has a blank sheet and a completed sample. The sample has two goals, "Self Control" and "Respect Boundaries." The number of minutes staff are engaged in several types of interactions are written in (Supports, Prompts, Coaching and Negotiations).

Direct care staff are instructed by behavior analysts that each column must add up to 60 minutes. The client sleeping is recorded as "Supports" minutes.

Evening shift adds the minutes across the day and enters totals into a computer spreadsheet. Tables/graphs later purport to document the way in which time was spent with the client during the day.

It is fairly obvious that one cannot differentiate those activities accurately within the hour period. Also, the same number of minutes is entered repeatedly. Finally, direct care are typically supervising more than one client, so it is impossible to be, for example, "coaching" or "negotiating" for some number of minutes with one client, without deducting from the 60 minute hour for another client.

Direct care staff reported that the data is often fabricated. It is easy to just write the same number, or a small variation, into the cell for each hour. A direct care staff stated, that he has "spoken out about" the "convoluted" hourly recording system for goals. Supervisory and Behavior Analyst staff confirmed that the data is useless, not used and ignored. A Behavior Analyst stated, "no one is using the minutes [entered in the PDS hourly} that I know of." That system, he/she said, "skews the data."

When asked why these data continue to be collected and entered, a Behavior Analyst said, "I'm too embarrassed to tell my staff that the information they are entering is not used by anyone."

In addition, there are other timeliness/accuracy issues. For example, on May 1, 2013, at 12:40 PM, the PDS for MR had a 9:00 AM notation but none for the intervening hours. MR's list of Groups was not accurate, nor was the Group list for JL.

As a safeguard against fabrication, errors in medical records are to be corrected by an initialed cross-out and writing in the corrected information. JL's April 20, 2013 PDS has data covered with white-out.

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[73] Ex. 9 (*Program Data Sheet).* Two areas referenced in the text are circled on the sample sheet. A completed sheet is page 2 of this exhibit.

Errors were also found in treatment plans, with inaccuracies in identifying the groups to which clients are assigned.

Inaccurate Information in Treatment Plan

A client's treatment plan dated May 2, 2013 inaccurately states, regarding his learning style, "Practitioners will chart in IMR group progress notes." (JL). However, the facility no longer uses IMR and there are no IMR groups.[74] For another client, his Behavior Support Plan lists IMR as "Equipment and Materials Required." (JS).

At the top of Treatment Plans, there is a space for "Anticipated Discharge Date." It is 90 days from the Treatment Plan date. A Cambridge professional who writes treatment plans told the Monitor on May 9 that this is a "made up" date; 90 days is the default. When the plan is reviewed, 30 days is just added to the original date. Neither is related to the individual client or the availability of a community placement.

Vocational Services

When METO was replaced by MSHS-Cambridge, the entire vocational program for clients was abruptly shut down. Multiple staff told the Monitor of their sadness and disagreement with that decision, and expressed that work provided clients with meaningful productive experience, one which taught or boosted skills, and enhanced client's self-esteem. When one client was asked on May 9, 2013 by the monitor what would most improve his life at Cambridge, he answered in one word: "Work." A direct care staff gave the same answer, "work," when she was asked the same question a week earlier. In recent months, Cambridge has begun a Job Club activity (though it is presently inactive) and a Work Assessment activity.[75]

The Work Assessment activity "does not fill a person's day with meaningful, valued activity over the course of a one to three month stay at MSHS-

[74] IMR stands for Illness, Management and Recovery. When METO closed, a former Cambridge director instituted IMR as the major treatment modality. This is a method developed for people with serious psychotic mental illness. It consists of intellectual discussion intended to assist people with such illness to set goals and look at other issues in their lives. Early in his appointment, the Monitor questioned the application of IMR to Cambridge clients. Under new Cambridge leadership, IMR was abandoned.

[75] *Internal Reviewer Monthly Report* (March 2013). The quotations in the next paragraph are from the same source.

Cambridge." Real jobs, including full-time employment, should be an option. "From staff report, there is no effort to develop a person-centered description or plan regarding a quality day time, or night time, experience." The Job Assessment Profile in use does not include plans or evaluations regarding improving the quality of life of the client.

Positive Behavior Supports

A Functional Behavior Analysis ("FBA") is a foundation for a Positive Behavior Support Plan. The Internal Reviewer has examined incidents at Cambridge and has made recommendations in several cases. Cambridge has not followed those recommendations, except that after a particularly egregious incident in March 2013 (a client was choking a staff person), Cambridge agreed to work on an FBA; as of May 2013, it is not completed.

On August 14, 2012, the Internal reviewer recommended that a Functional Behavior Analysis (FBA) be done for JS with regard to his wandering behavior. In addition, it was recommended that antecedents should be identified and that he should be taught to walk as a group. This recommendation was accepted with modifications. The modification was that they would not conduct an FBA because they believed it was a one-time incident. The team agreed to "(a) assess challenging behavior; (b/c) team will address if he needs to stay with group; (d) will adjust medication and evaluate changes. According to the Internal Reviewer's report, "(a) No assessment of challenging behavior; (b) Team assessed if he needed to walk as a group; (c) [the team] has him working on walking alone (not a formal program written in records); (d) no behavioral evaluation of medication." At the January follow-up, there had been no changes to JS' treatment plan. A PBS (Positive Behavior Support) Plan was written for the February follow up, but no FBA was completed. There were no changes as of the March follow-up.

In response to an incident occurring on January 18, 2013, the Internal Reviewer recommended that a comprehensive FBA be conducted with a PBS written based on the results of the FBA for EB. This recommendation was accepted, with a June 30, 2013 date promised for implementation. According to the Internal Reviewer Monthly Follow-Up report, a PBS plan was completed but it was not based on FBA results. There was nothing reported for the January follow-up, and no changes for the February or March follow-up.

On March 20, 2013, another incident occurred with the same client, prompting another review by the Internal Reviewer. In his review, he notes that the Recommendations from the January 18, 2013 incident had not been fully implemented. He reiterates his prior recommendations. The response

was that it would be implemented by the June 30, 2013 date promised by DHS in response to the prior recommendations. However, in response to a recommendation to staff to complete a Person Centered Description to inform his county case manager in the development of a community placement opportunity, to which they give a May 15, 2013 date, they also state, "Key staff are working with Dr. Danov to complete a functional behavior assessment so that effective interventions can be developed.

The April 2013 Internal Reviewer Report continues to find that (aside from a client in the community transitional home), Cambridge continues to fail to comply without explanation to uncontested recommendations, and that a person-centered orientation continues to be absent.[76]

FACTS SUMMARY[77]

1. *METO Closure*. The METO program closed June 30, 2011.[78]

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[76] Dr. Amado states:

> It appears the programs for Mr. W and Ms. D have been created without an appropriate assessment (functional behavior assessment) and it appears they do not teach skills/behavior to increase competence in situations in which they currently engage in challenging behavior. Whatever it is that is missing in the infrastructure at MSHS Cambridge that allows this outcome should be identified and corrected. It also appears from a review of the information considered by MSHS as "Person Centered information" that the staff are neither using the person centered tools as intended nor are they collecting information consistent with person centered processes. Because these staff have participated in person centered training, it appears they need additional on-the-job coaching. Again, it appears the Cambridge infrastructure needs to be addressed to that is supports person centered processes and activities. It appears there has been an attempt to imbed certain person centered concepts in the clinical and treatment activities. It might help to establish person centered planning and learning activities separate from the clinical processes and prior to them.

Dr. Richard Amado, *Internal Reviewer Monthly Report* (April 2013) at 3.

[77] These facts are in addition to those set forth in this section above.

[78] Exhibit 1A to *Defendants Status Report* (September 17, 2012), Dkt. 165.

2. *Olmstead* Compliance. *Olmstead* requires (quoting Governor Dayton's characterization in his recent Executive Order):

> *Olmstead v. L.* C., 527 U.S. 581 (1999), the United States Supreme Court interpreted Title II of the ADA to require states to place individuals with disabilities in community settings, rather than institutions, whenever treatment professionals determine that such placement is appropriate, the affected persons do not oppose such placement, and the state can reasonably accommodate the placement, taking into account the resources available to the state and the needs of others with disabilities.

In contrast, MSHS-Cambridge does not comply with the Supreme Court's decision in *Olmstead v. L.C.* DHS does not contend otherwise. The independent experts' reports confirm this fact, as do the Monitor's observations. The compliance findings in this report corroborate this conclusion.

3. *Best Practices, Person Centered Planning and Positive Behavior Supports.* Client treatment and services are not consistent with professional best practices. Each resident of Cambridge has an Individual Treatment Plan. The plan is not developed or implemented in accordance with person centered planning principles. The plan is written by a Cambridge staff professional and then signed off on (usually but not always) by others, such as the client and family member. The Treatment Plan is not developed through an inter-disciplinary team process, but rather is written by one or two of the Cambridge staff, and not revised collaboratively with a team.

4. Active treatment and habilitative services are not currently in place for the residents of MSHS-Cambridge. Client's daily activities are unstructured and client's are able to opt-out of recommended programs and activities.[79]

5. Risk Management assessments do not include a thorough historical context of client behaviors.[80]

6. The Behavior Plans do not incorporate a thorough Functional Behavior Analysis.[81]

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[79] Dr. Edwin Mikkelsen Report (May 15, 2013).

[80] *Id.*

[81] *Id.*

7. Behavior Support Plans do not meet minimal professional standards.
    - Current organizational structure, procedural requirements, and therapeutic orientation may compete with implementing best practices in positive behavior support and person-centered planning.
    - It is questionable whether Cambridge can identify individuals' support needs following best practices in the field.
    - There is a complete absence of functional behavioral assessments in all clients' Positive Behavior Support plans. The context of exhibited target behaviors occurring during baseline is not included, thus omitting important information,
    - Behavior Support Plans are not linked to hypotheses regarding the function of environmental determinants of problem behaviors.
    - There is no evidence that person centered orientation drives the support plan.
    - The extent of family or individual involvement in developing support plans is unclear.
    - There is no evidence of collaboration or teaming in development of behavior support plans.
    - There are no objectives in support plans that relate to age-appropriate forms of self-determination (for example, house governance, individualized job development).
    - Behavioral data are not analyzed professionally.
    - Support plans are not evaluated and modified professionally.
    - Behavior specialists have insufficient qualifications/training in positive behavior support and person centered planning.[82]

8. MSHS-Cambridge was cited on February 1, 2013 for the following habilitative areas: not sending progress review reports to two clients' legal representatives and case managers prior to the progress review meeting; incomplete or unmaintained behavior support plans for two clients; client access to common areas in the home was inaccessible based on household protocols and not individual assessments.; outcome-based services were not provided in response to identified needs in the clients' individual service plan.[83]

9. MSHS-Cambridge does serve clients with developmental disabilities who exhibit severe behaviors and pose a risk to public safety.

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[82] Repor of Dr. Fredda Brown and Dr. Linda Bambara.

[83] Minnesota Department of Human Services, DHS Licensing, Correction Order, Cambridge, February 1, 2013.

10. *Licensure*. The Settlement Agreement requires that Cambridge "be licensed to serve people with developmental disabilities." When the Monitor developed the evaluation criteria in the summer of 2012, he assumed that Cambridge was, and had been, licensed to serve its clients. He has since learned that that was not the case.

    Licensing of DHS programs in Minnesota has two layers. The Department of Health licenses for fundamental standards, such as life safety and health. No license can be issued without compliance with Health Department standards and no program can open or serve clients without this license.[84] In addition, DHS has a Licensing division which licenses for compliance with standards for providing services to individuals being served.

    As shown above in Part Three, Section II.A. MSHS-Cambridge was not licensed for 10 months, and DHS failed to report this critical lapse to the Court or the Plaintiffs.

DISCUSSION

METO closed effective June 30, 2011 and MSHS-Cambridge opened the next day. Although Cambridge served clients from day one (METO clients remained in the facility at the turnover), Cambridge was not licensed by the Department of Health for ten months thereafter. The failure to inform the Court and Plaintiffs that there was no MDH license was "inexcusable." This is the word used by DHS in acknowledging that DHS had not timely acted under the licensing statute. We add EC 1A on the licensure issue; when the Evaluation Criteria were established, it was assumed that licensure had not been an issue. The Monitor did not expect that there were any unknowns regarding licensure. That Cambridge was not licensed for many months, and that the Court and Plaintiffs were not informed, merits a finding of non-compliance. The recent revelation of the absence of a license has sharpened Plaintiffs' distrust of DHS.

DHS does not contend that it is in compliance with *Olmstead* under EC 2, or with EC 3 on use of person centered planning, positive behavior supports, best practices, including the cited professional standards. The evidence before the Monitor corroborates the existence of this deficiency.

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[84] Minn. Administrative Rules, ch. 4665 (Supervised Living Facilities), subd. 4665.0200 subd. 5 (licensee must show that "functional services are provided in safe, healthful, and sanitarily operated and maintained buildings"); id. at 4665.0300 (license issuance).

To its credit, in its response to the draft report, "The Department acknowledges this finding" and describes a number of steps it is now taking to "implement the foundational structures that align with the principles of Olmstead."[85]

DHS complies with EC 4 in that Cambridge serves only "Minnesotans who have developmental disabilities and exhibit severe behaviors which present a risk to public safety." We note, however, that DHS does not have a systematic or other method to evaluate the extent of public safety risk. *See* report of Dr. Edwin Mikkelsen.

COMPLIANCE

EC 1
METO CLOSED

Compliance	**Non-compliance**

Quality of Life

EC 1A
CAMBRIDGE HAS BEEN LICENSED

Compliance	**Non-compliance**

Quality of Life

EC 2
CAMBRIDGE COMPLIES WITH *OLMSTEAD*

Compliance	**Non-compliance**

Quality of Life

EC 3
CAMBRIDGE COMPLIES WITH BEST PRACTICES

Compliance	**Non-compliance**

Quality of Life

[85] Defendants' 6/4/13 Letter at 8 (noting the new Jensen Implementation Team, new Cambridge staff, additional staff training, and increase off-site vocational opportunities for residents). In this regard, Defendants also cite the intention to replace the campus-based facility with placement of clients "in the most integrated setting" without civil commitment.

EC 4
CAMBRIDGE SERVES ONLY ELIGIBLE INDIVIDUALS

Compliance	**Non-compliance**

Quality of Life

RECOMMENDATIONS

1. DHS should ensure that Cambridge's Administrative Procedures binder (and any copies) accurately reflect all procedures currently in effect.

2. DHS should consider what restrictions on furnishings in client rooms are necessary and appropriate, and revise any relevant procedures accordingly. For example, closet alcoves presently do not have a bar to hang clothes; a break-away bar might permit clothes-hanging but not pose a danger. A wooden chair might pose a risk that a plastic chair might not pose.

3. DHS should consider assisting clients to decorate and otherwise personalize their rooms.

4. DHS should consider use of furnishings, wall hangings/pictures, and other means to render Home common areas less stark.

5. Present staff involved in vocational work with Cambridge clients may be inadequate (in experience, training and implementation) to implement supported and customized employment, as well as job development. DHS should consider bringing to bear a consultant with experience in implementation of supported and customized employment, as well as job development, to advise Cambridge. DHS should also consider adding sufficient staff time to this vocational work effort.

6. Cambridge does not always promptly respond to the recommendations of the Internal Reviewer after his review of incidents. DHS should ensure that responses are provided to the Internal Reviewer within a short specific time period.

7. Cambridge has not implemented the recommendations of the Internal Reviewer after his review of incidents, sometimes for months. DHS should ensure that recommendations are implemented within a short specific time period. When DHS/Cambridge receive the Internal Reviewer's monthly reports, implementation failures should be addressed in responses to the Internal Reviewer.

8. The Cambridge official in charge of Health Information Management should promptly be provided with a printer, fax machine and copy machine (or an all-in-one machine), and trained in its use.

9. The Central Office liaison/coordination staff should be augmented by at least two to three skilled professionals. The leadership of that "Jensen Team" should have authority to ensure implementation of adopted changes.

10. The existing DHS Quality Assurance System (with augmented staff for the Central Office element) should be utilized to collect and analyze information related to compliance with the settlement agreement, and in deep coordination with the Central Office Jensen Team, and the Monitor.

EC 5

IV. METO CLOSURE
GUARDIAN COMMENT

SETTLEMENT LANGUAGE

(5) notify parents and guardians of residents, at least annually, of their opportunity to comment in writing, by e-mail, and in person, on the operation of the Facility.

FACTS

1. On both September 7, 2012 and December 28, 2012, 17 surveys were issued to families and/or other concerned persons. Three responses were received following the first survey and five were received following the second.[86]

2. In addition, on December 28, 2012, 10 surveys were sent to community providers (three responses were received); 2 post discharge surveys went to family and other concerned persons (one response was received); and 2 post discharge surveys went to community providers (one response was received).[87] Responses were almost entirely positive.

3. The next survey is planned for June 2013.

DISCUSSION

Surveys to parents and concerned persons have been conducted semi-annually and it appears that the trend will continue with a third survey being scheduled for June 2013.

The "annual" notification under the Settlement Agreement has been overtaken by the much shorter lengths of stay at Cambridge. Defendants comply with the settlement's requirement of "notification" of an opportunity to comment in writing. There may be other modes of communication which are utilized but these are not (and are not required to be) reflected in settlement reporting. Defendants are encouraged to go beyond the setttlement's minima to enhance the connection between the program and the families. This may increase in importance as the Cambridge program

[86] See November 11, 2012 and March 17, 2013 Updates to *Defendants' Status Report to the Court*, Dkt. 202.

[87] *Id.*

moves from facility- to community-based.

COMPLIANCE

EC 5
GUARDIANS NOTIFIED OF OPPORTUNITY TO COMMENT

Compliance	Non-compliance

Instrumental

RECOMMENDATIONS

None.

V.A. PROHIBITED TECHNIQUES RESTRAINTS GENERALLY

SETTLEMENT LANGUAGE

A. Except as provided in subpart V. B., below, the State and DRS 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, and the use of painful techniques to induce changes in behavior through punishment of 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.

FACTS

1. This settlement provision is the general prohibition on restraint. An exception is later made for manual restraint (hands-on) in an emergency.

2. Not included in the list in ¶2 above, or in the compliance determination below, is emergency manual restraint, which is permitted, or chemical restraint, which is specifically covered under EC 9-11 and 14-15.

3. There has been no use at Cambridge 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), prone restraint, seclusion, or the use of painful techniques to induce changes in behavior through punishment of residents with developmental disabilities.

DISCUSSION

The extensive, damaging and needless use of mechanical restraints, such as those in the list above, precipitated this lawsuit. It is an important accomplishment that such restraints have not been used at Cambridge at

least since the settlement approval. This accomplishment merits findings of compliance.

On medical restraint, the reader is referred to the discussion at EC 14-15.

COMPLIANCE

EC 6
DISCONTINUE ALL PROHIBITED RESTRAINTS

Compliance	**Non-compliance**

Quality of Life

EC 7
NO USE OF PROHBITED RESTRAINTS

Compliance	**Non-compliance**

Quality of Life

EC 8
MEDICAL RESTRAINT NOT USED

No finding is made here. See discussion under EC 14-15

Compliance	**Non-compliance**

Quality of Life

RECOMMENDATIONS

None.

EC 9 – 11 & 21

V.B. PROHIBITED TECHNIQUES POLICY

SETTLEMENT LANGUAGE

B. **Policy.** Notwithstanding subpart V. A. above, the Facility's policy, "Therapeutic Interventions and Emergency Use of Personal Safety Techniques," Attachment A to this Agreement, 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. Attachment A is incorporated into this Agreement by reference.

FACTS

1. The Monitor spot-checked the restraint reporting forms from Cambridge against the Progress Notes written contemporaneously by staff in the client's records. There was general consistency. In addition, the Internal Reviewer has not noted any inappropriate or incorrect reporting.

2. Restraints are used only in emergencies. No instance was found in which restraints were used in a non-emergency situation, except for the situation described in Fact Finding 6 below. [At the time of Dr. Mikkelsen's visit] there is no indication that emergency restraints are used at MSHS – Cambridge. However, 911 calls have been made to local police for assistance.[88]

3. Contrary to the settlement's terms permitting emergency restraint, numerous staff reported either that they believe that there is a "no touch" policy/practice which discourages touching clients even in an emergency, or that their practice is to refrain from emergency restraint because of the "bureaucratic" scrutiny which results, along with fear of losing their jobs if they do the restraint. One staff member reported that he is deterred from forcing a client to go to a treatment group: "If we forced a client to go to group and caused a behavior, you'd have a federal judge upset." Staff are calling 911 for police assistance as a result of the "no touch" practice (although that no touch practice is

[88] Dr. Edwin Mikkelsen Report (May 15, 2013).

inconsistent with the actual policy. Police may restrain clients during transport; police have threatened Taser use against Cambridge clients, showing a Taser as a means to induce client compliance. In addition, staff use the police to transport a client to the hospital where the client is likely to receive the PRN behavior control medication which Cambridge cannot administer.

4. Staff seek not to touch a client during a behavioral incident, although manual restraint is specifically permitted. Incident reports document that staff have sometimes retreated to their locked office, leaving the upset client to damage property in the common areas. In a March 14, 2013 incident, in which a client was choking a staff person, he was eventually pulled off by a female direct care staff. She told the Monitor that she hesitated to act, running through all her training in her mind and not wanting to touch the assaulting client. Finally, she said, she pulled him "by the shirt."

5. Another direct care staff expressed the fear that, with staff's no touch practice, "Someone's going to get killed."

6. DHS Licensing concluded in one case that a manual restraint (escorting a client) was done in a non-emergency situation, following an otherwise appropriate restraint.[89]

7. There is no information to suggest that prone restraint, seclusion or

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[89] DHS Licensing issued a correction order on October 26, 2012 finding that, during a restraint on August 10, 2012, the "license holder did not have sufficient information on the EUCP report to indicate the use of the escort met all requirements. DHS Licensing explained that one of the restraint methods used (escort) was not necessary:

> It was reported that staff, "wrapped [his/her] arms around [C1] from behind, holding [C1's] upper arms, for 10 seconds. [C1] stopped aggressing and did not resist or struggle. [Two staff] then escorted [C1] back to [his/her] home, using a simple escort technique. [C1] did not resist or struggle." This documentation did not establish that the immediate intervention of an escort was needed to bring C1 to safety when the person was in danger. Danger of C1 was not established; in fact the report states that C1 had stopped aggressing and did not resist or struggle. The report also does not establish that the use of an escort was the least intrusive intervention possible to react effectively to the emergency situation, and that the procedure complied with other standards in parts 9525.2700 to 9525.2710.

time out have been used at Cambridge.[90]

DISCUSSION

The only permitted restraint, manual (hands on) restraint, is used only in emergency situations, based on review of all restraint reports and information from staff.

The Monitor considers the DHS Licensing conclusion in the "escort" case to be of such a small degree as to not prompt a finding of non-compliance. The escort following a permitted restraint was a minimal intrusion in the client's life. DHS Licensing has not critiqued Cambridge's restraint reports in other cases.

It is apparent, and a subject on which Cambridge staff are outspoken, that the restraint restrictions in the settlement, and follow up scrutiny, are a major disincentive to the use of even manual emergency restraint. Whether this is a *sub silentio* argument for permission for additional restraint techniques, or an over-reaction to accountability, or has another basis, cannot be determined. It is clear, however, that staff need to be reminded that, in an emergency as defined in the decree, manual restraints are permitted. In current circumstances, the "no touch" approach poses a significant risk of serious injury to staff or clients.

The language of the settlement agreement compels the compliance ratings immediately below. However, it is very important that Cambridge address the misunderstandings and subversion of the intent of the requirements which one finds in the "no touch" practice and the resulting use of 911 calls.

COMPLIANCE

EC 9 and 21
RESTRAINTS USED ONLY IN EMERGENCY

Compliance	**Non-compliance**

Quality of Life

[90] The parties have discussed a situation in which, in administering a manual restraint involving moving a client to the ground, the client is briefly prone as his or per position is changed. This is often unavoidable and is permissible. One cannot say that a prohibited prone restraint was administered.

EC 10
RESTRAINT POLICY IS FOLLOWED

Compliance	**Non-compliance**

Quality of Life

EC 11
NO PRONE OR CHEMICAL RESTRAINT, SECLUSION OR TIME OUT

Compliance	**Non-compliance**

Quality of Life

RECOMMENDATIONS

11. All Cambridge staff should be reminded that manual (hands-on) restraint is permitted in an emergency. Training scenarios might be useful in that process. The "no touch" approach of at least some staff poses a significant risk of danger to staff and clients.

V.C. PROHIBITED TECHNIQUES SECLUSION AND TIME OUT

SETTLEMENT LANGUAGE

C. **Seclusion and Time Out from Positive Reinforcement.**
101. The Facility's use of seclusion is prohibited.
102. 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).

FACTS

1. Defendants' Status Reports to the Court state that there have been zero instances of either seclusion or time out from positive reinforcement during the reporting time period of January 2011 to March 2013.

2. The Internal Monitor reports no use of seclusion or time out.

3. The Monitor found no evidence of these practices. There are no seclusion rooms in the residences.[91]

DISCUSSION

[91] Each building has a bedroom located in the space between the two sides of the building. Staff call this a "swing room," since the doors on either side can be locked/ unlocked to permit it to be used as a bedroom for one side or another. It is important that Cambridge staff and administration be alert that the swing room not ever be used as a seclusion or timeout room.

DHS complies with these requirements.

COMPLIANCE

EC 12
ZERO SECLUSION

Compliance	**Non-compliance**

Quality of Life

EC 13
ZERO TIME OUT

Compliance	**Non-compliance**

Quality of Life

RECOMMENDATIONS

None.

EC 14-15

V.D. PROHIBITED TECHNIQUES CHEMICAL RESTRAINT

SETTLEMENT LANGUAGE

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).

FACTS

1. Compliance with this requirement is disputed by the Plaintiffs. However, Plaintiffs do not cite any example of the use of medication in an emergency to control behavior.

2. There is no indication that psychotropic medications are used to overtly manage behavior or restrain freedom of movement, or that PRNs are used for punishment, for the convenience of staff, or as a behavior modification technique.[92]

3. Eight months ago, the Monitor discovered two instances where, during an emergency restraint, staff administered behavior control medication on a PRN basis.[93] This prompted an examination of the issue by DHS' administration and the agency's psychiatrist consultant, followed by the adoption by DHS of a process for what the Monitor will call

[92] Dr. Edwin Mikkelsen Report (May 15, 2013).

[93] *See* Monitor's September 23 and 24, 2012 letters to Anne Barry regarding use of PRNs and the Monitor's First Quarterly Report to the Court (October 22, 2012) Dkt. 175 at 18.

"advance consent" for behavior control medication.[94]

4. At Cambridge, this results in approved psychotropic PRN use. Under Cambridge's Policy, "Guidelines for Psychotropic PRN Use," in order to administer a PRN the individual needs to have a "Psychotropic Medication Addendum-Informed Consent" (DHS#3649) form, the "PRN Protocol" (#3703) form and have a PRN medication order on file.[95] Cambridge reports the use of a PRN in conjunction with approval of the usual treatment plan, a multi-page document recites medications together with target behavior/symptoms and obtains the approval of the person or legal representative, in advance, for use of the medication. The target behavior/symptoms are those which would typically be present in an emergency.

5. A telephone conference with the parties organized by the Monitor did not result in an agreement on this process. DHS implemented its process January 1, 2013.

6. Plaintiffs object to this system as it appears to authorize the use of PRN psychotropic medication for purposes forbidden by the settlement agreement.

7. Policy now prohibits using one time emergency PRNs and instead calls for transporting the client to the emergency room. (The policy allows PRN usage if a protocol, *see* above, has been developed. Procedure 15904 (effect. January 25, 2013), "Administration of Psychotropic Medication to Persons with Developmental Disabilities." The result has been an increase in calls to 911 for police to come to the facility. Clients have been taken by police to the hospital, which may administer the PRN forbidden at Cambridge, and then the subdued client is brought back to Cambridge.

8. The policies and its implementation are confusing and not developed with precise attention to the settlement agreement.

9. MSHS-Cambridge was cited on February 1, 2013 for the following with regard to psychotropic medication: not administering and monitoring the use of psychotropic medications according to the requirements of the Psychotropic Medication use Checklist; not obtaining written

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[94] Ex.10 ("MSHS-Cambridge, Guidelines for Psychotropic PRN Use"). Ex. 113 to *Defendants' Jan. 17, 2013 Status Report to the Court.*

[95] Defendants' Ex. 113 in Defendants' *Status Report to the Court* (January 18, 2013), Dkt. 193.

informed consent prior to administering psychotropic medication on a non-emergency basis; and not completing a standardized assessment instrument for the client's file within 30 days of the initiation of a new psychotropic medication or dose increase.[96]

10. DHS' reporting on PRN behavior-control use includes the following:

    a. Under EC 15, Defendants' Status Reports to the Court state the following numbers of PRN use of medication per indicated time period:

9/17/12 Update, January 1, 2011 to August 31, 2012	0
11/17/12 Update, September 1, 2012 to October 31, 2012	0
1/17/13 Update, November 1, 2012 to December 31, 2012	0
3/17/13 Update, January 1, 2013 to February 29, 2013	4[97]

    The four instances in the 3/17/13 update, DHS reports, were PRN use of medication not for prohibited purposes but pre-approved PRNs for regular mental health treatment.

    b. Under EC 8, for each of the same time periods, DHS reports that "there were *no repo*rts of the use of medical restraint or psychotropic/ neuroleptic medication [for the prohibited purposes.]. (emphasis added).

    c. MSHS-Cambridge's internal reporting shows 1 instance of emergency psychotropic medication in May 2012, with a notation after that, "No longer use Emergency PRN."[98] This contradicts "a" and "b" above which state 0 for that time period.

A matter of concern: During the May 2013 review, DHS provided a document to the Monitor stating that there were 43 instances, called "Approved Behavioral PRNs. This 2013 terminology is retroactively applied to PRNs beginning January 2012, although there was no process in place to identify "Approved Behavioral PRNs" at that time.[99] Someone evidently went through 2012 psychotropic PRNs to create the Exhibit 11 list of 43 instances.

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[96] Minnesota Department of Human Services, DHS Licensing, Correction Order, Cambridge, February 1, 2013.

[97] The *March 17, 2013 Update to Defendants' Status Report to the Court*, Dkt. 202, states, "During the interval of this status report there were 4 reports of PRN use." Citing Defendants' Exhibit 125. Two of the four instances involve a client who lives in the successor transitional group home; here, Defendants are reporting on activity at that home; elsewhere they do not.

[98] Ex. 11. (*Psychotropic Med Usage*, received May, 2013, at 3).

[99] Ex. 11. (*Psychotropic Med Usage*, received May, 2013), at 3.

In fact, a significant number of the 43 instances were psychotropic PRNs in the midst of, or associated with, physical restraints. Therefore, the Monitor concludes that the Exhibit 11 list is misleading.

During 2012 PRNs were forbidden for "behavioral" control.

DISCUSSION

The new protocol, which became effective January 1, 2013, has the potential to be used to avoid the settlement's mandate against emergency use of medication for behavior control. The new protocol appears to be a pre-approval for PRN psychotropic medication use for behavior control. Procedure 15904 (effect. January 25, 2013), "Administration of Psychotropic Medication to Persons with Developmental Disabilities," adds a level of lack of clarity on this issue.

In any event, the prohibitions in EC 15 (¶D.2.) above are of EITHER behavior control medication as a "standing order" OR such medication on a "PRN" basis. This clearly refers to two situations. The pre-approval of behavior control medication under the January 1, 2013 protocol and Procedure 15904 is a "standing order" and is thus prohibited under the first prong of ¶D.2.[100]

The Monitor acknowledges the challenge of differentiating between medications which are "a standard treatment or dosage for the resident's condition," and those which are used for the prohibited behavior control or "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." The current protocol does not satisfactorily meet that challenge.

DHS needlessly includes voluntary medication, requested by the client, as covered by the prohibitions of the settlement. For example, there have been requests by self-aware clients for their prescribed PRN medication; this has occurred both before and during behavioral incidents. Such voluntary medication should not be considered a prohibited restraint if it is a medication prescribed by the physician in the usual course for a known client need. In the settlement language at ¶D.1. above, the phrase "when it is used for" should be interpreted to mean "when the *facility* uses it for…," thus emphasizing the facility's intent.

[100] For whatever reason, the Department's response to the draft report did not address this reason for the Monitor's non-compliance finding.

On account of DHS' retroactive categorization in Exhibit 11, and the advance approval protocol, which is a violation of the "standing order" prohibition, the Monitor finds non-compliance with EC 14 and 15.

COMPLIANCE

EC 14
ZERO PRN CHEMICAL RESTRAINT

Compliance	**Non-compliance**

Quality of Life

EC 15
ZERO PRN FOR BEHAVIOR CONTROL

Compliance	**Non-compliance**

Quality of Life

RECOMMENDATIONS

12. *DHS should reevaluate the "Approved Behavioral Medication" protocol, along with how to address voluntary requests for medications regularly prescribed outside of the behavior control context.*

13. *DHS should insure that reporting of PRN medication events is consistent, internally and externally, and are accurately reported to the Court.*

EC 16 – 20, 22[101]

V.E. PROHIBITED TECHNIQUES THIRD PARTY EXPERT

SETTLEMENT LANGUAGE

E. **Third Party Expert.** The Department shall establish a protocol to contact, on a rotating basis, a qualified Third Party Expert from a list of at least five (5) qualified Third Party Experts pre-approved by Plaintiffs and Defendants. The costs for the Third Party Expert shall be paid by the Department. This consultation shall occur as soon as reasonably possible upon the emergency presenting but no later than thirty (30) minutes after an emergency use of restraint consistent with the Facility's policy, *Therapeutic Interventions and Emergency Use of Personal Safety Techniques,* Attachment A to this Agreement. The Facility staff shall consult with the Third Party Expert in order to obtain professional assistance to abate the emergency condition, including the use of positive behavioral supports techniques, safety techniques, and other best practices. If the scheduled qualified Third Party Expert is not immediately available, DHS shall then utilize the Medical Officer Review protocol as described in subpart V.F, below. If the parties cannot develop the qualified list of Third Party Experts within 30 days of final approval of this Agreement, DHS shall utilize the Medical Officer Review described in subpart V. F, below.

FACTS

1. Defendants' Reports to the Court state that they have contacted nine individuals to fulfill this requirement. Although discussions have occurred with prospective list members, none have accepted the position. Therefore, a list of Third Party Experts does not exist.

2. Defendants initially issued a Request for Proposals, which was not successful in obtaining applicants. This was followed by Defendants reaching out to possible experts recommended by others. Plaintiffs dispute the vigor with which this outreach was conducted.

3. DHS has instead, as *per* the settlement, utilized the Medical Officer Review described in the last sentence of this requirement and also in subpart V.F. below.

[101] EC 21 is omitted because it requires that each use of restraint have been in an emergency. That issue is covered with EC 9 above.

DISCUSSION

The settlement contemplated a vigorous and immediate consultation with a qualified non-State expert immediately "after an emergency use of restraint." No list of qualified experts was developed by the parties. Plaintiffs relied on the DHS' efforts, with Dr. Colleen Wieck's input, to constitute the list.

Despite the 30 day time period contemplated by the settlement, Plaintiffs believe that the panel of third party experts, to be called upon within a half hour of a restraint use, should be put into place because, they state, Cambridge has an "excessive and improper response to incidents," and improper use of 911 emergency calls and PRN medication.[102] Neither Plaintiffs nor Defendants requested or put into writing an extension of the 30 day period.

It is unclear to the Monitor that, even if a panel of always-on-call experts could be identified, their input at a distance would affect any practices at Cambridge. The experts would necessarily be relying on Cambridge staff's description of an already-concluded incident; these incidents are occurring once or twice a month, and which are over in just a few minutes. The experts would not have in hand the client's individual plans, medical orders and recent progress notes.

At the time this settlement agreement provision was written, the Internal Reviewer had not had his reporting increased to include detailed and longitudinal analysis of each restraint incident, including record review and staff interviews. That process seems more attuned to what had been hoped for from the outside panel.

In any event, the Monitor is obliged by the settlement agreement terms which explicitly include the "fall back" that, in the absence of the agreed panel, staff consultation with the DHS Medical Director fulfills that role. Therefore, the Monitor must find Defendants in compliance with this requirement.[103]

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[102] Plaintiffs' Letter of June 4, 2013 at 15-16.

[103] The Ombudsman disagrees that there is compliance, stating that the "alternative [of using the Medical Director"] was not envisioned to be a permanent solution to the role of the third party expert." Ombudsman Comments, June 4, 2013, at 2. The difficulty with this conclusion is that the settlement agreement provided a 30 day period to identify the panel and specifically approves the Medical Director role if there is no panel. The settlement approves the Medical Director fall back "if the parties fail to

Plaintiffs and Defendants may continue to seek qualified third party experts; nothing in this report is intended to deter them from doing so.

Accepting the Medical Director consultation, per the settlement agreement, as proxy for the third party panel member, the Monitor finds compliance with the relevant criteria identified below. *See also* discussion of EC 23-25 immediately following.

COMPLIANCE

EC 16
PROTOCOL TO CONTACT THIRD PARTY EXPERT

For the above reasons, this requirement is not rated.

Compliance	Non-compliance

Instrumental

EC 17
LIST OF 5 EXPERTS

For the above reasons, this requirement is not rated.

Compliance	Non-compliance

Instrumental

EC 18
EXPERTS ARE PAID

For the above reasons, this requirement is not rated.

Compliance	Non-compliance

Instrumental

EC 19
LISTED EXPERT CONTACTED IN ALL INSTANCES OF EMERGENCY RESTRAINT

Compliance	Non-compliance

Instrumental

EC 20
CONSULTATION WITHIN 30 MINUTES

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develop the" panel list within 30 days of settlement approval. It is a *different* provision in the same paragraph which would have utilized the Medical Director if a panel member happened to be unavailable at the moment.

Compliance	Non-compliance

Instrumental

EC 22
CONSULTATION WAS TO OBTAIN ASSISTANCE

Compliance	Non-compliance

Instrumental

RECOMMENDATIONS

None.

EC 23 to 25

V.F. PROHIBITED TECHNIQUES MEDICAL OFFICER REVIEW

SETTLEMENT LANGUAGE

F. Medical Officer Review. No later than thirty (30) minutes after an emergency use of restraint 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.

FACTS

1. The chief medical officer for DHS, located in its central office, is Dr. Alan Radke. When a restraint has occurred at Cambridge, he has typically been the medical officer to speak with Cambridge staff under this requirement.

2. Within thirty minutes of the initiation of a manual restraint, the lead person at Cambridge calls Dr. Radke who asks regarding the person's condition, any antecedent behavior, what was tried pre-restraint, when restraint was administered, whether there are any injuries, the length of restraint, and about any debriefing with the client. Cambridge staff are organized in reporting the information to him. If Dr. Radke is not available, there are three designees.[104]

3. There is consistent documentation in the restraint forms of both timely consultation with Dr. Radke and of his response. The responses appear relevant to the situation, and not to be *pro forma*.

DISCUSSION

The Medical Officer Review is working well. It serves several purposes: a) it provides a rapid check on the use of restraint, b) the prospect of the medical consultation at a high DHS level may deter premature or unnecessary restraint use, c) it gives staff feedback on their actions.

[104] Monitor Interview, Dr. Alan Radke, DHS (May 6, 2013). Review of restraint forms.

The settlement agreement (EC 23-24) sets a maximum of 30 minutes for the call to the medical officer, and that he/she may approve or order discontinuation of the restraint. The experience has been that restraints have been used for no more than several minutes generally, and not close to the 30 minutes period.[105] To the extent that the medical officer review was expected to reduce restraint while restraint is in process, it has not done so, because restraint is over so quickly. However, the deterrence and reinforcement/teaching factors support continuing this settlement requirement.

COMPLIANCE

EC 23
MEDICAL OFFICER CONTACTED

Compliance	**Non-compliance**

Instrumental

EC 24
MEDICAL OFFICER ASSESSED SITUATION

Compliance	**Non-compliance**

Instrumental

EC 25
MEDICAL OFFICER REVIEW DOCUMENTED

Compliance	**Non-compliance**

Instrumental

RECOMMENDATIONS

None.

[105] The maximum time for a manual restraint has been 15 minutes. Most are several minutes or fewer.

EC 26-28

V.G. PROHIBITED TECHNIQUES
ZERO TOLERANCE FOR ABUSE AND NEGLECT

SETTLEMENT LANGUAGE

G. Zero Tolerance for Abuse and Neglect. 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 who has committed 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.

FACTS

1. DHS adopted an appropriate policy consistent with the requirements of the settlement agreement. However, the Zero Tolerance policy was effective 9/18/12 which was nine (9) months after approval of the settlement.

2. Since January December 5, 2011, there have been six allegations of abuse or neglect. All were investigated and none were substantiated.

3. The Monitor identified, and previously reported, that an allegation of sexual abuse was insufficiently investigated.[106] A female client reported that a male client, in the presence of staff, reached out and touched her vaginal area. She immediately stood and left the area, returning to her Home. Cambridge management investigated and decided simply to believe the alleged perpetrator's denial. No trained investigator was involved prior to Cambridge ending its cursory review. In addition, no consideration was given to possible staff neglect or client supervision lapse. The in-house inquiry was essentially *pro forma*.

As the site review for this report ended, there was a report of a client

[106] After the Monitor's report, DHS re-reviewed the original investigation at a higher level. We have not been informed of any additional action taken.

ingesting the cleaning fluid "Mr. Clean," taken from a cabinet which is supposed to be kept locked. Reportedly, a staff person did not lock the cabinet. If confirmed, this would likely be staff neglect. This is being investigated.

DISCUSSION

The one instance described above was serious. The superficial extent of the inquiry seriously undermines confidence in the investigation process. "[T]he Department agrees with the Report's conclusion that the incident was insufficiently investigated by the Department."[107] Therefore, EC 26 is rated in non-compliance.

Defendants' 6/4/13 Response to Draft Report

On or before June 15, 2013, the Department will retain an independent investigator to reinvestigate this incident and Cambridge's response to it. The Department will request that the investigator simultaneously provide his/her findings to the Court Monitor, Deputy Commissioner of Human Services, Settlement Class Counsel, Ombudsman Opheim, and Dr. Wieck.

The zero tolerance policy was not adopted until nine months after approval of the settlement.

Because there were no perpetrators identified, the Monitor is not rating EC 27 on discipline of perpetrators. Similarly, EC 27 on referral to the county attorney is not rated; there were no appropriate cases for referral.[108]

COMPLIANCE

EC 26
ALL ALLEGATIONS INVESTIGATED

Compliance	**Non-compliance**

Quality of Life

EC 27
PERPETRATORS DISCIPLINED

Not possible to rate

Compliance	Non-compliance

[107] Defendants' 6/4/13 Letter at 10.

[108] The draft report rated this requirement as in compliance. On further review, the rating is changed because, in the absence of any relevant instance, the Monitor cannot evaluate compliance here. *See* Ombudsman's Comments, June 4, 2013 at 2.

Instrumental

EC 28
REFERRAL TO COUNTY ATTORNEY

Not possible to rate

Compliance	Non-compliance

Instrumental

RECOMMENDATIONS

None.

EC 29 - 31

VI.A. RESTRAINT REPORTING AND MANAGEMENT DOCUMENTATION COMPLETION

SETTLEMENT LANGUAGE

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. Attachment C is incorporated into this Agreement by reference.

FACTS

1. This requirement is for the timely completion of the restraint reporting form. Timely means "the end of the shift." Review of restraint forms indicate compliance, and staff take the paperwork associated with restraint very seriously. At the conclusion of an incident, staff complete a computerized form on the computer in the office within the Home. It is then printed within the building, the required notices are emailed/sent, and the printed form is taken to the administration building and placed in what is called the "gray box" for further processing. The Monitor observed the fillable form on a Home computer.

2. Before the computerized system, Form 31032 was completed by hand.

3. The form states the type of restraint used and thus indicates that no prohibited restraint was used.

4. The Monitor has reviewed near-contemporaneous handwritten nursing/progress notes associated with restraint incidents, and has not identified contradictions regarding basic facts.[109]

DISCUSSION

DHS is in compliance. There is no indication of non-compliance. Staff take this responsibility seriously.

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[109] In one early instance, the Monitor was concerned that an initial staff report had been edited by a supervisor. In practice, all initial reports are reviewed by a supervisor for completeness and compliance with requirements. Such supervision is a positive, not a negative.

COMPLIANCE

EC 29
RESTRAINT FORM COMPLETED

Compliance	**Non-compliance**

Instrumental

EC 30
RESTRAINT FORM TIMELY

Compliance	**Non-compliance**

Instrumental

EC 31
FORM STATES NO PROHIBITED RESTRAINT

Compliance	**Non-compliance**

Instrumental

RECOMMENDATIONS

None.

EC 32 - 38

VI.B. RESTRAINT REPORTING AND MANAGEMENT 24 HOURS TO REPORT

SETTLEMENT LANGUAGE

B. DHS shall undertake reasonable efforts to submit within twenty four (24) hours, but no later than one (l) business day, the completed METO Form 31032 by electronic means, fax or personal delivery, to the following:

1. Office of Health Facility Complaints ("OHFC");
2. Ombudsman for Mental Health and Developmental Disabilities;
3. DHS Licensing;
4. DHS Internal Reviewer;
5. Client's family and/or legal representative;
6. Case manager;
7. Plaintiffs' counsel.

FACTS

1. All DHS Status Reports to the Court state that all notices of the restraint use form were timely submitted to the listed offices/persons, that is, within twenty-four (24) hours, with one exception. The noted exception is that DHS informed the Court that on October 25, 2012, the DHS Licensing Division sent a correction order with regard to the timeliness requirement.[110]

2. The DHS Status Reports to the Court are incorrect in this regard. There were other correction orders for the same violations, unreported to the Court.

3. The October 25, 2012 DHS Licensing Division correction order (which was identified to the Court) states that DHS failed to timely notify the Ombudsman for Mental Health and Developmental Disabilities, and the DHS Internal Reviewer.

4. DHS Licensing Division, in contrast, states on October 25, 2012, that this is a "repeat licensing violation," with similar violations having occurred: February 5, 2012, July 5, 2012 and July 12, 2012.

[110] DHS Status Report to the Court (Nov. 19, 2012), Dkt. 180, Ex. 99 and 100.

5. The February 15, 2012 (not the 5th) correction order states that "the license holder notified DHS Licensing, Ombudsman for Mental Health and Developmental Disabilities, Case Manager, and Plaintiffs' Council [*sic*], on January 29, 2012," as was required.

6. The July 5, 2012 correction order states that "it could not be determined" whether notices were timely, as the "area on the form to document the date and time of the notification was left blank."

DISCUSSION

It is of serious concern that several DHS Status Reports to the Court are inaccurate. The Court was led to believe that there was only one violation instance; instead, there were four. This reporting was misleading.

It is important that prompt notice is provided when restraint is used. Those who must receive notice include offices or individuals who have authority to investigate, and include the client's legal representative and counsel.

Especially considering the small number of restraints in this period, the multiple violations established by DHS Licensing are disquieting.

DHS states: "The Department acknowledges that it inaccurately reported untimely notices of restraint use to the Court. These errors were inadvertent and were in no way intended to mislead the Court, the Court Monitor, Settlement Class Counsel or any other individual. The Department sincerely apologizes for its errors."[111]

COMPLIANCE

EC 32 - 38
TIMELY NOTICE OF RESTRAINT

Compliance	**Non-compliance**

Administrative

RECOMMENDATIONS

14. *All citations by DHS Licensing, or any other licensing body, should be fully and accurately reported to the Monitor in the Department's status*

[111] Defendants' June 4, 2013 Letter at 3.

reports.[112]

[112] DHS' bi-monthly reports no longer need to be filed with the Court. As the Court's judicial adjunct, the Monitor, of course, expects the same diligence and accuracy in reports to him, as one expects in reports directly to the Court.

EC 39

VI.C. RESTRAINT REPORTING AND MANAGEMENT NOT REPLACE OTHER REQUIREMENTS

SETTLEMENT LANGUAGE

> The reporting requirements in this Section VI shall not replace any other applicable requirement for incident reporting, investigation, analysis and follow up.

FACTS

1. Defendants' Status Reports to the Court state that no abuse/neglect allegations were made arising from restraint use. However, the settlement language is not limited to abuse/neglect investigations. It refers to "any other applicable requirement" for incident reporting or investigation. Therefore, because of an "under-reading" of the settlement agreement provisions, Defendants may have failed to note and report instances that are covered.

2. DHS Licensing issued a correction order on October 26, 2012 finding that, during a restraint on August 10, 2012, the "license holder did not have sufficient information on the EUCP report to indicate the use of the escort met all requirements."[113] DHS Licensing explained that one of the restraint methods used (escort) was not necessary:

> > It was reported that staff, "wrapped [his/her] arms around [C1] from behind, holding [C1's] upper arms, for 10 seconds. [C1] stopped aggressing and did not resist or struggle. [Two staff] then escorted [C1] back to [his/her] home, using a simple escort technique. [C1] did not resist or struggle." This documentation did not establish that the immediate intervention of an escort was needed to bring C1 to safety when the person was in danger. Danger of C1 was not established; in fact the report states that C1 had stopped aggressing and did not resist or struggle. The report also does not establish that the use of an escort was the least intrusive intervention possible to react effectively to the emergency situation, and that the procedure complied with

[113] Ex.12. (Minnesota Department of Human Services, DHS Licensing, Correction Order, Cambridge, October 26, 2012).

other standards in parts 9525.2700 to 9525.2710.

DISCUSSION

There is no evidence that the "under-reading" of the requirement noted in the Facts above resulted in a failure to make incident or other reports to other entities. Cambridge has a system for incident reporting, and reviews even very minor incidents are recorded/reported (scratches, for example).

Because the incident described in DHS Licensing findings were based on the restraint report by Cambridge, there is no violation of the reporting requirement under this Evaluation Criterion.

COMPLIANCE

EC 39
NOT REPLACE OTHER REPORTING

Compliance	**Non-compliance**

Instrumental

RECOMMENDATIONS

None.

EC 40 – 42

VII.A. INTERNAL AND EXTERNAL REVIEWER
INTERNAL REVIEWER

SETTLEMENT LANGUAGE

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 VI. B., above, within twenty four (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.

FACTS

1. DHS appointed Dr. Richard S. Amado, a DHS official, as the Internal Reviewer. Dr. Amado's qualifications for this role have not been questioned.

2. The initial phase of the Internal Reviewer work was critiqued by the Monitor because it was essentially a paper review, which was accomplished without discussion with Cambridge staff and without follow-up. Even with this paper review, Cambridge leadership at the time frequently refused to accept the reasoned guidance of the expert Internal Reviewer.

3. After the Monitor's mid-course critique, DHS with Dr. Amado strengthened the review, adding consultation with staff, and including monthly reports. Also, Dr. Amado is providing information on whether Cambridge is implementing his recommendations. These reports are detailed and reflect the appropriate independence of the reviewer.

4. Cambridge no longer quibbles and resists the Internal Reviewer's

recommendations. However, Cambridge has often failed to implement these recommendations, for weeks at a time, and done so without explanation.

5. The Internal Reviewer did not consistently receive the required timely notice of restraint use. *See* findings at EC 32-38.[114]

DISCUSSION

The Internal Reviewer's initial lapse was immediately followed by enhanced and meticulous reviews. These have included both review of specific incidents and also a broader consideration of compliance at the facility.

The Internal Reviewer has also followed up on Cambridge's implementation of his prior client-specific recommendations, finding disappointing performance by Cambridge on that score. One would hope that Cambridge would internally monitor its own implementation in this regard.

The fact of appropriate consultation is rated Compliance because Dr. Amado performs his function with precision and settlement-centered attention. Cambridge's fulfillment of his recommendations would be rated as Non-Compliance if the settlement had such a requirement.[115]

COMPLIANCE

EC 40
INTERNAL REVIEWER DESIGNATED

Compliance	**Non-compliance**

Administrative

EC 41
TIMELY NOTICE TO INTERNAL REVIEWER

Compliance	**Non-compliance**

[114] In addition, the Internal Reviewer reports that he did not receive timely notice of the January 18, 2013 incident involving client E.B. at Cambridge, or January 16 and 17, 2013 incidents at the transitional home. These, however, were not restraint incidents. Interview with Stacy Danov, May 6, 2013.

[115] The failure to implement the recommendations, however, is a consideration in the overall faulting of DHS regarding positive behavior supports and person-centered planning.

Instrumental

EC 42
INTERNAL REVIEWER CONSULTATION

Compliance	Non-compliance

Instrumental

RECOMMENDATIONS

15. *Cambridge should internally monitor its own implementation of the Internal Reviewer's recommendations for timeliness and content.*

EC 43 – 51

VII.B. INTERNAL AND EXTERNAL REVIEW EXTERNAL REVIEWER

SETTLEMENT LANGUAGE

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 set forth in Minn. Stat. § l44A.53, *et. seq*.
SUPPLANTED BY COURT ORDER, QUOTED BELOW

FACTS

1. The parties were unable to identify an External Reviewer and, therefore, at the Court's suggestion, agreed that the Monitor would be the External Reviewer.

2. The Court ordered on April 25, 2013:

> The external reviewer function, as set forth in the Stipulated Class Action Settlement Agreement at paragraph VII.B (External Reviewer) will be subsumed within the Monitor's role as originally set forth in the Court's July 17, 2012 Order, at which time the Court appointed David Ferleger as the Court's independent consultant and monitor.

3. The delay in resolving the External Reviewer issue meant that months elapsed without an independent assessment with a review and comment period.

DISCUSSION

There is an External Reviewer.

COMPLIANCE

EC 43 – 51
EXTERNAL REVIEWER

Compliance	**Non-compliance**

RECOMMENDATIONS

None.

EC 52 – 53

VII.B. INTERNAL AND EXTERNAL REVIEW INTERESTED PARTIES ACCESS TO FACILITY

SETTLEMENT LANGUAGE

7. 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 and pursuant to the Protective Order in this case.

FACTS

1. The Office of Ombudsman for Mental Health and Developmental Disabilities has exercised its access to Cambridge and has issued reports regarding its site visits.

2. The Monitor is not aware whether Plaintiffs' Counsel and/or the Disability Law Center have accessed Cambridge. Plaintiffs' Counsel has vigorously sought and obtained various documents and records regarding compliance, although there have been disputes – heated at times -- regarding timeliness and completeness of some of DHS' responses.

3. The Monitor has not received any complaints by those named in this requirement regarding their access to the facility.

DISCUSSION

The requirement is for physical access to the Cambridge facility. There is no indication that such access has been limited or denied. EC 52 guarantees access and EC 53 references exercise of access. The two criteria are combined below.

COMPLIANCE

EC 52 – 53

ADVOCATE ACCESS TO FACILITY

Compliance	**Non-compliance**

Instrumental

RECOMMENDATIONS

None.

EC 54 – 60

VIII. TRANSITION PLANNING

SETTLEMENT LANGUAGE

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 person's 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 permitted to 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 placement alternatives. It is the State's goal that all residents be served in integrated community settings with adequate protections, supports, and other necessary resources which are identified as available by service coordination. 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).

FACTS

1. DHS' Status Reports to the Court do not demonstrate compliance with the Transition Planning requirement, nor do any of the individual client "discharge plans" for individuals who have left the facility, nor do the reports of DHS' Internal Reviewer. DHS' letter to the Monitor immediately before this review did not identify the Transition Planning requirements as being in compliance, and instead suggested a delay in compliance review.

2. DHS' Status Reports include "Discharge Plans," but no "Transition Plans." No procedure or policy for Transition Planning exists.

Cambridge's Procedure No. 15864 ("Discharge Procedure," eff. 1/15/13) provides for a "discharge summary," but not a Transition Plan. That procedure does not reference nor does it embody any element of person centered planning or positive behavior supports.

3. The two clients admitted and discharged in December 2012, the Internal Reviewer found that in "both cases there appeared to be no planning consistent with *Olmstead*."[116]

4. DHS' Bi-monthly Reports to the Court state that DHS is "continuing to plan for improving the transition planning process," with – as stated in two reports – "anticipated full implementation" by March 31, 2013. The process was not defined by March 31, 2013 or by the submission of this report. The process has not been adopted and, thus, it has not been implemented.

5. Gaps between the County service systems and DHS hinder effective and timely transition planning and the development of appropriate individual placements. Inadequate action on the part of County Case Managers slows the process. Clients are deemed ready for community placement several weeks to months prior to the identification of a community placement that will accept them. [117]

6. The following is an example of the discontinuities in the system. A client was admitted to Cambridge on December 21, 2012. For the 14 days before his commitment, he was held in the Emergency Room at St. Mary's Hospital in a "small room with no windows" simply on account of his developmental disabilities commitment. He left Cambridge a few days later, with "no evidence" at Cambridge of "*Olmstead* compliant planning,"[118]

7. Consultants Dr. Bambara and Brown recommended that it be considered whether the Cambridge facility is necessary:

   Consider whether the Cambridge Program is necessary. In our opinion, although it is sometimes necessary to remove individuals who have dangerous behaviors from the setting in which severe challenging behaviors occur, the primary purposes of Cambridge (e.g., crisis stabilization and transition planning)

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[116] *Internal Reviewer Monthly Report* (December 2012).

[117] Dr. Edwin Mikkelsen Report (May 15, 2013).

[118] *Internal Reviewer Monthly Report* (December 2012).

can be achieved in alternative community settings while ensuring individual and community safety. Removing individuals from community settings is inconsistent with implementing person-centered practices with the goal of preparing individuals to live in the most integrated setting (Bulletin #12-76-01).[119]

8. According to Dr. Mikkelsen, the "function of the MSHS-Cambridge could be carried out in more community residences" with appropriate enhancements."[120]

DISCUSSION

There is no contention that DHS complies with these requirements. The 27 clients discharged since approval of the settlement have been denied the benefit of a person centered placement process with all the other safeguards specified in EC 54-60. Going forward with the "most integrated setting" and *Olmstead* principles in mind, DHS and Plaintiffs agree with the Monitor's consultants that the functions of the Cambridge facility can beneficially be carried out in community residences.

"The Department agrees that more work is needed regarding Transition Planning."[121]

After attending a discharge planning meeting, the Internal Reviewer observed, "In spite of the presence of some person centered language during the meeting, the community arrangement chosen to receive the discharge was not selected using a person centered plan of any sort. The county providing case management arranged for him to go to the next-available-and-willing program with an empty

Defendants 6/4/13 Response to Draft Report

". . . the Department agree[s] that the Department should retain an outside consultant to specifically address transition planning." The consultant – to be retained by June 30, 2013 -- will be "responsible for designing and assisting in the implementation of a new transition planning program that is consistent with the *Olmstead* principles, the Settlement Agreement and best practices."

"Further, the Department agrees with the Court Monitor's recommendation that there must be state-wide training on Transition Planning that includes both State and County staff. The Department will address this recommendation, in detail, in its updated implementation plan that will be submitted on or before June 30, 2013."

[119] Dr. Brown and Dr. Mikkelsen Report (May 20, 2013) at 14.

[120] Dr. Edwin Mikkelsen Report (May 15, 2013) at 39.

[121] Defendants' 6/4/13 Letter at 11.

bed."[122]

County case management must be revised to enable compliance. Transition planning will not likely be timely or effective unless DHS exerts maximum regulatory and funding leverage to ensure cooperation and action by its counterpart County systems. As the Monitor's expert observed after discussions at Cambridge, "One factor that complicates and can delay a MSHS-Cambridge residence to a community setting is the variable resources of the respective individual's county of origin, which is responsible for both developing and financing this program."[123]

While attention is now being paid to Transition Planning, it is unacceptable that this critical requirement was not prioritized and implementation begun much earlier.

COMPLIANCE

EC 54
ENSURE MOST INTEGRATED APPROPRIATE SETTING
BEST EFFORTS

Compliance	**Non-compliance**

Quality of Life

EC 55
ACTIVELY PURSUE DISCHARGE WITH TRANSITION PLANS

Compliance	**Non-compliance**

Quality of Life

EC 56
FAMILY ACTIVELY INVOLVED

Compliance	**Non-compliance**

Quality of Life

EC 57

[122] *Internal Reviewer Monthly Report* (March 2013).

[123] Mikkelsen Report at 39.

PERSON CENTERED PLANNING AT EACH STAGE

Compliance	**Non-compliance**

Quality of Life

EC 58
RESIDENT CHOICE

Compliance	**Non-compliance**

Quality of Life

EC 59
BEST EFFORTS FOR PLACEMENT ALTERNATIVES

Compliance	**Non-compliance**

Quality of Life

EC 60
IMPLEMENT IN ACCORD WITH *OLMSTEAD*

Compliance	**Non-compliance**

Quality of Life

RECOMMENDATIONS

16. *In the area of providing person centered planning and practices and to ensure compliance with the Settlement Agreement by the Counties, DHS should exert maximum regulatory and funding authority to ensure cooperation and action by its counterpart County systems. This should be done on an urgent or emergency basis, minimizing red tape.*

17. *To the extent it would assist DHS in implementing the above recommendation to have a court order in place in this regard, DHS should come forward immediately to suggest the terms of such an order.*

18. *DHS should immediately engage an outside consultant individual or firm, approved by the Monitor and Plaintiffs, to draft the Transition Planning process and any needed forms, with a 40-day target for completion.*

19. *State-wide training on Transition Planning, including both State and County staff, should be implemented promptly. Such training should be under a written training plan, reviewed in advance by the Monitor, Plaintiffs and the consultants. The plan should specific in terms of directing training resources at identified audiences, providing start and end dates for training to occur, training locations, specifying the curricula and the level of competence desired in those being trained.*

EC 61 – 65

IX.A.B. OTHER PRACTICES
STAFF TRAINING

SETTLEMENT LANGUAGE

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 into this Agreement by reference. All training shall be 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).

B. 1. Staff at the Facility shall receive the specified number of hours of training subsequent to September l, 2010 and prior to 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."

2. Staff at the Facility shall receive the specified number of hours of training subsequent to September 1, 2010 and prior to March 31,2012:

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

FACTS

1. In a prior review, the Monitor faulted DHS for failure to fully

implement this requirement.[124] Defendants were in non-compliance and had not meet the mandated deadlines, did not meet the requirements that all staff be trained and that staff did perform restraints without the training that was required The situation has changed.

2. Current staff at Cambridge have received the currently required training, with a single exception.[125]

3. DHS has an organized system for tracking compliance with this requirement.

4. Training is provided on a curriculum organized and approved by Dr. Richard Amado, the Internal Reviewer. An outside consultant, who is an expert in person centered planning, has also provided training. Plaintiffs' Counsel has sought and obtained from DHS the training materials and expressed some criticism of the training for failing to encompass certain elements of any training course.

5. The Monitor notes that this is not a review of staff fidelity to the training they received.

DISCUSSION

The Monitor shares Plaintiffs' Counsel's structural concern with the training system, in part, but notes that the settlement agreement and its attachment on training do not speak to that concern. The settlement agreement does speak to the content of the training and there appears to be no disagreement that the content adheres to the requirements.

There is an unfortunate disjunction between the support in place at Cambridge and the training in person centered planning and person centered thinking. Staff are learning to do person centered plans, but no person centered plans are being developed for any of the Cambridge residents. DHS is still in the planning phase for implementing that piece.

This specific evaluation criterion does not discuss staff implementation of

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[124] Monitor's *First Quarterly Report to the Court* (September 4, 2012), Dkt. 163.

[125] Ex. 130 to Defendants' Status Report to the Court (March 18, 2013), Dkt. 202. Training is currently deficient for one person (T.B.), a manager for the transitional home (not Cambridge), and one person (C.W.) who requires the 3 additional hours which had been missing, as of the Monitor's earlier report.

what they have been taught, so non-compliance is not the rating at this time. In the future, however, carry-over to client care (which may be called, fidelity) will be studied as an element of review of implementation of person centered planning and thinking.

With regard to the delivery of the settlement-required training, Defendants are in compliance.

COMPLIANCE

EC 61
TRAINING INCLUDING PERSON CENTERED & OTHER

Compliance	**Non-compliance**

Instrumental

EC 62
TRAINING IS BEST PRACTICES

Compliance	**Non-compliance**

Instrumental

EC 63
SPECIFIED TRAINING BEFORE 12/31/11

Compliance	**Non-compliance**

Instrumental

EC 64
TRAINING BEFORE RESTRAINT INVOLVEMENT

Compliance	**Non-compliance**

Instrumental

EC 65
SPECIFIED TRAINING BEFORE 3/31/12

Compliance	**Non-compliance**

Instrumental

RECOMMENDATIONS

20. *Given this Report's findings regarding person centered planning and*

the treatment/activities at Cambridge, DHS should consider whether changes in the training requirements, or implementation of the training, is advisable and submit any recommendations to the Monitor and Plaintiffs' counsel. In doing so, DHS should consider the Plaintiff Class' prior critiques of the training program.

21. *When person centered plans are developed for Cambridge residents, the planning meetings should be facilitated by professionals experienced in both development and implementation of such plans, to model person centered planning for Cambridge staff. In-class training should not be considered a sufficient basis for actualizing person centered planning.*

IX.C. OTHER PRACTICES
VISITOR POLICY

SETTLEMENT LANGUAGE

C. **Visitor Policy.** The State and DHS shall permit residents unscheduled and scheduled visits with immediate family and/or guardians, at reasonable hours, unless the Interdisciplinary Team (IDT) reasonably 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 reasonably determines this is contraindicated.

FACTS

Three Policies

1. A very restrictive and non-compliant visitor procedure was in effect at the time of the settlement. The non-compliant policy was provided to the Court September 17, 2012.[126] It was effective September 15, 2009 and titled, "Client Care – Visitor Procedure" and numbered Procedure No. 15899.

2. The non-compliant policy continued for 10 months into the settlement period, through to at least October 8, 2012, On November 17, 2012, a new visitor procedure, No. 15899, was provided to the Court, stating that it was effective October 8, 2012; it is identified as Procedure No. 15899 ("Client Care") and states that it supersedes the 2009 policy.[127] This policy generally complies with the Settlement Agreement standards.

3. There is a third procedure as well, which is the only Visitor procedure

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[126] Ex. 13 ("Client Care – Visitor Procedure," Procedure No. 15899, eff. September 15, 2009).This is also Ex. 66A to Defendants' Status Report to the Court, Dkt. 165-14 (September 17, 2012).

[127] Ex. 14 ("Client Care: Involvement with Family, Guardian and Friends," Procedure No. 15899, eff. October 8, 2012). This is Ex. 106 to Defendants' Status Report to the Court, Dkt. 180-10 (Nov. 17, 2012).

in the formal Cambridge Administrative Procedures book. The Settlement Agreement's provisions are contradicted in important respects by this third procedure, the existing Cambridge Procedure No. 15091 (Client Care: Visits, Outings and Vacations for MSHS-Cambridge Clients, eff. 11/5/10). This procedure was not explicitly superseded when the 2012 procedure was formulated.

4. It appears that the 2009 procedure is no longer in effect. However, it also appears that the 2012 procedure provided to the Court has not filtered down to Cambridge, which represents that the non-compliant 2010 procedure is in effect.

A Client's Visitation Guidelines

5. During the May, 2013 review, a two-page "Visitation Guidelines" dated January 16, 2013 for client JL was found in his chart. Among other things, it requires that "visits will be directly supervised by MSHS staff," and that there be "at least a two day notice" for on-campus visits, and "5 days" advance notice for off-campus visits. The Guidelines were "Written by [Staff Name], Behavior Analyst 1." Neither the Guidelines nor the client's Individual Treatment Plan note that the Interdisciplinary Team made any determinations regarding these restrictions. The Guidelines do not include any explanation or justification for any of the restrictions.

General

6. Plaintiffs' Counsel at one point alleged that there were instances of denial of visitation but no specific information was provided (*e.g.,* date/s, names of client and visitors, *etc*.).

7. On February 1, 2013, Cambridge was found in non-compliance by DHS Licensing for denying clients access to the kitchen and laundry room areas of a home; staff provided contradictory reasons for the locked doors.[128] The settlement agreement provides visitor access, and does not address the client access which is addressed by DHS Licensing.

DISCUSSION

Based on what has been filed with the Court, Defendants were in non-compliance until the new procedure was issued October 8, 2012. It is troubling that DHS, as *per* its filing with the Court as the current policy,

[128] DHS Licensing, *Correction Order* (Feb. 1, 2013) at 9.

maintained the obviously non-compliant 2009 procedure for 10 months after the Court's adoption of the Settlement Agreement.

However, the only procedure represented formally at Cambridge as in effect is the 2010 non-compliant procedure in its official procedures book. This procedure was not provided to the Court or explicitly negated in the 2012 procedure.

Defendants' policy was in non-compliance for 10 of the 17 months since approval of the settlement agreement. This cannot be considered a minor matter. Family and friend visitation to Cambridge clients are an important connection to clients' communities, which are typically far from Cambridge; the restrictive 2009 procedure does not comply with the settlement agreement.

That the 2010 procedure is officially in place at Cambridge adds a layer of confusion. Of course, a pre-settlement procedure (very different from the 2012 procedure presented to the Court) cannot be said to comply with the settlement.

EC 66 and 68 are rated non-compliant on account of the January 16, 2013 restrictions for JL (requiring scheduled and supervised visits), which are not documented as determined by the Interdisciplinary Team. Since the JL restrictions do not reference the location/extent of visits, EC 67 is rated as compliant based on the current 2012 procedure which the Monitor will accept is in effect.

The individual's January 16, 2013 Visitation Guidelines violate the settlement agreement. It may well be that the restrictions comport with some treatment or security needs. The Monitor is aware, for example, that clients committed under Criminal Rule 20 may present specific concerns. However, the settlement requires that such determinations be made by the Interdisciplinary Team; there is no indication that the Team made those determinations.

COMPLIANCE

EC 66
VISITORS PERMITTED

Compliance	**Non-compliance**

Quality of Life

EC 67
VISITOR FULL ACCESS

Compliance	Non-compliance

Quality of Life

EC 68
PRIVATE VISITATION

Compliance	Non-compliance

Quality of Life

RECOMMENDATIONS

22. DHS should immediately resolve the questions presented by Cambridge's inclusion of the 2010 visitation procedure as current, and explain to the Monitor whether and how staff were informed of, and trained on, the 2012 procedure filed with the Court.

23. All staff should be specially trained on the 2012 procedure and informed that all prior procedures are no longer in effect.

24. All visitation restrictions should be reviewed by senior Cambridge staff for compliance with the 2012 procedure.

25. No visitation restrictions should be maintained or imposed without thorough consideration and explanation by the Interdisciplinary Team, with participation of the client, family and legal representative.

26. As a safeguard and temporarily until December 31, 2013, Plaintiffs' Counsel and the Monitor should receive documentation of any visitation restrictions.

EC 69 - 71

IX.D. OTHER PRACTICES AT THE FACILITY NO INCONSISTENT PUBLICITY

SETTLEMENT LANGUAGE

> D. Upon Court approval of this Agreement, the State and DHS will discontinue any marketing of, recruitment or publicity inconsistent with the mission of the Facility.

FACTS

1. The State and DHS are not marketing or recruiting for individuals to be admitted to Cambridge. There are no brochures advertising Cambridge.

2. The current mission of Cambridge is described in a formal document, adopted December 31, 2012.[129] This bulletin defines the purpose of MSHS' Cambridge's program, its admission and continued stay and discharge criteria. It emphasizes the intended short-term nature of services at Cambridge, and that Cambridge's goal is that "all individuals be served in integrated community settings with adequate protections, supports, and other necessary resources which are identified as available by service coordination." A 90 to 180 day maximum length of stay is contemplated.

3. During the May 2013 review, several direct care staff were asked whether they knew anything about Cambridge's admissions policy. None did.

4. Cambridge maintains as "current" a February 5, 2010 procedure titled "MISSION STATEMENT," which is not consistent with the current mission of the facility and which pre-dates the settlement agreement. This procedure is in the Cambridge Administrative Procedures book.

DISCUSSION

The Monitor does not consider establishment and dissemination of admission and discharge policies to be "marketing or recruiting." Potential clients come to the attention of DHS through referrals from community programs or from

[129] *See* Ex. 2, *supra* (Bulletin #12-76-01, *MSHS-Cambridge: Admission and Discharge Criteria, Crisis Stabilization Services, and Transition Planning*, adopted December 31, 2012), Dkt, 202-2.

other state facilities. Some clients are committed to Cambridge by the courts criminally or civilly.

The simultaneous existence of both the 2012 admission/discharge bulletin and the 2010 procedure are potentially confusing. However, the 2012 bulletin, issued state-wide over the Deputy Commissioner's signature, likely dissipates any confusion which the Cambridge-only 2010 procedure might generate.

COMPLIANCE

EC 69
MARKETING, RECRUITMENT & PUBLICITY

Compliance	Non-compliance

Instrumental

EC 70
MISSION CONSISTENT WITH SETTLEMENT

Compliance	Non-compliance

Quality of Life

EC 71
PUBLICITY AND MISSION ARE CONSISTENT

Compliance	Non-compliance

Instrumental

RECOMMENDATIONS

27. Provide all Cambridge staff with a copy of Bulletin #12-76-01 and provide training to both MSHS-Cambridge staff and to community case management administrators and case managers on the Bulletin's intent and content.

28. Withdraw the 2010 Cambridge policy titled, "Mission Statement."

IX.E. OTHER PRACTICES AT THE FACILITY POSTING REQUIREMENTS

SETTLEMENT LANGUAGE

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.

FACTS

1. The Health Care Bill of Rights is posted on both sides of Homes 7 and 8 (each being half of one building), taped to the inside of the office glass, with just the first page of the nine page document visible to the common area.

2. The Health Care Bill of Rights is posted on both sides of Homes 3 and 4 (each being half of one building), taped to the inside of the office glass, with each of the nine page document side-by-side up against the top of the office glass, facing the common area but too high for one to read the text. *See* photo below.

3. The same single space document is hanging next to the table at which visitors sign in, inside the administration building.

4. DHS posts the verbatim Bill of Rights statute, single space and in the verbatim legislative language which is not likely to be understandable to clients or most non-lawyers. The legislative language would be confusing to the young adults at Cambridge (and probably friends and family). For example, the definitions define "patient" differently from "resident" and, in discussion of just these two words, contain more than a dozen cross-references to other statutes and subdivisions. Subdivision 33, titled "Restraints," discusses only restraints in a nursing home.

5. Not posted in each of the four Homes is the name and phone number of the person within the Facility to whom inquiries about care and treatment may be directed.

6. Not posted in each of the four Homes is 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.

7. Cambridge was sited by DHS Licensing on February 1, 2013 for failure to inform two clients' legal representatives of all their policies and procedures required.[130]

DISCUSSION

"The Department agrees with the Report's findings and related recommendations."[131] Revisions are to be posted and provided by June 30, 2013.

The posting of the Bill of Rights is to inform residents and family/guardians of protections afforded by law, and is a safeguard of those rights.[132] Although not present in the statute, a requirement that the "form and content" be "understandable" by residents and family/guardians is included in the evaluation criteria.

Posting of multiple small print pages with the technical legislative language, which DHS chooses to do, is not likely to be understandable in context. The height at which the pages are posting (in two Homes), and the "one page visible" method (in the other two Homes) raises a question of whether they were intended to be readable. A compliant response to the settlement requirement, for example, would be a print poster, with natural language, and perhaps with graphics and examples.

The settlement includes the additional requirements of posting the name and contact information of a person at Cambridge to whom inquiries on treatment may be made, and a description of how a complaint to the Office of Health

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[130] Minnesota Department of Human Services, DHS Licensing, Correction Order, Cambridge, February 1, 2013.

[131] Defendants' June 4, 2013 Letter at 5.

[132] Defendants state that they provide a handbook to clients on admission. Defendants' Status Report to the Court (March 18, 2013), Dkt. 202. The Handbook can be found at attachment 72A to the Defendants' Status Report to the Court (September 17, 2012), Dkt. 165.

The court requirement, however, is for posting. Continuous posting provides immediate information. A handbook may be lost or forgotten during months of stay at Cambridge.

Facility Complaints may be made. These postings were not present in any of the Homes.[133]

COMPLIANCE

EC 72
NOTICE OF RIGHTS IS POSTED

Compliance	Non-compliance

Instrumental

EC 73
NOTICE OF RIGHTS IS UNDERSTANDABLE

Compliance	Non-compliance

Instrumental

RECOMMENDATIONS

29. The Health Care Bill of Rights should be redone for posting in language appropriate to the reading level of Cambridge clients, and with significant use of graphics and examples for those who may have difficulty with the text. A poster format might be considered.

30. The name and phone number of a person at Cambridge to whom inquiries on treatment may be made, and a description of how a complaint to the Office of Health Facility Complaints may be made, should be posted.

[133] In one location, the standard letter titled "Welcome" is posted; a line at the end provides Director Steve Jensen's name and phone number. This does not comport with the special posting required by the settlement agreement.

EC 74 – 82

X.A. SYSTEM WIDE IMPROVEMENTS EXPANSION OF COMMUNITY SUPPORT SERVICES

SETTLEMENT LANGUAGE

1.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 seventy five (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 three (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 with 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 will be targeted to prepare for increased community capacity to support individuals in their community.

FACTS

1. On system-wide improvements related to "expansion of community services," the settlement agreement includes the sections quoted above, which are labeled "goals and objectives," but are not requirements.[134] These settlement provisions are identified as "not requirements" in EC 74 to 82.

[134] Section X.A.1 identifies Sections X.A.a., b. & c. as "goals and objectives," and not "requirements."

2. The Monitor did not verify compliance with these provisions because they are not "requirements" of the Settlement Agreement. Also, review would require on-site verification state-wide of DHS' compliance with these diverse provisions.

DISCUSSION

The expert reviewers' findings are that there is cause for concern that the "goals and objectives" of these provisions are not being met. Compliance at MSHS-Cambridge would appear to benefit from improvement in the areas covered in these community support settlement provisions. In addition, these community support services are highly relevant to the planned re-allocation of Cambridge facility resources to dispersed homes in the community.

The described activities include:

- long term monitoring of individuals and to provide systemic strategies and prevent multiple transfers of individuals,
- crisis management "where the consumer lives," including mobile wrap-around response teams located state-wide, with a three-hour maximum response time, and
- staff training at a community-based level in person centered thinking, positive behavior supports, and other skills to increase community capacity to support individuals in the community.

COMPLIANCE

For the reasons stated above, no compliance findings are made. These are "goals and objectives," not requirements. However, there is a link between weaknesses in the community, and deficiencies at Cambridge. As recommended immediately below, it would be protective of the Plaintiff Class for these provisions to be mandatory.

RECOMMENDATIONS

31. *It is recommended that the parties agree to convert these community expansion provisions to requirements of the Settlement Agreement.*

32. *Absent agreement of the parties, it is recommended that the Court consider whether these or similar community expansion provisions should be adopted as additional relief or as a remedy for non-compliance with other requirements of the Court's mandate.*

EC 83 – 84A

X.A. SYSTEM WIDE IMPROVEMENTS ADDITIONAL COMMUNITY STAFF

SETTLEMENT LANGUAGE

2. Expansion of CSS will begin in February of 2011 with an estimated completion date of June 30, 2011. This increase will be an additional fourteen (14) full time equivalent positions which will equate to fifteen (15) people. The proposed positions are as follows:

Two (2) Behavior Analyst 3 positions;
One(1) CommunitySeniorSpecialist3;
Two (2) Behavior Analyst 1;
Five (5) Social Worker Specialist positions; and
Five (5) Behavior Management Assistants.

Total cost of salaries for these staff is estimated by DHS to be eight hundred twenty three thousand dollars ($823,000). The estimated cost of equipment and space is estimated by DHS to be one hundred seven thousand eight hundred dollars ($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.

FACTS

1. DHS has hired the requisite number of additional staff for Community Support Services. These hires benefit the state's community system generally and may indirectly affect review referrals to Cambridge and service for potential clients at Cambridge, as well as referrals for community or other placement.

2. The positions continue to be filled.

3. DHS has hired as "behavior analyst" individuals who fail to meet the settlement-required qualifications as behavior analysts.

DISCUSSION

During the initial phase of implementation, DHS hired the requisite number of professional staff to enhance community services administration and field staff. None of those positions is vacant.

An additional Evaluation Criterion 84A is added here to address behavior analyst qualifications. Behavior analysts are specially trained to collect and analyze data to formulate and assist in implementation of plans to address behavior issues for people with developmental disabilities. These behavior issues affect individual's quality of life. At the time the evaluation criteria were developed, it was not expected that the settlement agreement's definition would be an issue. Soon, however, in discussions with the parties it developed that DHS itself acknowledges that some staff with the title "behavior analyst" do not meet the settlement-required definition. DHS suggested that it propose a modification of the definition. No modification has been suggested.

Defendants concur that there is non-compliance in this regard. "The [Monitor's] Report states that behavior analysts hired by the Department do not have the qualifications required by the Settlement Agreement. (Report, p. 110.) The Department agrees with this finding."[135] The Department is planning some steps to improve the situation but these will not lead to compliance in the near term.

COMPLIANCE

EC 83
HIRING ADDITIONAL COMMUNITY PROFESSIONALS

Compliance	Non-compliance

Instrumental

EC 84
NO VACANCIES IN ADDITIONAL COMMUNITY HIRES

Compliance	Non-compliance

Instrumental

EC 84A
BEHAVIOR ANALYST QUALIFICATIONS MET

Compliance	Non-compliance

Instrumental

RECOMMENDATIONS

[135] Defendants' June 4, 2013 Letter at 6.

33. A vigorous effort to recruit qualified behavior analysts should be undertaken, including national searches and salaries and benefits sufficient to attract appropriate candidates.

34. DHS should consider joint (or separately funded) educational programs with universities and other organizations, and other longer-term efforts to provide needed credentialing and experience in behavior analysis to supplement the currently available pool in this field.

35. For current DHS employees, at Cambridge and other institutions and in the community, DHS should consider subsidizing enrollment in educational and certification programs in behavior analysis.

EC 85 - 88

X.B. SYSTEM WIDE IMPROVEMENTS – OLMSTEAD PLAN

SETTLEMENT LANGUAGE

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 recommendations within ten (l0) months of the Court's Order approving this Agreement. Within eighteen (18) 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 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.

FACTS

1. The *Olmstead* Planning Committee was established with a first meeting occurring on March, 7, 2012. [136]

2. Public Recommendations were included in the document: *The Promise of Olmstead: Recommendations of the Olmstead Planning Committee* dated October 23, 2012.[137] By its own admission, this report was incomplete, did not address key areas (such as transportation and the elderly), did not provide resolution of issues such as waiting lists, and was missing detail, deadlines and resolution of resource issues.

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[136] Defendants' *Status Report to the Court* (March 18, 2012), Dkt. 202.

[137] Ex. 109 to Defendants' *Status Report to the Court* (November 19, 2012), Dkt. 189.

Plaintiffs complained that the report was provided to lobbyists before it was provided to committee members.

3. Governor Dayton issued Executive Order 13-01[138] on January 28, 2013, which established an *Olmstead* Sub-cabinet to develop Minnesota's *Olmstead* Plan. The Sub-cabinet met on January 29, 2013 and February 20, 2013 and will continue to meet monthly on the second Tuesday of the month.

4. The Sub-cabinet has not retained staff or other assistance from either an individual or an organization which has experience in a large state in developing an *Olmstead* plan. As the draft of this report was being written, the Monitor was informed on May 16, 2013 that the Sub-cabinet is considering retaining consultants.

5. Plaintiffs and others have vigorously objected to the manner in which the planning committee's recommendations were developed and presented, and, more recently, to the workings of the Sub-Cabinet under the Governor's Order.

6. There is concern that the Governor's Order distances itself from this litigation. The Executive Order was a positive step. The Governor's Order acknowledges the imperative to provide services and supports in the most integrated setting, and speaks to the importance of community services. The Order is, however, lacking in several respects.

    - It does not mention this litigation.
    - It does not acknowledge that, under the court's decree in this case, "the State and the Department shall develop and implement" the plan.
    - The plan and its implementation are subject to Court approval, monitoring and enforcement.
    - The Governor's Order does not direct the Sub-cabinet to submit the Plan to the Court for review and approval.

The above omissions, together the *Olmstead* Planning Committee report having questioning whether there is even an obligation for an Olmstead Plan, are cause for concern.

7. Minnesota's *Olmstead* Plan has not been developed. The Plan is due to be presented to the Court this Fall. It seems quite possible that the

[138] Ex. 133 to Defendants' *Status Report to the Court* (March 18, 2012), Dkt. 202.

Plan will be delayed beyond the current November 1, 2013 deadline, as DHS reported this month that it "in the process of securing additional experts to assist it in developing the substantive components and format of Minnesota's Olmstead plan."[139]

8. The Olmstead Plan will be comprehensive, will cover nearly all State Departments, and all people with disabilities, and will include measurable goals. The Plan must then be implemented state-wide. Implementation will of necessity take many months.

DISCUSSION

Defendants' Lack of Response
So far as the Monitor is informed, the Governor, Lieutenant Governor, the Olmstead Plan sub-cabinet, and its staff were not informed of the Monitor's comments in the draft of this Report. Defendants' response to the draft did not acknowledge or respond to the above criticism of the Executive Order.

The Governor's Order does not acknowledge that, under the court's decree in this case, "the State and the Department shall develop and implement" the plan. The plan and its implementation are subject to Court approval, monitoring and enforcement. Also, the Governor's Order does not direct the Sub-cabinet to submit the Plan to the Court for review and approval. These omissions, together with the *Olmstead* Planning Committee questioning whether there is an obligation for an Olmstead Plan, are cause for concern.

The absence of Defendants' response (see inset above), especially considering the Court's highlighting its concern in the Order of April 25, 2013 establishing this compliance review, supports the need for the Court to attend to ensuring appropriate development, review and approval of the Olmstead Plan.

Plaintiffs' Counsel and others have objected in detail to the manner in which the Planning Committee's final report was adopted and presented, and to some of its content. Plaintiffs maintain their strong objection to the Olmstead Planning Committee failing to "to develop a proposed plan or any consensus recommendations" and they object to the final document that "DHS, held out as the work of the committee, when the committee was never provided with a proposed final document to review and consider."[140] In this instance, as on Rule 40, Plaintiffs object to being excluded from, or ignored, in various

[139] Defendants' June 4, 2013 Letter at 6.

[140] Plaintiffs' 6/4/13 Letter at 13.

elements of the development process. Resolution of these concerns is not necessary within the context of the Court's charge for this report.

The Monitor expects to receive and review the *Olmstead* Plan for its adequacy and its compliance with the "comprehensive" standards articulated in the settlement agreement, and also to review implementation of the plan. At that point, it may be appropriate to consider deficiencies in its development, which have affected the product.

The Sub-cabinet has not retained staff or other assistance from an individual or an organization which has experience in a large state in developing an *Olmstead* plan. Note that the Executive Order permits retaining consultants. It may be that the Sub-cabinet is considering consultant use in the final phases of the planning.

The Plan is due to be presented to the Court this Fall. It seems quite possible that the Plan will be delayed beyond the current November 1, 2013 deadline, as DHS reported this month that it "in the process of securing additional experts to assist it in developing the substantive components and format of Minnesota's *Olmstead* plan."[141]

The *Olmstead* Plan will be comprehensive, will cover nearly all State Departments, and all people with disabilities, and will include measurable goals. The Plan must then be implemented state-wide. Implementation will of necessity take many months.

Recommendations were issued October 23, 2012, later than the October 5, 2012 due date. DHS did not request the Court to grant an extension of time.

COMPLIANCE

EC 85
OLMSTEAD PLANNING COMMITTEE ESTABLISHED

Compliance	**Non-compliance**

Instrumental

EC 86
OLMSTEAD RECOMMENDATIONS WERE ISSUED BY OCTOBER 5, 2012

[141] Defendants' 6/4/13 Letter at 6.

Compliance	**Non-compliance**

Instrumental

EC 87
OLMSTEAD PLAN IS DEVELOPED AND IMPLEMENTED

Not rated. The Plan is not yet developed

Compliance	Non-compliance

Instrumental

EC 88
OLMSTEAD PLANNING COMMITTEE MEMBERS

Compliance	Non-compliance

Administrative

RECOMMENDATIONS

36. The Governor's Order does not acknowledge that, under the court's decree in this case, "the State and the Department shall develop and implement" the plan. The plan and its implementation are subject to Court approval, monitoring and enforcement. Also, the Governor's Order does not direct the Sub-cabinet to submit the Plan to the Court for review and approval. The Governor's Order should be amended both to reference this litigation and to acknowledge the State's obligation under the Court's orders to development and implement the plan, as well as the obligation to submit the plan for the Court's review and approval and, once approved, for monitoring and enforcement.

37. Development of a comprehensive single Olmstead Plan that meets the standard established in the settlement agreement is a very complex task. The plan will affect individuals with all disabilities state-wide, and will necessarily affect multiple state agencies. DHS should consider whether there is a need to retain consultation from a person or organization with experience in the evaluation, formulation and implementation of Olmstead plans.

EC 89 - 93

X.C. SYSTEM WIDE IMPROVEMENTS – RULE 40

SETTLEMENT LANGUAGE

1. Within sixty (60) days from the date of the Order approving this Agreement, the Department shall organize and convene a Rule 40 (Minn. R. 9525.2700-.28lO) Advisory 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 advise the Department on how to 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 sixty (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.

FACTS

1. The first Rule 40 Advisory Committee Meeting took place on January 30, 2012.[142] No waiver of the Rule was requested for Cambridge.

2. The Department timely issued a Request for Comments regarding possible amendment to Rules Governing Aversive and Deprivation

[142] Ex. 89 to Defendants' *Status Report to the Court* (September 17, 2012), Dkt. 165..

Procedures in Licensed Facilities serving Persons with Developmental Disabilities.[143]

3. Defendants' Status Report to the Court[144] states that the Department and the Committee have continued to work and redraft the recommendations. As of the March 17, 2013 Status Report to the Court, the Department was waiting for the final issuance of the recommendations of the Rule 40 Committee. DHS states that draft legislation adopting many of the recommendations is pending.

4. There have been heated clashes within the Committee and outside it over both the process for drafting and approving the Committee's Rule 40 narrative, and the content of some of its provisions. The work is not done.

5. The Omnibus DHS Bill pending in the Legislature at the time of this writing erroneously include language inconsistent with the Rule 40 process, and with Department leadership intentions; the Department requested changes from the Conference Committee. Plaintiff Class counsel strongly disagrees with some language in the Bill, which permits a so-called 'transitional' use of restraints which are forbidden by the settlement agreement. Plaintiff Class Counsel also objects to its exclusion from the formulation of the legislative proposal.

6. Whether DHS contends that the Omnibus DHS Bill is, in any way, a product of the Rule 40 process or approved by the Rule 40 Committee, is unclear and should be clarified promptly.

DISCUSSION

The modernization of Rule 40, like the Olmstead Plan, was to have been a centerpiece of the state-wide impact of the settlement. The Rule 40 Committee work has been beset by internal disagreements and unresolved debate, and by claims of miscommunication and exclusion from decision-making. In recent weeks, legislation submitted in the Omnibus DHS Bill related to Rule 40 was reportedly not first vetted by the Rule 40 Committee and, aside from that, was not fully satisfactory to DHS leadership itself. The Rule 40 Committee should get is house in order and meet a fixed date for submitting its product to the Court.

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[143] Ex. 92A to Defendants' *Status Report to the Court* (September 17, 2012), Dkt. 165.

[144] Defendants' *Status Report to the Court* (March 18, 2013), Dkt. 202.

The Rule 40 Committee has not issued its planned report for Rule 40 modernization, including any rule or policy changes.

The issuance of the Rule 40 report has been unduly delayed without a formal explanation to the Court or the Monitor. It has been 14 months since the Committee first convened. The absence of the report merits a non-compliance finding on EC 90.

Defendants disagree with the non-compliance finding because "the Settlement Agreement contains no deadline for the issuance of the Rule 40 Advisory Committee's recommendations (Settlement Agreement, p. 19), and due to the serious nature of the Committee's work and the diversity of opinions of its members, the Committee's work has taken longer than originally anticipated."[145] The Department "anticipates" that the Committee will issue its final recommendations by June 30, 2013.[146]

The Importance of the Charge. The Rule 40 Advisory Committee is to "study, review and advise the Department" on how to "modernize" to reflect current best practices including positive behavioral supports, and the development of placement plans consistent with principles of "most integrated setting" and "person centered planning," and the Supreme Court's decision in *Olmstead v. L.C.* A variety of stakeholders are represented on the committee including parents, subject matter experts, DHS representatives, advocates and others. Settlement Agreement at §X.C., page 19; EC 90. The rule contemplates that, once the "advice" is given to the Department, there will be "administrative rule making."

Rule 40 Review

The Rule 40 Advisory Committee report, as well as subsequent action by DHS, will be judged against the terms of the Settlement Agreement, which include best practices in the field, principles under those of the Association of Positive Behavior Supports, the use of positive and social behavioral supports, and the development of placement plans consistent with the principles of the "most integrated setting" and person centered planning, and development of the *Olmstead* Plan.

The importance of the Rule 40 process is indicated in the "State's" goal (not simply DHS' goal) to utilize the Rule 40 Committee process to extend "the application of the provisions in this Agreement to all state operated locations

[145] Defendants' Letter of June 4, 2013 at 7.

[146] *Id.*

serving people with developmental disabilities with severe behavioral problems or others conditions that would quality for admission to METO, its Cambridge, Minnesota successor, or the two new adult foster care transitional homes." Recitals at ¶7, page 3.

Plaintiffs' Critique. Plaintiffs condemn the Rule 40 Settlement Agreement process as it has been implemented by Defendant DHS. The process is "an abject failure" with recommendations which were never provided to the committee members for discussion and agreement; the process "has failed miserably."[147] Plaintiffs assert that the court-ordered process "has been replaced by the DHS unilateral intention to include restraint and seclusion provisions in its narrative and in proposed legislation that it has sought to hide from the Rule 40 Committee and Settlement Class Counsel."[148]

Defendants' acknowledge a "diversity of opinions" of the Committee's members and the "serious nature" of its work.[149]

Monitor's Comments. The Monitor's emphasis on the current state of compliance, rather than on prior incomplete and often disputed process or on "promises" of future action, results in a "non-compliance" finding on Rule 40.

At this time, the Monitor will not evaluate the internal committee process or comment on Plaintiffs' description of the situation. Such an evaluation would require an evidentiary hearing on both the process and on whether the current not-yet-adopted draft "narrative" accurately represents the views of the committee.

There is no need for an immediate hearing, although continued delay may change the Monitor's view on that issue. It is sufficient that no report has been issued by the Committee after 14 months. As detailed by Plaintiffs, on Rule 40 and the associated DHS Omnibus Bill issue (see below), there does not seem to be a prospect for a quick resolution of this matter.

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[147] Plaintiffs' 6/4/13 Letter at 9-10. The failure includes "DHS repeatedly refusing to include the suggestions and consensus of committee members, unilaterally writing its own narrative, excluding the committee, and then taking the incredulous position that the current narrative represents the views of the committee." *Id.* at 9.

[148] Plaintiffs' 6/4/13 Letter at 10.

[149] Defendants' Letter of June 4, 2013 at 7.

As on the Olmstead Plan, there appears to be a need for the Court to attend to ensuring appropriate development, review and approval of the Rule 40 modernization.

DHS Omnibus Bill

The Court recently noted that there was an Omnibus DHS Bill moving through the state legislature in which it "appears that DHS has proposed a ban on all restraint and seclusion, EXCEPT for individuals with developmental disabilities." Order of April 25, 2013 (Dkt. 212). Four pages of Plaintiffs' 19 page June 4, 2013 letter are devoted to an appraisal of the original Bill, a hurried amendment process, and a conclusion that bill, as originally proposed and amended, violates both the Settlement Agreement and the civil rights of people with developmental disabilities.

Plaintiffs also object to what they describe as a "secret" process for submitting the Bill, and to DHS failing to heed or address Plaintiffs' serious objections and failing to keep the Court and Plaintiffs' properly advised.[150]

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[150] For example,

- "The DHS omnibus bill amendment language was submitted in secret, in derogation of the Rule 40 Settlement process, without notice to the Court, Settlement Class Counsel, the consultants, or the Rule 40 Committee, in violation of the civil rights of people with developmental disabilities." Plaintiffs' 6/4/13 Letter at 11.
- "Over the repeated objections of Settlement Class Counsel, and in direct violation of the Settlement Agreement, the DHS legislative position advocated the expressed, intentional disparate treatment of people with developmental disabilities in violation of their civil rights, allowing them to be mechanically restrained without qualification, possibly in leg irons and shackles, while other populations would be protected against such abusive civil rights violations." Plaintiffs' 6/4/13 Letter at 11.
- ". . . a "transition" period hidden within the DHS omnibus bill and not deleted by DHS after it expressly promised to remove language that excepted people with developmental disabilities from being restrained and secluded. In the recent party meeting, DHS leadership and counsel could not even advise Settlement Class Counsel whether the omnibus bill precluded any type of mechanical restraint, what safeguards, if any, the facilities using restraint and seclusion on people with developmental disabilities were employing, or a listing of the types of restraints used." Plaintiffs' 6/4/13 Letter at 13.

COMPLIANCE

EC 89
CONVENE RULE 40 ADVISORY COMMITTEE
BY FEBRUARY 5, 2012

Compliance	**Non-compliance**

Instrumental

EC 90
FUNCTION AND PRODUCT OF THE RULE 40 ADVISORY COMMITTEE

Compliance	**Non-compliance**

Instrumental

EC 91
BEST PRACTICES REVIEW

Compliance	**Non-compliance**

Instrumental

EC 92
PUBLIC NOTICE OF RULE MAKING INTENT
BY FEBRUARY 5, 2012

Compliance	**Non-compliance**

Instrumental

EC 93
NO WAIVER OF RULE 40 FOR FACILITY.

Compliance	**Non-compliance**

Instrumental

RECOMMENDATIONS

38. Whether DHS contends that the Omnibus DHS Bill is, in any way, a product of the Rule 40 process or approved by the Rule 40 Committee, is unclear and should be clarified promptly by DHS. Such clarification should specify which sections of the Omnibus DHS Bill were approved by the Rule 40 Committee, and when and how they were approved by the Committee.

39. The Rule 40 report should be submitted to the Monitor and Court by August 1, 2013.

EC 94 - 97

X.D. SYSTEM WIDE IMPROVEMENTS – MINNESOTA SECURITY HOSPITAL

SETTLEMENT LANGUAGE

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, psychopathic personality, 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 change in commitment status of any person originally committed solely as a person with a developmental disability without proper notice to that person's parent and/or guardian and a full hearing before the appropriate adjudicative body.
3. No later than December 1, 2011, persons presently confined at Minnesota Security Hospital who were committed solely as a person with a developmental disability and who were not admitted with other forms of commitment or predatory offender status set forth in paragraph 1, above, shall be transferred by the Department to the most integrated setting consistent with *Olmstead* v. *L.c.,* 527 U.S. 581 (1999).

FACTS

1. Defendants report in their Status Reports to the Court[151] that there have been no transfers or placements of persons committed solely as a person with a developmental disability.

[151] Defendants' *Status Report to the Court* (March 18, 2013),Dkt. 202.

2. At the time of their September 19, 2012 Status Report to the Court, Defendants reported that there were three individuals who resided at the Minnesota Security Hospital who were committed solely with a developmental disability. As of the Defendants' January 17, 2013 Status Report to the Court, Defendants report that all three individuals have been transitioned to the community.[152]

3. The transfer of three individuals from MSH to the community was accomplished without a person centered plan and without an *Olmstead* analysis. There is no evidence that the transfers took place with the required Transition Planning under the settlement.[153]

DISCUSSION

This settlement provision is clearly intended to prevent individuals with developmental disabilities from institutionalization at the Minnesota Security Hospital, a secure facility for individuals committed as mentally ill and dangerous. Care at MSH was criticized recently by the Office of the Legislative Auditor, and inadequate psychiatric staffing has been the subject of recent press accounts.

Individuals with developmental disabilities may have co-occurring mental illness. The extent to which one or the other affects the person's life varies, of course, by the individual. The level and nature of needed support or treatment also varies individually. This is a nuanced question for each such person.

The settlement agreement language, "committed solely" as a person with developmental disabilities (emphasis added) essentially dismisses consideration of any individual situation. If the commitment to MSH is both for developmental disabilities and another disability/condition, then the protections otherwise in this paragraph evaporate.

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[152] *Id.*

[153] Defendants' response to the draft report describes (without documentation) meetings with the clients, and placement visits, and the use of a "matching tool" to identify client preferences. The response also states that DHS have an "understanding" that the individuals "are doing well." Defendants' 6/4/13 Letter at 13. These statements in the letter do not demonstrate that these individuals' placements (unlike those of clients' discharged from Cambridge since settlement approval) were provided with *Olmstead*-compliant person-centered planning.

As noted above and in the related footnote, there is no evidence that the three transferred clients were provided with *Olmstead*-compliant person-centered planning. The current supports, treatment and plans for the three individuals transferred from MSH to the community under the settlement agreement should be independently reviewed for compliance with *Olmstead* and person-centered requirements.

Defendants' 6/4/13 Response to Draft Report

To assist the Department in this effort, the Department will – as recommended by the Report – retain an independent reviewer to conduct a review of these transfers. * * * It is the Department's intention to use the findings of this independent reviewer to further refine and improve its transfer process and ensure best practices are adopted and implemented.

The Monitor suggests it would be useful for the parties to revisit this MSH language to determine whether it continues to serve its intended purposes. The Monitor expresses no opinion on whether or not any revision is advisable.

COMPLIANCE

EC 94
BEST EFFORTS TO ENSURE NO MOVES TO MSH BASED SOLELY ON DEVELOPMENTAL DISABILITY STARTING 2/2/12

Compliance	**Non-compliance**

Instrumental

EC 95
NO MOVES TO MSH BASED SOLELY ON DEVELOPMENTAL DISABILITY, STARTING 7/1/11

Compliance	**Non-compliance**

Instrumental

EC 96
NO CHANGE IN COMMITMENT STATUS WITHOUT HEARING

Compliance	**Non-compliance**

Instrumental

EC 97

ALL DEVELOPMENTAL DISABILITIES COMMITMENTS AT MSH TRANSFERRED TO "MOST INTEGRATED SETTING" *PER OLMSTEAD*

Compliance	**Non-compliance**

Quality of Life

RECOMMENDATIONS

40. *DHS and Plaintiffs should revisit this MSH "solely committed" language to determine whether it continues to serve its intended purposes. The Monitor expresses no opinion on whether or not any revision is advisable.*

41. *The current supports, treatment and plans for the three individuals transferred from MSH to the community under the settlement agreement should be independently reviewed for compliance with Olmstead.*

X.E. SYSTEM WIDE IMPROVEMENTS
ANOKA

SETTLEMENT LANGUAGE

> Persons committed solely as a person with a developmental disability may be transferred to AMRTC only if they have an acute psychiatric condition. Within thirty (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 from AMRTC. The transfer shall be to the most integrated setting consistent with *Olmstead* v. *L.c.,* 527 U.S. 581 (1999).

FACTS

1. Defendants' Status Report to the Court[154] lists one individual with a developmental disability being admitted to Anoka. This individual was admitted under Rule 20.01 "treat to competency order". This admission occurred prior to the Defendants' September 17, 2012 Status Report Update. Because DHS does not control Rule 20 placements, this situation is unaffected by the settlement while that client's Rule 20 order is in place.

2. Defendants report there have been no admissions solely based on a developmental disability since that time.

DISCUSSION

DHS complies with this provision of the settlement regarding no commitments of anyone solely with developmental disabilities.

This requirement also incorporates *Olmstead* compliance. It is rated as in compliance, but subject to revision if a client becomes a resident of AMRTC and is not immediately transferred in accordance with *Olmstead*.

COMPLIANCE

EC 98

[154] Defendants' *Status Report to the Court* (March 18, 2013), Dkt. 202.

MOVE FROM ANOKA UNDER *OLMSTEAD* PERSONS WITH DEVELOPMENTAL DISABILITY AND NO ACUTE MENTAL ILLNESS

Compliance	**Non-compliance**

Instrumental

RECOMMENDATIONS

None.

EC 99 - 100

X.F. SYSTEM WIDE IMPROVEMENTS LANGUAGE

SETTLEMENT LANGUAGE

> F. DHS shall substitute the term "developmental disabilities" for the term "mental retardation" where it appears in any DHS policy, bulletin, website, brochure, or other publication, at the next printing or revision of the publication, provided the change does not directly conflict with federal law, jeopardize receipt of federal funds, or impair the health care billing process. DRS also agrees to draft a bill for the Minnesota Legislature that will require the replacement of terms such as "insane," "mentally incompetent," "mental deficiency," and other similar inappropriate terms that appear in Minnesota statutes and rules.

FACTS

1. Defendants report[155] that they have worked to replace outdated language and continue to monitor and correct as necessary. However, a May 15, 2013 computer search on DHS' website turns up 55 pages with the phrase "mental retardation," typically in DHS produced material, references to Waiver funding categories, diagnostic references, and the like.

2. Draft legislative language for the 2013 legislative session has been submitted and is pending. The Governor's Council on Developmental Disabilities notes that the "mental retardation" terminology was addressed by the Legislature in 2005 and that the settlement provision is aimed at implementation.[156]

DISCUSSION

There is a compliance issue because a May 15, 2013 computer search on DHS' website turns up 55 pages with the phrase "mental retardation," It appears that the parties did not anticipate the challenge of wiping a now-inappropriate phrase from a website with much historical material, material

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[155] Defendants' *Status Report to the Court* (March 18, 2013), Dkt. 202.

[156] Comments of the Governor's Council on Developmental Disabilities, June 4, 2013, at 12.

produced by third parties, and contractual and governmental forms which include the phrase.

One option which may, at least in part, satisfy the intent of this criterion is a disclaimer, either on the home page of the website or on every page. DHS may have other tools or ideas to remedy this non-compliance.

The Department agrees with the finding of non-compliance with regard to the replacement of the term "mental retardation." By June 30, 2013, DHS intends to add a disclaimer to its home page and "on the introduction of any search activity page." [157]

Legislative language has been submitted for the current session. Because of its essentially *pro forma*, though important, nature, there is no apparent obstacle to its enactment. Compliance is found, subject to change if necessary.

COMPLIANCE

EC 99
ELIMINATE "MENTAL RETARDATION" IN DHS PUBLICATIONS

Compliance	**Non-compliance**

Administrative

EC 100
REPLACE OUTDATED TERMINOLOGY IN STATUTES

Compliance	Non-compliance

Administrative

RECOMMENDATIONS

42. DHS should immediately add to the home page, or all pages, of its website a footer approved by the Monitor, and reviewed by Plaintiff Class. The

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[157] Defendants' June 4, 2013 Letter at 4. The disclaimer will read:

> The terminology used to describe People with Disabilities has changed over time. The Minnesota Department of Human Services ("Department") supports the use of "People First" language. Although outmoded and offensive terms might be found within documents on the Department's website, the Department does not endorse these terms.

footer will briefly explain that DHS does not endorse the outmoded term "mental retardation." In the alternative, DHS should adopt other means to comply with this requirement.

CONCLUSION

This Status Report on Compliance is respectfully submitted to this Honorable Court for its consideration.

Respectfully submitted,

/s/ David Ferleger
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Independent Consultant and
Monitor

June 11, 2013

APPENDICES

RECAPITULATION
OF MONITOR REPORT RECOMMENDATIONS

The recommendations appear in the order of
their appearance in the body of the report.

Closure of the METO Program, Olmstead, Best Practices, Licensure, and Parent Notification (EC 1-4)

1. *DHS should ensure that Cambridge's Administrative Procedures binder (and any copies) accurately reflect all procedures currently in effect.*

2. *DHS should consider what restrictions on furnishings in client rooms are necessary and appropriate, and revise any relevant procedures accordingly. For example, closet alcoves presently do not have a bar to hang clothes; a break-away bar might permit clothes-hanging but not pose a danger. A wooden chair might pose a risk that a plastic chair might not pose.*

3. *DHS should consider assisting clients to decorate and otherwise personalize their rooms.*

4. *DHS should consider use of furnishings, wall hangings/pictures, and other means to render Home common areas less stark.*

5. *Present staff involved in vocational work with Cambridge clients may be inadequate (in experience, training and implementation) to implement supported and customized employment, as well as job development. DHS should consider bringing to bear a consultant with experience in implementation of supported and customized employment, as well as job development, to advise Cambridge. DHS should also consider adding sufficient staff time to this vocational work effort.*

6. *Cambridge does not always promptly respond to the recommendations of the Internal Reviewer after his review of incidents. DHS should ensure that responses are provided to the Internal Reviewer within a short specific time period.*

7. *Cambridge has not implemented the recommendations of the Internal Reviewer after his review of incidents, sometimes for months. DHS should ensure that recommendations are implemented within a short specific time period. When DHS/Cambridge receive the Internal Reviewer's monthly reports, implementation failures should be addressed in responses to the Internal Reviewer.*

8. *The Cambridge official in charge of Health Information Management should promptly be provided with a printer, fax machine and copy machine (or an all-in-one machine), and trained in its use.*

9. *The Central Office liaison/coordination staff should be augmented by at least two to three skilled professionals. The leadership of that "Jensen Team" should have authority to ensure implementation of adopted changes.*

10. *The existing DHS Quality Assurance System (with augmented staff for the Central Office element) should be utilized to collect and analyze information related to compliance with the settlement agreement, and in deep coordination with the Central Office Jensen Team, and the Monitor.*

Prohibited Techniques: Policy (EC 9 – 11 & 21)

11. *All Cambridge staff should be reminded that manual (hands-on) restraint is permitted in an emergency. Training scenarios might be useful in that process. The "no touch" approach of at least some staff poses a significant risk of danger to staff and clients.*

Prohibited Techniques: Chemical Restraint (EC 14 – 15)

12. *DHS should reevaluate the "Approved Behavioral Medication" protocol, along with how to address voluntary requests for medications regularly prescribed outside of the behavior control context.*

13. *DHS should insure that reporting of PRN medication events is consistent, internally and externally, and are accurately reported to the Court.*

Restraint Reporting and Management: 24 Hours to Report (EC 32 – 38)

14. *All citations by DHS Licensing, or any other licensing body, should be fully and accurately reported to the Monitor in the Department's status*

Internal and External Reviewer: Internal Reviewer (EC 40 – 42)

15. *Cambridge should internally monitor its own implementation of the Internal Reviewer's recommendations for timeliness and content.*

Transition Planning (EC 54 – 60)

16. *In the area of providing person centered planning and practices and to ensure compliance with the Settlement Agreement by the Counties, DHS*

should exert maximum regulatory and funding authority to ensure cooperation and action by its counterpart County systems. This should be done on an urgent or emergency basis, minimizing red tape.DHS should exert maximum regulatory and funding authority to ensure cooperation and action by its counterpart County systems. This should be done on an urgent or emergency basis, minimizing red tape.

17. *To the extent it would assist DHS in implementing the above recommendation to have a court order in place in this regard, DHS should come forward immediately to suggest the terms of such an order.*

18. *DHS should immediately engage an outside consultant individual or firm, approved by the Monitor and Plaintiffs, to draft the Transition Planning process and any needed forms, with a 40-day target for completion.*

19. *State-wide training on Transition Planning, including both State and County staff, should be implemented promptly. Such training should be under a written training plan, reviewed in advance by the Monitor, Plaintiffs and the consultants. The plan should specific in terms of directing training resources at identified audiences, providing start and end dates for training to occur, training locations, specifying the curricula and the level of competence desired in those being trained.*

Staff Training (EC 61 – 65)

20. *Given this Report's findings regarding person centered planning and the treatment/activities at Cambridge, DHS should consider whether changes in the training requirements, or implementation of the training, is advisable and submit any recommendations to the Monitor and Plaintiffs' counsel. In doing so, DHS should consider the Plaintiff Class' prior critiques of the training program.*

21. *When person centered plans are developed for Cambridge residents, the planning meetings should be facilitated by professionals experienced in both development and implementation of such plans, to model person centered planning for Cambridge staff. In-class training should not be considered a sufficient basis for actualizing person centered planning.*

Visitor Policy (EC 66 – 68)

22. *DHS should immediately resolve the questions presented by Cambridge's inclusion of the 2010 visitation procedure as current, and explain to the Monitor whether and how staff were informed of, and trained on, the 2012 procedure filed with the Court.*

23. *All staff should be specially trained on the 2012 procedure and informed that all prior procedures are no longer in effect.*

24. *All visitation restrictions should be reviewed by senior Cambridge staff for compliance with the 2012 procedure.*

25. *No visitation restrictions should be maintained or imposed without thorough consideration and explanation by the Interdisciplinary Team, with participation of the client, family and legal representative.*

26. *As a safeguard and temporarily until December 31, 2013, Plaintiffs' Counsel and the Monitor should receive documentation of any visitation restrictions.*

No Inconsistent Publicity (EC 69 – 71)

27. *Provide all Cambridge staff with a copy of Bulletin #12-76-01 and provide training to both MSHS-Cambridge staff and to community case management administrators and case managers on the Bulletin's intent and content.*

28. *Withdraw the 2010 Cambridge policy titled, "Mission Statement."*

Posting Requirements (EC 72 – 73)

29. *The Health Care Bill of Rights should be redone for posting in language appropriate to the reading level of Cambridge clients, and with significant use of graphics and examples for those who may have difficulty with the text. A poster format might be considered.*

30. *The name and phone number of a person at Cambridge to whom inquiries on treatment may be made, and a description of how a complaint to the Office of Health Facility Complaints may be made, should be posted.*

System Wide Improvements Expansion of Community Support Services (EC 74 – 82)

31. *It is recommended that the parties agree to convert these community expansion provisions to requirements of the Settlement Agreement.*

32. *Absent agreement of the parties, it is recommended that the Court consider whether these or similar community expansion provisions should be adopted as additional relief or as a remedy for non-compliance with other requirements of the Court's mandate.*

System Wide Improvements: Additional Community Staff (EC 83 – 84A)

33. *A vigorous effort to recruit qualified behavior analysts should be undertaken, including national searches and salaries and benefits sufficient to attract appropriate candidates.*

34. *DHS should consider joint (or separately funded) educational programs with universities and other organizations, and other longer-term efforts to provide needed credentialing and experience in behavior analysis to supplement the currently available pool in this field.*

35. *For current DHS employees, at Cambridge and other institutions and in the community, DHS should consider subsidizing enrollment in educational and certification programs in behavior analysis.*

System Wide Improvements – Olmstead Plan (EC 85 – 88)

36. *The Governor's Order does not acknowledge that, under the court's decree in this case, "the State and the Department shall develop and implement" the plan. The plan and its implementation are subject to Court approval, monitoring and enforcement. Also, the Governor's Order does not direct the Sub-cabinet to submit the Plan to the Court for review and approval. The Governor's Order should be amended both to reference this litigation and to acknowledge the State's obligation under the Court's orders to development and implement the plan, as well as the obligation to submit the plan for the Court's review and approval and, once approved, for monitoring and enforcement.*

37. *Development of a comprehensive single Olmstead Plan that meets the standard established in the settlement agreement is a very complex task. The plan will affect individuals with all disabilities state-wide, and will necessarily affect multiple state agencies. DHS should consider whether there is a need to retain consultation from a person or organization with experience in the evaluation, formulation and implementation of Olmstead plans.*

System Wide Improvements – Rule 40 (EC 89 – 93)

38. *Whether DHS contends that the Omnibus DHS Bill is, in any way, a product of the Rule 40 process or approved by the Rule 40 Committee, is unclear and should be clarified promptly by DHS. Such clarification should specify which sections of the Omnibus DHS Bill were approved by the Rule 40 Committee, and when and how they were approved by the Committee.*

39. *The Rule 40 report should be submitted to the Monitor and Court by August 1, 2013.*

System Wide Improvements – Minnesota Security Hospital (EC 94 – 97)

40. *DSH and Plaintiffs should revisit this MSH "solely committed" language to determine whether it continues to serve its intended purposes. The Monitor expresses no opinion on whether or not any revision is advisable.*

41. *The current supports, treatment and plans for the three individuals transferred from MSH to the community under the settlement agreement should be independently reviewed for compliance with Olmstead.*

System Wide Improvements – Language (EC 99 – 100)

42. *DHS should immediately add to the home page, or all pages, of its website a footer approved by the Monitor, and reviewed by Plaintiff Class. The footer will briefly explain that DHS does not endorse the outmoded term "mental retardation." In the alternative, DHS should adopt other means to comply with this requirement.*

Report Regarding Use of Positive Behavior Supports and Person-Centered Planning at MSHS-Cambridge

May 20, 2013

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Lehigh University

Dr. Fredda Brown
Queens College, City University of New York

This report is based on our observations at MSHS-Cambridge on May 8th and May 9th, 2013; a review of documents; and interviews with residents and staff. Documents included all residents' Positive Behavioral Support Plan When Psychotropic Medication(s) Are Prescribed, all incident reports since January 2013, and a sample of Risk Management Plans and Transition Plans. Interviews were conducted with three residents, a Behavior Analyst 1, a Behavior Analyst 2, a Designated Coordinator, one direct care staff, and the director of the facility.

I. Does Cambridge utilize applicable best practices, utilize person centered planning principles and positive behavior support, consistent with best practices?

The following sections represent various components of the APBS Standards of Practice. Our comments below are based on a review of the documents described above, observations, and interviews. It should be noted that in at least one situation, we discovered that there were additional behavioral and evaluation strategies that were written up and employed on the unit. We do not know how for how many residents this might be the case. If this is true for all residents, we would recommend that all strategies that are implemented for any one individual be coordinated into an easily understood document, or set of documents, describing the behavior support and evaluation strategies, and that this be consistent across units and individuals.

For each PBS Standards section below, we offer overall comments.

PBS STANDARDS

VI. Development and Implementation of Comprehensive, Multi-element Behavior Support Plans

A. PBS practitioners apply the following considerations/foundations across all

elements of a PBS plan

1. Behavior support plans are developed in collaboration with the individual and his or her team
2. Behavior support plans are driven by the results of person centered and functional behavior assessments
3. Behavior support plans facilitate the individual's preferred lifestyle
4. Behavior support plans are designed for contextual fit, specifically in relation to:
a. The values and goals of the team
b. The current and desired routines within the various settings in which the individual participates
c. The skills and buy-in of those who will be implementing the plan
d. Administrative support
5. Behavior support plans include strategies for evaluating each component of the plan

Comments:

- *There is a complete absence of functional behavioral assessments (FBAs) in all PBS plans. Data, if provided in the support plan, are either frequency counts or percentages of targeted behaviors during a baseline period. The context of the exhibited target behaviors occurring during baseline are not included, thus omitting important information that could be used when developing the behavior support plan. Further, it is difficult to understand what some of the data mean. For example, it is unclear what "Self-Control: 40%" means. Does this mean 40% of opportunities to demonstrate self- control (implying that there are a specific number of times that self-control is to be exhibited)? Or is it 40% of intervals throughout the day?*
- *Behavior support plans are not linked to hypotheses regarding the function or environmental determinants of problem behaviors. Some documents attempt to link problem behaviors with perceived function, but these functions are not substantiated with functional assessment data.*
- *PBS plans are developed with a focus on living at Cambridge, and are not linked to a) expected future environments in integrated settings, or b) the individual's preferred lifestyle in community settings.*
- *Some evidence of person-centered orientation is apparent in language used, but there is no evidence that a person's interests and/or dreams for the future drive the support plan. No PCP assessments are included.*

- *It is not clear that the individual (or his family) is involved in development of the PBS plan. Signatures on the PBS Plan include Cambridge staff, and do not include any space for the target individual, or family member, to sign. In an interview with WR, he reported that he did not know that there is any type of behavior plan for him. He did indicate, however, that he can get points for snacks, but has no idea about how he gets points. JS also was unaware of any type of behavior plan.*
- *Data collection on the behavior support plan is loosely identified in the form of a checklist of data collection methods (e.g., frequency count, duration recording, interval recording). Methods of data collection are not linked to specific components of the plan, and sometimes are not linked to the specific behavioral targets (alternative behaviors, challenging behaviors).*
- *PBS plans identify who authored the plan and who is responsible for implementing the plan (not always completed), but there is no evidence of collaboration or teaming. Interviews with direct care staff, behavior specialists, and a designated coordinator, who is not a BA, suggest that collaboration among those who will implement the plan does not consistently happen.*

B. Behavior Support Plans include interventions to improve/support Quality of Life in at least the following areas:

1. Achieving the individual's dreams
2. The individual's health and physiological needs
3. Promote all aspects of self determination
4. Improvement in individual's active, successful participation in inclusive school, work, home and community settings
5. Promotion of social interactions, relationships, and enhanced social networks
6. Increased fun and success in the individual's life
7. Improved leisure, relaxation, and recreational activities for the individual throughout the day

- *PBS plans do not include interventions that are directed toward improving individual's quality of life; rather they are focused primarily on the reduction of problem behaviors . A positive aspect of JL's experience at Cambridge is his employment, about two days a week, doing cleaning. He reports that this is the only thing he looks forward to. When asked about JL's "dreams"—he indicated that he would like to start his own lawn care business. It seems that this dream would not be too difficult to address, at least in part. For example, can JL work with the Cambridge groundskeepers on some level? Can he be given tutoring on what it takes*

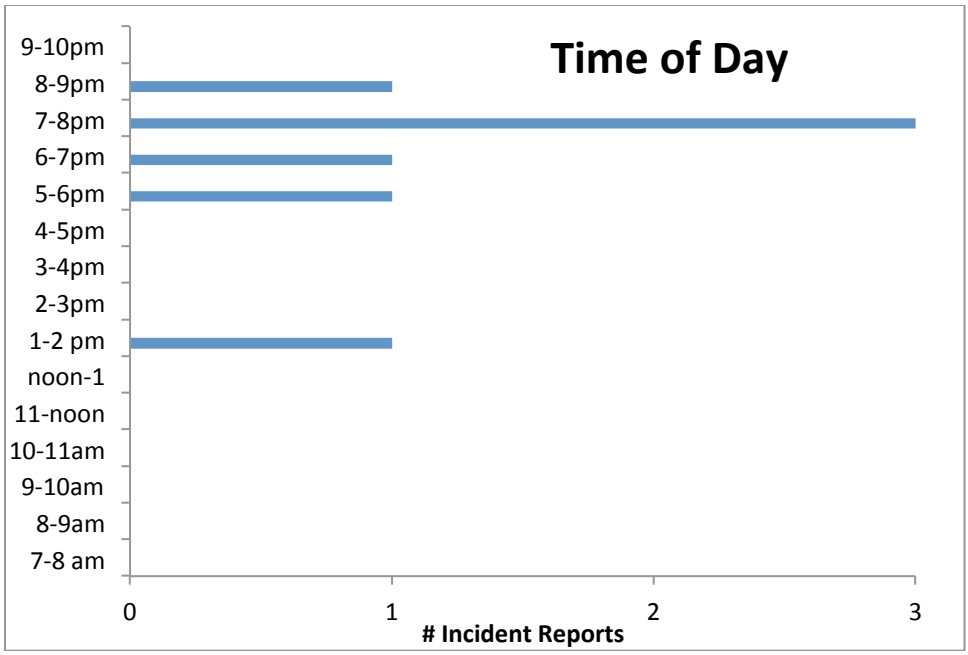
to run a business? What can staff do to support these interests? Now that it is spring, can he start seeds indoors for a garden? JL also likes to cook. What can be done within his current environment to support this interest?

- *Person-centered planning documents are implemented, but interviews revealed that this is not complete for all individuals. Person centered information, such as the individual's dream of a preferred lifestyle is not included in the PBS plans. PBS Plans would benefit from integrating the PCP information gathered into the plan.*
- *There are no objectives delineated in the PBS Plans that relate to age-appropriate forms of self-determination (e.g., house governance; individualized job development). In an interview with WR, he expressed that no one can leave his room after 10:00 pm, and his TV had to be off at 10. He expressed that he has told staff that he cannot sleep yet at that time, and would like to stay up and watch TV. He reported that staff said he could not do this. When inquired about house rules, or any type of input into house rules, he indicated that there was no input, and there were no house meetings.*
- *Although some PBS Plans include reference to "offering choices"—these choices appear to be regulated by staff and refer to objects or activities that are used to redirect the individual, or to use as a consequence for appropriate behavior, rather than to improving daily life or to life planning. WR, for example, has only one behavioral objective listed on his PBS Plan: "W will maintain a positive reputation 80% of all opportunities by 6/2013." Without observable and measureable objectives in the area of self-determination, there can be no assurance of focus on this area of social/personal development, or monitoring of progress. Although the way that "Positive Reputation" is described may refer to some element of self-determination – the level of self-determination described is focused on controlling himself (e.g., not posturing; turning in contraband, following household rules), rather than having any control over his environment (e.g., deciding his schedule, helping define household rules).*
- *It does not appear that residents of Cambridge have a schedule of activities, so it is impossible to determine to what degree, if any, residents are involved in self-determined leisure, relaxation, or recreational activities. Two of the three residents whom we interviewed expressed that the only activities they have access to are attending groups, going to the canteen, and going to the gym on campus. Both WR and JL indicated that they did not want to go to the canteen. JL indicated that he did not like going to the Wellness Group, as all they do is walk around the room. Further WR indicated that he had not been out of his unit for a few weeks because of an incident that occurred. WR's report is that not only was he not allowed to go to the gym, but he was not allowed to go to his group meetings The incident refers to an elopement, which according to the Incident Report occurred on April 30, 2013. . W's PBS plan was revised on 5/8/13, and includes "Staff should escort W with 2 staff at all times when outside of the building. At this time, W will only leave the building for medical or dentist appointments on campus or off campus." It is acknowledged that community safety must be maintained, however, the plan does not include how long this consequence will be in effect for, and what replacement activities should occur for him while he is secluded there. Having no activities to engage in may be a setting event for further problem behaviors.*

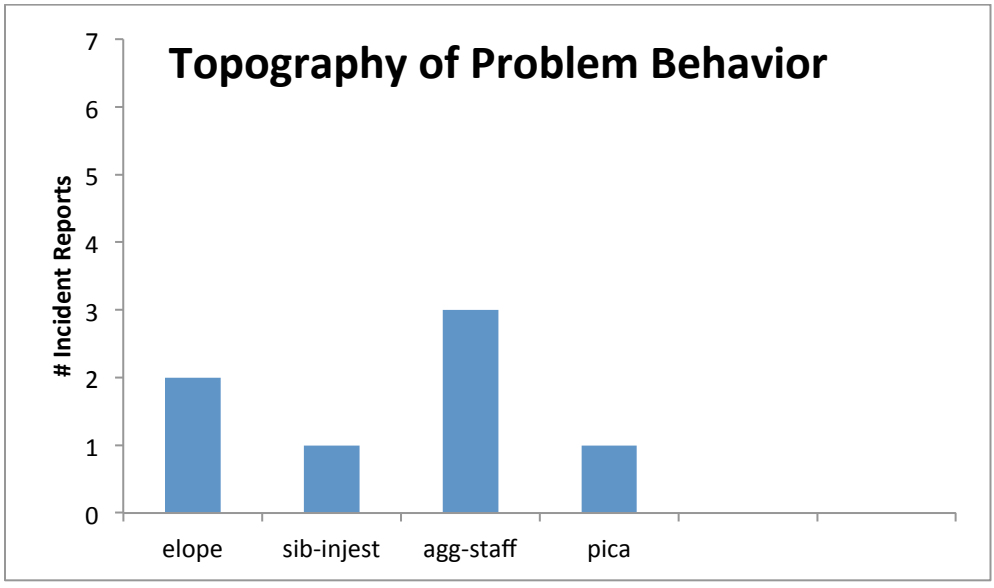
C. PBS practitioners develop behavior support plans that include antecedent interventions to prevent the need for problem behavior using the following strategies:

1. Alter or eliminate setting events to preclude the need for problem behavior
2. Modify specific antecedent triggers/circumstances based on the FBA
3. Identify and address behaviors using precursors (i.e. individual's signal that a problem behavior is likely to occur)
4. Make the individual's environment/routines predictable (e.g., personal schedule in format the individual can understand)
5. Build opportunities for choice/control throughout the day that are age appropriate and contextually appropriate
6. Create clear expectations
7. Modify curriculum/job demands so the individual can successfully complete tasks

- *Little evidence that modifications of setting events or antecedents that trigger problem behaviors are included in the behavior support plans. Some support plans include antecedent strategies like "use of a daily schedule," "choice", and clear "expectations" but these are not linked to hypotheses for problem behaviors. For the most part, items listed under "proactive strategies" are strategies to defuse problem behaviors at their early onset, and not strategies to avoid or prevent environmental triggers to problem behavior.*
- *A powerful way of discovering contextual and antecedent events is to look for trends in individual behavioral data as well as collectively across individuals. The intent of these types of analyses is to detect possible trends regarding the facility. For example, 10 incident reports were completed since January 2013; 7 had to do with problem behaviors, and the remaining three included two related to falling/slipping outside, and one related to a complaint regarding a residents' representative payee. The following graphic displays and ensuing implications are an example of how incident report data can be used. The following graphs are based on only the 7 behavioral incident reports, so one cannot be confident in any conclusions; ideally, more data across time would be needed to establish more valid trends. These data are presented to demonstrate an analytic process.*



Implications for analysis: These data would suggest that units should examine what occurs during the hours of 7:00 – 8:00 pm. For example: What activities occur, if any, at this time? What are the expectations of residents at this time? Are there staff shift changes? Are certain staff associated with this time? Is this a transition time? Are medications distributed at this time? And so on….



Implications for analysis: Aggression to staff appears to be the most frequent behavioral challenge. Further analysis would look if these incidents are associated with a particular staff, or with a particular resident.

With sufficient data across time, many analyses are possible. For example: Where are the incidents occurring—inside the home; if so where? Outside—if so, what are the staffing concerns that need to be addressed?

The current 10 incident reports indicate that they are being completed in different ways by different staff. It is important that there be consistency in the depth of incident descriptions, especially in the area of events leading up to behavioral incidents. This will allow for more in-depth and varied analysis, such as identification of triggers to behaviors.

D. PBS plans address effective instructional intervention strategies that may include the following:

1. Match instructional strategies to the individual's learning style 12

2. Provide instruction in the context in which the problem behaviors occur and the use of alternative skills, including instruction in skills such as:
a. Communication skills
b. Social skills
c. Self-management/ monitoring skills
d. Other adaptive behaviors as indicated by the FBA and continued evaluation of progress data (e.g., relaxation techniques)
3. Teach replacement behavior(s) based on competing behavior analysis
4. Select and teach replacement behaviors that can be as or more effective than the problem behavior
5. Utilize instructional methods of addressing a problem behavior proactively (including pre-instruction; modeling; rehearsal; social stories; incidental teaching; use of peer buddies; meeting sensory needs; direct instruction; verbal, physical, and/or visual prompting)

- A section on "Desired Alternative Behaviors" is included in each behavior support plan. In the absence of functional assessment data and hypotheses, it is difficult to evaluate how individualized these targets are to individual needs. While some seem person specific, others seem to be driven by program specific language and therapeutic interventions (e.g., utilize self-control techniques, maintain personal boundaries); that is, Cambridge uses a specific therapeutic strategy, and this is applied to all individuals, rather than the individual's need determining the strategy.
- In the absence of functional assessment data and hypotheses for problem behaviors, it is unclear if targeted alternatives serve as replacements for problem behaviors. It appears that desired alternative behaviors fit within a DRO/DRA program (which is consequence-based), rather than targeted replacement skills linked to the function of problem behavior.
- There are sections in each support plan on "Techniques that are used that are consistent with the consumer's communication mode" and "learning style." While some completed sections seem highly individualized and thoughtful, others seem cursory at best.
- Most support plans describe strategies for staff to support and/or teach desired alternative behaviors in daily contexts.

E. PBS practitioners employ consequence intervention strategies that consider the following:

1. Reinforcement strategies are function based and rely on naturally occurring reinforcers as much as possible.
2. Use the least intrusive behavior reduction strategy (e.g., error correction, extinction, differential reinforcement)
3. Emergency intervention strategies are used only where safety of the individual or others must be assured
4. Plans for avoiding power struggles and provocation
5. Plan for potential natural consequences. Consider when these should happen and when there should be attempts to avoid them. Although some natural consequences are helpful to the individual (e.g., losing money, missing a bus), others can be detrimental and provide no meaningful experience (e.g., being hit by a car, admission to psychiatric unit).

- *Most PBS plans include detailed procedures on how to respond to problem behaviors should they occur. Reactive strategies include redirection to appropriate desired behaviors or alternative activities, and or "mini" crisis management plans (who to call, how to protect the individuals and others). At least one plan makes reference to the use of PRN and calling the police.*
- *All behavior support plans have a section for "Reinforcement Systems" which are directed toward reinforcing "incompatible behaviors." Entries for some individuals describe an external reinforcement system (e.g., token system) contingent on the absence of problem behaviors and incompatible desired behaviors. However, others indicate a plan for data collection and recording and do not describe how data collection will be used to provide feedback to the individual. The three residents who were interviewed reported that they were not aware of the relationship between their behavior, points earned and the arranged consequences.*
- *No plan identifies natural reinforcement for desired alternatives.*

F. PBS practitioners develop plans for successful implementation of positive behavior support plans that include:

1. Action plans for implementation of all components of the intervention including:
a. Activities, dates and documentation describing who is responsible for completing each task
b. Materials, training and support needed for those doing intervention

c. How data will be collected and analyzed to address both impact and fidelity of intervention

d. Timelines for meetings, data analysis and targeted outcomes
e. Training, supports and time needed for plan implementation
f. Criteria for team meetings for immediate modification of PBS plan
g. Plans for review of contextual fit. Function based interventions, and lifestyle enhancements
2. Strategies to address systems change needed for implementation of PBS plans that may include:
a. Modifying policies/regulations
b. Support and training for personnel & families
c. Accessing needed resources (financial & personnel)
d. Increasing flexibility in routines, & staffing schedules
e. Recruiting additional individuals to be team members (e.g. bus driver, peers, neighbors, extended family
f. Interagency collaboration

- *How plans are carried out, analyzed, and modified are not made explicit in the behavior support plans. Interviews with behavior support specialists, direct support staff, and one designated coordinator indicate that a systematic process implemented for carrying out and monitoring behavior plans consistently across all teams is needed.*

G. PBS Practitioners evaluate plan implementation and use data to make needed modifications

1. Implement plan, evaluate and monitor progress according to timelines
2. Collect data identified for each component of PBS plan
3. Analyze data on regular basis to determine needed adjustments
4. Evaluate progress on Person Centered Plans (e.g. quality of life, social networks, personal preferences, upcoming transitions)
5. Modify each element of the PBS plan as indicated by evaluation data

- *Based on our "spot" observations of data collection systems, and interviews with staff, it appears that data are collected regularly for each individual and graphed. The system of data collection targets the frequency of problem behavior, mood or psychological symptoms, and the level of support needed to intervene on problem behaviors or coach desired alternatives (i.e., prompts, coaching, negotiations). It is reported, at least on one unit, that these data are graphed and shared with team members and the psychiatrist. However, the extent to which the data are used to inform modifications of the behavior support plan is unclear. Staff interviews suggest that the use of data to inform modification of supports is inconsistent at best.*
- *There is no evidence that other forms of evaluation (e.g., social validity, treatment fidelity) are used.*
- *There seems to be no monitoring of progress on person-centered plans or quality of life types of objectives.*

II. *Critical Issues that impact positive behavior support, person-centered planning, and full-integration into community life.*

1. **Training and qualifications of Cambridge Staff to Implement Best Practices in Behavior Support and Person-Centered Planning.**
   - Behavior specialists appear to have insufficient qualifications/training in PBS/Person-Centered planning
     - Two BA specialists (BAI and BAII) were interviewed.
     - Neither held degrees in ABA or related fields
       - BAI currently working on a degree in Applied Behavior Sciences
       - BAII has a BA in Criminal Justice
     - Although both have substantial experience working at Cambridge and have been trained in personal safety techniques, therapeutic interventions, and negotiations, training in PBS is not yet complete. Both enrolled in a 9 month course in PBS offered by the University of Minnesota, but have not completed the practicum component (implementation of FBA/Behavior Support plans) due to the lack of clinical supervision at Cambridge at this time.
   - Direct support staff/practitioners received a two-day introductory workshop in PBS practices, however, this alone does not qualify staff to competently write support plans.
   - Under the current structure at Cambridge, Designated Coordinators, who have various backgrounds (e.g., recreation therapist, nurse) may write behavior support plans.
     - These practitioners may have been only exposed two day training in PBS
     - Written behavior support plans may or may not be guided by a BA specialist.
   - Although there are plans to hire a clinical director with expertise in PBS, there is currently no supervision of the BA specialists with regard the development and implementation of PBS supports.

2. **Current organizational structure, procedural requirements, and therapeutic orientation may compete with implementing best practices in PBS and person-centered planning.**
   - According to the Behavior Specialists interviewed, support plans must be written with 10 days of admission to Cambridge. Although there seems to be no rules against revising a support plan, this requirement may compete with the time required to conduct a through functional assessment.
   - Behavior Support Specialists (and Designated Coordinators) have direct care responsibilities (e.g., preparing food; cleaning). This restricts or competes with time needed by Behavior Support Specialists to fulfill their principal job responsibilities with regard to the development, implementation, and monitoring of treatment programs, including direct training of support staff to implement behavior support plans. BA specialists report being strapped for time.

- Cambridge adheres to a therapeutic model of intervention for the support of Cambridge clients. Clients are encouraged to attend therapy groups, some of which (e.g., IM&R) were developed for individuals with mental illness, not developmental disabilities and/or dual diagnosis. This therapeutic model appears to drive both PBS plans and person-centered planning in that PBS and PCP are designed to fit within the current structure. Thus, PBS and PCP are only as individualized to the client needs as the therapeutic structure allows. This foundational structure offers at least partial explanation for why the interventions within the PBS plans appear similar across clients.
- Cambridge staff complete numerous client program plans including a *Individualized Treatment Plan, Risk Management Plan, Behavior Support Plan, Discharge Plan, and Person Centered planning worksheets.* As each appear to be stand alone documents, it's not clear whether there is consistency across these plans in terms of unified, person-centered outcomes for each individual.

3. **Can Cambridge successfully meet its purpose of crisis stabilization and transition planning to the most integrated setting "following person-centered principles to facilitate the identification of the individual's specific interests, goals, likes and dislikes, abilities and strengths, as well as support needs? (Bulletin #12-76-01).**

- Individuals who are served by Cambridge are removed from integrated community settings, thus, any assessments of their needs to participate in integrated communities not related to the settings from which individuals are expected to live and work. In other words, how successful can Cambridge be in conducting relevant assessments of what is needed to be fully re-integrated in the community if the person is removed from that setting? While a certain amount of information can be gathered within person-centered teams involving the individual, family, county case managers, and so forth, observation of the individual, direct and authentic information which can only be gathered by observing the individual in the environment in which they are expected to function cannot be obtained. Further, it would be difficult to arrange supports in those environments. This begs the question of whether Cambridge can truly identify individuals support needs following best practices in the field.
- Serving individuals under "Rule 20" seems incompatible to the requirement that "discharge planning shall begin upon the date of admission" in that their future at the point of admission is uncertain. Transition planning will be dependent on the outcomes of an examination and report of an individual's competency to participate in proceedings.

III. Recommendations

1. **Consider whether the Cambridge Program is necessary.** In our opinion, although it is sometimes necessary to remove individuals who have dangerous behaviors from the setting in which severe challenging behaviors occur, the primary purposes of Cambridge (e.g., crisis stabilization and transition planning) can be achieved in alternative community settings while ensuring individual and community safety. Removing individuals from community settings is inconsistent with implementing person-centered practices with the goal of preparing individuals to live in the most integrated setting (Bulletin #12-76-01). Recommendations for person-centered, individualized supports for integrated settings must be made with an understanding of how the individual performs in integrated settings

and what he/she needs to be successful. Assessment and planning in segregated contexts such as Cambridge, may not translate to community contexts. This is demonstrated in the lack vision of the PBS plans and other planning documents.

2. **Make person-centered planning the focal point of all treatment plans.** In other words, person-centered planning should drive all treatment efforts including PBS plans and transition plans. We suggest beginning with the person's goals, dreams, or vision for community participation (where to live, where to work, preferred community involvement). Then from this basis, begin an assessment process of how these goals can be achieved given the person's needs (including safety) and what services and supports, including PBS, are needed to achieve these goals. For transition plans, we recommend goal statements be made in terms of measureable outcomes, such as: "Bill will obtain competitive employment in the hotel industry." "Jeremy will live with two compatible roommates in house in Cambridge given staff support for…." From these goal statements, all other treatment plans can be derived. For example, functional assessments and behavior support plans can be linked to long-term outcomes, and activities to support a preferred quality of life could be identified. Transition plans can identify services that will promote access to these goals. Making person-centered planning principles the focal point, will facilitate the integration of all plans toward common outcomes in integrated community settings.
3. **Include Cambridge residents, and family members if appropriate, in behavior support planning, person-centered-planning, transition planning, and self-governance.**
4. **To the extent that individuals need positive behavior support plans (and not just person-centered life plans for community life), be sure that support plans include all key elements according to the APBS standards of practice.** This includes functional behavioral assessments and individualized interventions and supports that are clearly linked to hypotheses for problem behaviors and quality of life outcomes. Interventions should be driven by hypotheses for problem behaviors informed by functional assessments and individual's preferred life, and not driven by available treatment programs. Decisions about program development and modification should be data-based.
5. **Build capacity for expertise in positive behavior supports and person-centered planning.** This includes attending to the training qualifications of lead staff who are responsible for writing, implementing, and monitoring PBS and person-centered plans, as well as relieving them of direct support responsibilities so that they can meet their responsibilities. We also recommend that all direct support staff meet weekly or bi-weekly and work as team to collaborate participate in the support plan process including developing, implementing, and monitoring supports.
6. **Strengthen the organizational commitment to using PBS and PCP practices by gathering organizational data on how well the organization is doing on meeting PCP and PBS goals.**

REVIEW OF THE PSYCHIATRIC AND HABILITATIVE SERVICES
MINNESOTA SPECIALTY HEALTH SERVICES
CAMBRIDGE, MINNESOTA

Prepared by

Edwin J. Mikkelsen, M.D.

Psychiatric Consultant

INTRODUCTION AND OVERVIEW

The onsite review of the Minnesota Specialty Health Services (MSHS) facility at Cambridge, MN was conducted on May 3rd and 4th, 2013. I was accompanied to the MSHS by Attorney David Ferleger, who is serving as the court-appointed Monitor in the Settlement Agreement related to the facility. However, Attorney Ferleger was not present during any of my onsite interviews with members of the facility's staff or its residents.

The May 3rd activities consisted of a tour of the facility, during which I was accompanied by Attorney Ferleger. Subsequently, I was able to interview Janet Marciniak, R.N., whose title is "R.N. Consultant," who provided me with a brief history of the facility, and the related Settlement Agreement. She also coordinated the assembling of the sections of individual records that I requested in order to complete this review. I also spoke at length with Katy Mattson, Admission and Discharge Coordinator. I was able to conduct a telephone interview on 5/3/13 with Dr. Peter Miller, the Consulting Psychiatrist. Mr. Steve Jensen, Facility Administrator, was on vacation at the time of the onsite review, but I was able to contact Mr. Jensen via a telephone interview on 5/14/13.

Over the two-day onsite review, I was able to interview all of the individuals who currently reside at the facility, with the exception of one individual (JL), who declined to be interviewed. These interviews occurred over the course of the two days of the onsite review. The interviews were also attended by at least one and occasionally two staff members, with the permission of the individual. I also made it clear at the beginning of each interview that the individual could terminate the meeting at any time, and further, if there was a subject that they did not prefer to discuss, they could inform me of that and I would not pursue that topic.

During the onsite interviews, I requested the following sections of each individual's record, which the facility made available to me either during the onsite interview, or subsequently:

- Diagnostic Assessment (done on day of admission)
- Nursing Assessment
- History & Physical examination (H&P)
- Medication profile
- Most recent Medication Administration Record (MAR)
- Most recent Abnormal Involuntary Movement Scale (AIMS)
- Monitoring of Side Effects Scale (MOSES)
- Monthly Medication Review Form (last 4 months)
- Psychiatric Progress Notes (last 4 months)
- Last week of Progress Notes
- Monthly Progress Report (last 2 months)

- Risk Management Plan (current)
- Positive Support Plan
- Psychotropic Medication addendum to Treatment Plan (Informed Consent)
- Psychotropic Medication Use Checklist (PMCL)
- Summary of Limitation/Restrictions
- Risk Management Plan
- Continued Stay Criteria Assessment

1. CLIENTS SERVED

Who is served at Cambridge?

The Minnesota Specialty Health System (MSHS), located in Cambridge, Minnesota, is one element in the system of residential care provided by the Minnesota State Operated Community Systems. The brochure that describes the range of services offered at MSHS-Cambridge, provides the following description of the facility:

Minnesota Specialty Health System – Cambridge

- *The program is a specialty residential program for adults with developmental disabilities or related conditions, who have highly complex service related needs, including possible history of legal problems and public safety and/or personal safety concerns due to significant behavioral disturbances related to poorly managed mental health and/or medical conditions*
- *Residential treatment services are delivered within a flex-lock facility*
- *Specialty services offered: functional behavioral analysis, sensory modulation and recreation therapy*

The Cambridge facility is a secure residential facility, as it utilizes an intricate system of locking doors to maintain perimeter security at the level of each individual residential home. Specifically, each room has a working lock, and exterior doors are locked as well as the interior doors that separate the two residential homes contained within each building. However, each resident has a key, which will open the door to their own room, and some of the common rooms. An individual may also be granted the privilege to carry electronic key fob, which will allow them to exit the external doors when it is held against an electronic plate next to the door. This privilege is granted on an individual basis, depending on their clinical and legal status. The facility does not maintain a level of external security beyond the individual residences, such as a fence or wall.

The utilization of one-to-one staffing for movement outside of the buildings is determined on an individual basis. However, all individuals who have been court-ordered to have a “Rule 20” Competency-to-Stand Trial evaluation are required to have one-to-one supervision for any activity that occurs outside of the building.

Beside the entry doors to each room is another vertical locking door that is approximately six-to-eight inches in width. This door parallels the main door, but does not extend for the full vertical length of the primary door. During the onsite review, I was informed by the residential staff that this door is currently utilized to do the overnight visual checks on the residents without creating the noise or intrusiveness that would result from opening the main door. Historically, the purpose of the side doors was to maintain visual observation of individuals who had barricaded themselves in their rooms, thereby preventing staff entry. These side doors also allowed the staff

to maintain verbal contact with the individual to facilitate the de-escalation of a clinical situation. However, I was told that this function had not been needed for a number of years. The handles on the doors to the individual rooms were referred to as "break away" handles, meaning that when you exert downward pressure on the handle, there is no resistance. I was also told that this was implemented several years ago, after a resident was able to commit suicide by hanging within one of the units. Following this incident, the living units were thoroughly re-engineered to ensure that there were no rigid objects which could serve as an anchor for a makeshift rope. Within the last several months, one of the current residents was able to gain egress from the residence by kicking out the window to his/her room. This was part of a larger incident that required staff intervention, and they were able to apprehend the individual before he/she had progressed too far from the facility. In addition, a 911 Call had been placed and police were summoned to the residence.

The facility's role in the continuum of care that is provided by the Minnesota Department of Human Services can be illustrated by a review of the current living situation of the ten individuals who reside there; the date of admission; their previous residence before being transferred to MSHS-Cambridge; and the rationale for their admission to the facility.

The most succinct manner for presenting this information is to provide a brief overview of the salient individual factors, systemic reasons that led to their admission to the facility, and the current status of the efforts to return them to a more normalized community setting. In order to avoid the risk of misinterpreting or distorting this import information, I will utilize excerpts from the individuals' active records, drawing from those sections of the record that were reviewed.

The method identified by the Court Monitor to ensure confidentiality is to utilize the individuals' initials only. I will also not refer to their gender or their specific date of birth. The vast majority of individuals admitted to the facility are males.

SW

The following excerpts were derived from the "MINNESOTA DEPARTMENT OF HUMAN SERVICES STATE OPERATED SERVICES DIAGNOSTIC ASSESSMENT MSHS Cambridge."

Date of assessment: 9/7/2012 *Date of admission: 9/4/2012*

Reason for initial referral:

[SW] was brought to the New Ulm Medical Center after [he/she] threatened [his/her] staff at the MBW group home. [SW] pleaded with law enforcement to "just shoot me and put me out of my misery." The treating psychiatrist, Dr. RePass, reported that [SW] had decompensated in [his/her] mood and behavior for the past few months and is cognitively impaired with markedly poor insight and judgment. Medication adjustments on an outpatient basis have had no lasting benefit. [SW] has become more aggressive, less amenable to redirection, and posed a risk of elopement with imminent risk of harm to staff and to self. [SW] struggles with physical/verbal aggression, elopement, self-injurious behaviors, property destruction and suicidal tendencies.

Legal history:

As noted above, [SW] was placed on probation for terroristic threats that were made towards a mental health worker at school. [He /she] also had legal charges related to fleeing a police officer. Police were noted to feel threatened. [SW] was recently commitment as a person with mental illness and as a person with developmental disabilities (MI/DD).

DIAGNOSTIC IMPRESSION

Axis 1 (clinical disorders):

Pervasive Developmental Disorder (NOS); Mixed Expressive and Receptive Language Disorder; Oppositional Defiant Disorder; Impulse Control Disorder (NOS); Sexual Disorder (NOS); and Adjustment Disorder with Mixed Disturbance of Emotions and Conduct (secondary to family sexual abuse).

Needs:

Given [SW's] significant aggressions and recent struggles to remain within structured community settings, the level of structure and support that MSHS Cambridge provides would meet medical necessity for [his/her] treatment. [SW] needs to develop effective strategies to moderate [his/her] aggressions and to follow relevant supervision. Assessment and on-going monitoring of [his/her] current medications in this controlled setting is essential and may generate changes that can contribute to [his/her] on-going mood stability. Also, improving [his/her] coping skills to internally manage [his/her] emotional dysfunction and to cope with [his/her] sexual abuse were identified treatment needs that would strengthen [SW's] capacity to live successfully in a less restrictive community placement.

Recommendations *(Prioritize areas to be addressed in treatment and indicate areas of treatment to be deferred until after discharge):*

Treatment interventions need to focus on helping [SW] accept limits in [his/her] activities of daily living that interfere with [his/her] community living. Increasing [his /her] willingness to accept relevant supervision (due to [his/her social and interpersonal deficits in [his/her] adaptive functioning) and increasing [his/her] frustration tolerance to minimize aggressive acts towards others and towards [himself/herself] will aid [SW] in successful community living. Equally as important, an assessment of [his/her] current medication management would assure appropriate dosage and use of medication. Educational and treatment components of group therapy modalities (such as the Illness Management and Recovery Program) and of structured milieu programming would be beneficial for [SW] as well. Given [his/her] history of family sexual abuse, [his/her] treatment team needs to determine if other treatment recommendations related to this abuse are warranted.

REFERRALS REQUESTED

Psychological testing: No
Psychiatric consultation: Yes
Neurological examination: No
Functional Behavioral Assessment: No
Medical Provider: No
Other referral: No

Electronically authenticated by: JACK KASL, PH.D/PSY.D, LP on 9/7/2012 at 05:03 PM

SW received psychiatric care from Diane Lawrence, Psychiatric Nurse Practitioner, and Dr. Peter Miller. SW was seen at least monthly by one of these providers. SW was most recently seen by Dr. Miller on 4/10/13.

SW's current psychiatric medications at the time of this visit were as follows:

CURRENT MEDICATIONS:

Risperidone 1 mg po BID (11/15/12 Risperidone 0.5 mg po at Noon discontinued)
Divalproex 500mg po 8am, 750 mgs po HS
Fluoxetine 40 mgs po AM
Guanfacine 1 mg po BID 8-2, 2 mgs po HS
Melatonin 6 mg po at HS
Cogentin 0.5 mg po daily am (10/18/12 decreased from BID)

His/her status at that time is described as follows:

STAFF NOTES:

Target Behavior(s):

AWOL, Suicide attempt (plastic bag over head), intimidation (staring or getting in others personal space.) Severe Property Destruction (ripping doors off hinges, punching holes in walls, ripping up carpet). Poor boundaries (Public masturbation, rough-housing/wresting, hugging, taking things, teasing). Physical Aggression, Verbal aggression (threats, name calling, swearing at others.)

Triggers/Antecedents:

Loud noises, being asked to end [his/] video game, denied requests, inconsistency. Lack of structure or change.

Supports:

[SW] is encouraged to attend IM&R, DBT, START, Sensory activities, and Wellness. Throughout the day staff encourage support and praise [him/her] for using appropriate boundaries, using self-control, and maintain [his/her] grooming. Staff conduct in the moment supports and training in appropriate social skills as well.

Goals:

Maintain Safe Boundaries, use Self-Control, and follow a daily grooming regimen.

Discharge Plans: GARD-2A:

Questionable if [SW] is yet stable. [He/she] is making slow progress toward treatment goals. [SW's] CCM and guardian are questioning the possibility of [SW] moving to a home by the same provider [he/she] came from (but a different house). No concrete plans at this time other than to stabilize [him/her] and provide treatment and training in the identified areas.

Notes: [SW] has continued to be less engaged in daily activities such as grooming, socializing, playing video games, and skipping some meals. [He/she] has also been sleeping more often. [He/she] CCM reported at [his/her] monthly meeting on 3/11/13 that this has been a pattern of [his/hers]. CCM also reported that around Easter, it will be the year anniversary since [he/she] has seen [his/her] mother. When [SW] is asked why [he/she] is sleeping so much, [he/she] has responded, "I don't know kinda bored, sad sometimes." After Easter weekend, [SW's] challenging behaviors have decreased. Staff not[e] that [he/she] has been sleeping "hard." [SW's] CCM has reported that this pattern of participating then having disinterest has been reoccurring for [him/her]. Review medication regimen.

Medical: 4/10/2012

During the last 2 weeks of March [SW] had a sharp decrease in the use of sensory exercises on the home and in the sensory room. There was also a noted decrease in [his/her] daily grooming. [He/she] was sleeping more during the day time and occasionally refusing meals. Dr. Miller was notified of [SW's] increase in depressive symptoms on 3/21/13. [SW] was seen on 3/29/13 by Psychiatric Nurse Practitioner. Depakote [Divalproex] was increased at this time. [SW's] depressive symptoms have improved over the past 10 days, though [he/she] continues to have a poor appetite and flat affect at times. [SW] had lab work on 4/02/13 and [his/her] lipids are abnormal. Zocor was discontinued and Lipitor started on 4/8/13. A lipid panel has been ordered in 3 months.

PSYCHIATRIST NOTES (4/10/13)

SUMMARY:

Above notes were reviewed and discussed with [his/her] team. Overall, [SW] has been doing fairly well. Staff describe [him/her] as being a little better but not back to [his/her] baseline after [his/her] episode of depression and some irritability in the middle of March. [He/she] still continues to be quite a bit sleepy. Today, in talking with [the] staff, [he/she] talks about feeling

very bored. [He/she] has an upcoming 30-day review on Friday, 4/12/13, and discharge planning is in progress.

END OF SW

MR

The following excerpts from the Minnesota Department of Human Services State Operated Services Diagnostic Assessment provides an overview of the reasons for this admission to MSHS-Cambridge, which was prepared by Jack Kasl, Ph.D./Psy.D.

Date of assessment: *2/2/2012* ***Date of admission:*** *2/1/2012*

Reason for initial referral: *[MR] was transferred from Young Adults and Adolescent Unit at Minnesota Security Hospital for a more appropriate placement due [to] [his/her] intellectual abilities. [He/She] was placed on a judicial hold with a MI and D commitment pending. Subsequently, [he/she] was civilly committed as a person with developmental disabilities.*

BRIEF HISTORY

Current life situation: *Currently, [MR] is a 20-year-old unmarried [male/female] who was initially in sexual offender treatment at Mille Lacs Academy in Onamia, Minnesota. This treatment was initiated due to [his/her] sexually abuse of two minors: an eight-year-old [child] and another 13-year-old [child]. While [he/she] was in this placement, incidents of aggression became more frequent and were directed toward peers and staff; also, [he/she] threatened to kill staff. Staff described [him/her] as difficult to redirect once [he/she] started escalating in [his/her] aggressive behavior. Records indicated that minor issues, such as wanting to watch something different on the television than what another peer was watching would evoke challenging behaviors from [MR]. Current, [he/she] resides in Home 4 on the campus of the Minnesota Specialty Health System-Cambridge.*

Legal history: *Legal charges were filed for recent sexual offenses and include: Two counts of 1st Degree Criminal Sexual Conduct (separate victims), and one count of 4th Degree Sexual Conduct. [MR] completed two Rule 20.01 evaluations which reportedly resulted in [his/her] adjudication as being incompetent to stand trial. [He/She] was incarcerated twice in a county jail for about three months for each time (4/20/2010 to 7/1/2010, 7/16/2011 to 10/18/2010). Currently, [he/she] is civilly committed as a person with developmental disabilities after [he/she] was initially considered for a commitment of mental ill and dangerous. [He/She] has a review of [his/her] Rule 20 status in 2013. Treatment reports may be required every six months.*

Strengths and protective factors *(identify both internal and external strengths/protective factors): [MR] communicates verbally, writes and reads the English language. [He/She is open to engage in conversations and is willing to participate in [his/her] initial appointments for this admission. [He/She] is physically health, has a future-orientation to wanting to live outside this facility and wants to return to school to be an auto mechanic. [He/She] enjoys such hobbies as putting together model cars and video games and has enjoys repairing small engines.*

Needs: *Given [MR's] intellectual disabilities and acts of aggression, [he/she] requires a level of structure and support that MSHS-Cambridge can provide where coping skills in anger management and appropriate personal interactions can be enhanced to prevent future and predictable acts of physical aggression. Further assessment around the functions of [his/her] aggressive behaviors is warrant as well as reassessment of [his/her] medications.*

Recommendations *(prioritize areas to be addressed in IRTS treatment and indicate areas of treatment to be deferred):*

[MR] could benefit from completing a behavioral assessment of [his/her] challenging behaviors as these behaviors prevent [his/her] mental health treatment being provided in a lower level of care.

Review of [his/her] medications is warranted and to rule out any side effects that may exacerbate [his/her] adaptive impairments and aggressive tendencies.

Resuming individual therapy may prove beneficial due to the on-going experience of failure and life disruptions.

Educational and treatment components of group therapy modalities (such as Illness Management and Recovery programming and behavioral milieu programming provided in a safe environment) will assist [MR] in coping with anger, depression, aggression and appropriate sexual boundaries.

Treatment for sexual offending can be provided in a less structured and intensive setting once the frequency and intensity of [his/her] aggression abate.

MR has been followed psychiatrically by Diane Lawrence, Psychiatric Nurse Practitioner, and Dr. Peter Miller. The Progress Notes indicate that he/she was seen by one of these providers at least monthly. The most recent Note by Dr. Miller identifies the following psychiatric diagnoses and medications.

CURRENT DIAGNOSES: revised on 3/5/13 (taken from Diagnostic assessment of Dr. Kasl dated 2/20/12)

I: Impulse Control Disorder
Mood Disorder, NOS
Organic Personality Syndrome
R/O Pedophilia
II. Mild Intellectual Disabilities
Personality Disorder, NOS (due to general medical condition)
Antisocial Personality Traits
III. Partial Complex Seizures
Allergies: BEE STINGS – (no need for epipen)

CURRENT MEDICATIONS:

Lithium 675 mg po HS (Increased on 3/15/13)
Seroquel 150 mg po HS
Depakote E.C. 1250 mg PO BID (12noon and 8pm) (seizure control)
Inderal 60 mg po TID (Increased 2/13/13)

This Note also indicated an “anticipated discharge date currently set for July 2013.”

END OF MR

WS

The following excerpts from the assessment prepared by Shannon Torborg, PH.D./PSY.D., LP, provided an overview of the events that preceded the individual's admission to MSHS:

MINNESOTA DEPARTMENT OF HUMAN SERVICES STATE OPERATED SERVICES
DIAGNOSTIC ASSESSMENT MSHS Cambridge

Date of assessment: *4/19/2013* ***Date of admission:*** *4/17/2013*

Reason for initial referral: *WS was referred for a psychological assessment on 4/17/13 for purposes of diagnostic clarification. The undersigned conducted a review of records, clinical interview, and risk assessment with WS on 4/19/13.*

BRIEF HISTORY

Current life situation: *WS is a never-married, 29-year-old, Caucasian [individual]. [He/she] is dually committed in Chipppewa County as a person with mental illness and developmental disability. [He/She] transferred from Anoka Metro Regional Treatment Center to MSHS Cambridge on 4/17/13.*

Legal history: *According to available records, [WS] has no known legal history. He is committed as a person with mental illness and developmental disability.*

History of dangerous behaviors and risk factors *(Include the precipitants and stressors for the individual that have a history of leading to violent/dangerous behaviors to the individual or others, such as triggering events like medical illness, loss of housing, grief over death, and issues that make them feel shame or despair):*

Prior to the most recent hospitalization at Anoka Metro Regional Treatment Center, [WS] reported having sexual fantasies about having sex with [his/her] mother, sister, sister-in-law, a paternal and maternal aunt, and his/her mother's brother's wife. In a previous report, [he/she] suggested that [he/she] prefers to "stay in the house or the man cave" because of [his/her] thoughts about rape. [WS] was reportedly a victim of sexual assault at age 18, by a man named Greg. Prior to hospitalization, [he/she] was reportedly hearing Greg's voice telling [him/her] to commit sexual acts. [He/She] admitted that Greg told [him/her] to take [his/her] 11-month-old niece's diaper off and have sex with her. [He/she] also admitted that Greg told [him/her] to "do little Jay," [his/her] four-year-old nephew. It does not appear that [WS] acted on any of these thoughts; however, a safety plan requiring [him/her] to have 24 hour supervision was immediately put into place. There was also concern about the guns at [his/her] parent's home. When WS was asked what [he/she] would do if [he/she] could retrieve the key and get the guns, [he/she] replied, "I would probably shoot people and myself." Due to the social worker's reservations about the safety plan being followed and the safety of WS and others, commitment was pursued. Dr. Anderson signed an Examiner's statement in support of a petition for judicial commitment on 2/4/2013.

Prior to hospitalization, [WS] also admitted to touching [his/her] sister in a sexual manner. [He/she] also threatened to physically hurt [his/her] sister but denied intent to act on the threats.

Apparently two police officers stopped by the home to discuss [his/her] sexualized thoughts and encouraged [him/her] to call 911 if [he/she] ever felt [he/she] needed help. A few days later, [he/she] was having thoughts about touching [his/her] sister and [he/she] wanted to call 911, but [his/her] father would not let [him/her] call. [He/She] responded by pushing, punching, and kicking [his/her] sister, and punching [his/her] father. [He/She] then calmed [himself/herself] down by taking a shower for half an hour. After that [his/her] sister was afraid to sleep that night because she was afraid that [he/she] would touch her or stab her. [He/She] was then seen by psychiatrist, William Del Monte, MD, at the ER in Marshall. [He/She] was not able to be admitted to the behavioral health unit as it was full, so [he/she] remained at the hospital until police officers could transport [him/her] to Divine Health Crisis Home in Kerkhoven.

DIAGNOSTIC IMPRESSION

***Axis I** (clinical disorders): Psychotic Disorder NOS*
Sexual Abuse of Adult (victim)
Somatoform Disorder (by history)

***Axis II** (developmental/personality disorders): Mild Mental Retardation*

***Axis III** (general medical conditions): GERD, psoriasis, thoracic scoliosis, congenital prosencephaly, hypertension, nighttime enuresis, and seizure disorder.*

***Axis IV** (psychosocial and environmental problems): Psychosocial stressors revolve around [his/her] psychiatric status and the impact on the family and living situation*

***Axis V** (current GAF): At the time of hospitalization: 15: Some danger of hurting self or others*
Current: 40 Some impairment in family relations, judgment, thinking, or mood

I was informed that no psychiatric Consultation Notes were available, as WS had been seen by Dr. Miller on 5/1/13. The dictation had not yet been transcribed.

END OF WS

LD

The excerpts from the assessment prepared by Shannon Torborg, PH.D./PSY.D., LP, provide an overview of the events that led up to his/her admission to MSHS-Cambridge.

Current life situation: *[LD] is a 25-year-old, never-married, African American [male/female] who has an extensive history of oppositional behavior, failed community placement, and hospitalization dating back to childhood. [He/She] also has a history of legal charges, dating back to late childhood. [He/She] was committed as a person with Mental Illness and Dangerous behavior. [He/She] was admitted to Minnesota Security Hospital (MSH) on 10/26/12 and transferred to Anoka Metro Regional Treatment Center (AMRTC) under court order from Hennepin County on 11/9/12 for purposes of neuropsychological testing. It was later determined that MSHS Cambridge is a more appropriate treatment setting than MSH for [LD] and [he/she] was transferred to the Cambridge program on 1/15/13.*

Legal history: *[LD] has an extensive history of legal problems, beginning in adolescence. Juvenile charges include 5th degree assault (6/99 and 10/05) and interfering with a 911 call (5/04). Adult charges have included several 5th degree assaults, three including interfering with a 911 call (10/06, 2/10, 4/10), two for 4th degree damage of property-intentional damage (4/12 and 5/12), and two for assaulting staff/peers (10/11 and 12/11), a domestic assault charge (9/07), and misdemeanor theft (11/11). On July 11, 2012, [LD] had a disagreement with staff at [his/her] group home, Options Residential Adult Foster Care. After the disagreement, [LD] went on to the porch of the apartment building and set a garbage can on fire. [He/She] then walked across the street to another apartment building owned by Options and knocked on the door. Staff noticed the fire burning on the adjacent building and managed to retrieve a fire extinguisher and put out the fire before it spread. The police were called and [LD] was placed on a hold and taken to Fairview University Medical Center on 7/11/12. [He/she] was charged with arson. The court concluded that the diagnosis given to [LD] by medical professionals, coupled with [his/her] violent and aggressive history and [his/her] most recent dangerous acts do rise to the level of proof required for commitment as mentally ill and dangerous.*

DIAGNOSTIC IMPRESSION

Axis I *(clinical disorders): Reactive Attachment Disorder versus Posttraumatic Stress Disorder, Chronic*

Axis II *(developmental/personality disorders): Borderline Intellectual Functioning*

Axis III *(general medical conditions): Alcohol Related Neurodevelopmental Disorder/Fetal Alcohol Spectrum Disorder*
(Static Encephalopathy secondary to prenatal alcohol exposure)

Axis IV *(psychosocial and environmental problems): Interactions with the legal system; limited support system*

Axis V *(current GAF): GAF = 20: some danger of hurting others, history of impulsive violence*

LD has received psychiatric care from Diane Lawrence, Psychiatric Nurse Practitioner, and Dr. Peter Miller, since his/her admission to MSHS-Cambridge. The available Progress Notes would indicate that LD has been seen at least monthly by one of the two providers.

The following excerpts from Dr. Miller's Progress Note, dated 4/10/13, provides an overview of LD's psychiatric status at that time.

CURRENT DIAGNOSES:

1: Mood Disorder NOS
Alcohol, Marijuana, and Opioid abuse
Cognitive Disorder NOS associated with Fetal Alcohol Exposure
II. Borderline Intellectual Functioning
III. GERD
Hypercholestremia
Obesity
Fetal Alcohol Spectrum Disorder
Seasonal Allergies
Elevated Prolactin

Allergies: NKDA; seasonal allergies

CURRENT MEDICATIONS:

Zyprexa Zydis 10mg ODT daily (Dosage increased and changed to Zydis 3/15/13)
Topamax 200mg BID
Risperdal M tab 3mg BID
Lamictal 200mg in AM
Melatonin 5mg at HS
Benadryl 50mg at HS
Singulair 10mg at HS
Prilosec 20mg in AM
Multiple vitamin (MVI) 1 tab daily
Senna Plus 2 tabs BID
Opcon ophthalmic Drops BID
Flonase 2 sprays each nostril daily

ASSESSMENT:

1. *Mood disorder NOS with psychotic features good response to current treatment.*
2. *Continued elevated prolactin, probably related to Risperidone, leading to pituitary changes as noted in the MRI. We expect this will respond to elimination of Risperidone.*

3. *Other diagnoses as noted above. We discussed [his/her] obesity but also noted that [he/she] has been able to manage without any weight gain since admission. All the same there is a need to work toward weight reduction. [He/She] seems at least somewhat interested in this.*

PLAN:

1. *Will reduce Risperidone to 2 mg BID and monitor closely in case there is any resurgence of any aggressive or otherwise inappropriate behavior.*

2. *Will change both Risperidone and Olanzapine to regular rather than the orally disintegrating tablets.*

3. *Will ask for [his/her] to be seen by Primary Care in review of the low neutrophil counts. Would consider starting Lithium as a way to boost these.*

END OF LD

JS

The following excerpts from the assessment completed by Shannon Torborg, PH.D./PSY.D., LP, provide an overview of the reasons for JS's admission to MSHS-Cambridge.

> ***Current life situation:*** *[JS] is a never-married, 19-year-old, [individual] who was voluntarily admitted to the University of Minnesota Medical Center, Fairview on 2/11/2013 after [he/she] struck [his/her] mother in the head with a pan and attempted to stab her with scissors. [He/She] remained at Fairview until [his/her] voluntary transfer to MSHS-Cambridge on 4/12/2013. [His/Her] mother is [his/her] guardian.*
>
> *[JS's] history of prescribed daily medication includes Abilify, Geodon, Risperdal, Zyprexa Injection or Zydis, Celexa, Catapres, Glucophage, Topamax, and Adderall XR ER capsule, Clonidine, Seroquel, Citalopram, and Metformin. Current medications include Topamax 25 mg po, Celexa 20 mg at bedtime, Glucophage 500 mg BID, Catapres 0.1 mg BID, Risperdal 0.5 mg BID, Miralax 17 g daily, and Adderall XR 20 mg daily.*
>
> *History of dangerous behaviors and risk factors (Include the precipitants and stressors for the individual that have a history of leading to violent/dangerous behaviors to the individual or others, such as triggering events like medical illness, loss of housing, grief over death, and issues that make them feel shame or despair.) JS has a history of intermittent, serious physical aggression toward others, often using items as weapons. It will be important to adapt [his/her] environment to limit [his/her] access to potential weapons, such as scissors, knives, and/or pots and pans. If [he/she] is demonstrating evidence of escalation, it is recommended that the environment be stripped of items that could be used as weapons, such as lamps, brooms, writing utensils, etc. It appears that [his/her] anger often results when [he/she] receives an answer that [he/she] does not want to hear or is blocked from a preferred activity.*
>
> ***DIAGNOSTIC IMPRESSION***
>
> ***Axis I*** *(clinical disorders): Autistic Spectrum Disorder (by history)*
> *Attention Deficit Hyperactivity Disorder (by history)*
> ***Axis II*** *(developmental/personality disorders): Mild Mental Retardation (by history)*
> ***Axis III*** *(general medical conditions): Obesity, dyslipidemia, NASH, insulin resistance, and constipation.*
> ***Axis IV*** *(psychosocial and environmental problems): Loss of housing in family home, change in routine, school, and living situation.*
> ***Axis V*** *(current GAF): 40 Major impairment in school, family relations, judgment and thinking.*

There were no Psychiatric Consultation Notes in JS's record. I was told this was because he had been seen by Dr. Miller on 5/1/13, and the Notes had not yet been dictated.

END OF JS

WR

The excerpts from the following document, produced by Shannon Torborg, PH.D./PSY.D., LP, provide an overview of the reasons WR was admitted to MSHS-Cambridge.

MINNESOTA DEPARTMENT OF HUMAN SERVICES STATE OPERATED SERVICES
DIAGNOSTIC ASSESSMENT MSHS Cambridge

Date of assessment: *3/15/2013* ***Date of admission:*** *3/13/13*

Reason for initial referral: *[WR] was referred for a psychological evaluation on 3/13/13 for purposes of diagnostic clarification. The undersigned conducted a review of records, clinical interview, and risk assessment with [WR] on 3/15/13.*

Informed consent:

[WR] was informed of the nature of the evaluation and limits of confidentiality. [He/She] was specifically informed that the information [he/she] shared today would be included in a report to be made available to [his/her] treatment team, guardian, case manager, future placements, and potentially the court. [He/She] indicated that [he/she] understood the limits of confidentiality and agreed to proceed with the assessment process.

BRIEF HISTORY

Current life situation: *[WR] is a 25-year-old, never-married, Native American [male/female]. [He/She] is indeterminately committed as a person with Developmental Disability. [He/She] was placed at MSHS-Cambridge on 3/13/13 after [his/her] provisional discharged was revoked on 10/2212. [He/She] has a court hearing in Hennepin County District Court-Criminal Division for a Rule 20 status review on 8/13/2013.*

Legal history: *Records suggest that [WR's] criminal history dates back to adolescence. As a juvenile, [he/she] was found incompetent to proceed to court in September 1999 and August 2004. [He/she] was again found incompetent to proceed to court in 2009, 2010, and 2011. Legal charges as an adult have included, but are not limited to, giving a police officer a false name, trespassing, two charges of fleeing a police officer, two domestic assaults, public urination, and 5th degree assault. The public urination and 5th degree assault charges were dismissed as well as one of the domestic assault charges. [WR] was charged with theft of an automobile on 2/15/2011 and admitted to AMRTC on 6/6/11 from Hennepin County Jail, where [he/she] had been held given [he/she] had been found incompetent to proceed to court for the theft.*

[WR] was transferred from AMRTC to the St. Peter Competency Restoration Program (CRP) on 10/31/12 to complete training and another Rule 20 assessment. On 2/23/12, [he/she] was discharged from St. Peter CRP to MSOCS East Central in Cambridge, MN. [He/She] eloped from staff during an outing to the Mall of America on 3/15/2012 and was found by police at the transit station. [WR] again eloped from staff during a home visit on 3/17/2012. [He/She] was charged with giving a Peace Officer a false name on 6/18/2012. [He/She] was returned to MSOCS East Central from the Hennepin County jail on 7/11/2012. [He/She] was charged with trespassing on 7/15/2012. Resultantly, a request for revocation of provisional discharged was filed with Hennepin County Court. The provisional discharge was revoked 10-22-12.

On 1/18/2013, a complaint was filed charging [WR], with Criminal Sexual Conduct in the Third Degree (felony); on January 24, 2013, the court found probable cause to believe a crime was committed and that [WR] committed it. Tricia Lynn Aiken, Psy.D., L.P., Senior Clinical Forensic Psychologist, was ordered to conduct an examination and evaluate [WR's] mental condition pursuant to Minn.R.Crim. P. 20.01. It was determined in this assessment that [WR] may be mentally ill or mentally deficient (sic) so as to be incompetent to stand trial. [WR's] next court hearing in Hennepin County District Court-Criminal Division, on the criminal matter and status review of Rule 20, Minn.R.Crim.P., is August 13, 2013 at 9:00am.

According to records, [WR] may have also stabbed a homeless man at some point, but it is unclear if [he/she] was charged. During [his/her] last commitment, [he/she] was accused of beating [his/her] mother and girlfriend with a frying pan.

The Diagnostic Assessment and Recommendations at that time were as follows:

***Axis I** (clinical disorders): Cannabis Dependence, In a Controlled Environment, Alcohol Dependence, In a Controlled Environment*
***Axis II** (developmental/personality disorders): Moderate Mental Retardation, Personality Disorder NOS, with antisocial traits*
***Axis III** (general medical conditions): Fetal Alcohol Effects/Status Encephalopathy*
***Axis IV** (psychosocial and environmental problems): Pending Legal Charges, Indeterminate DD Commitment, Separated from Family*
***Axis V** (current GAF): GAF = 40 (Serious impairments in several domains*

***Recommendations (**prioritize areas to be addressed in treatment and indicate areas of treatment to be deferred until after discharge):*

1. *[WR] appears to benefit from a highly structured environment. [His/Her] records indicate that too much unstructured time on [his/her] hands and lack of supervision can lead to problematic behaviors. It is the opinion of this Examiner that [WR] would benefit from a living environment that will provide consistency in treatment, expectations, and consequences.*

2. *Treatment planning and behavior programming should take into account [WR's] limited intellectual capacity. [He/She] may need extra time to process information and may not grasp all the major points in conversations. Care is needed when relaying important or complex information verbally. Use of concrete and simple language is recommended whenever possible, as well as asking for [WR] to summarize and relay the conversation back to ensure comprehension. Care should be taken by [his/her] treatment team to ensure that [he/she] has the time and appropriate means to comprehend information presented to [him/her], especially when discussing important aspects of [his/her] treatment.*

3. *Results of the current assessment suggest that [WR] has long-standing problems with substance abuse that have gone untreated. [His/Her] pattern of substance abuse appears to have contributed to interpersonal and legal problems for [him/her]. The undersigned is of the belief that [WR] will return to substance abuse when discharged if significant support is not provided. Return to substance abuse could set [him/her] up for relapse into other problematic patterns, such as impulse control problems, legal problems, and anger problems. A formal chemical dependency evaluation is recommended, as well as following through on any recommendations that come out of that assessment.*

REFERRALS REQUESTED

Functional Behavioral Assessment: Yes
Medical provider: Yes
Electronically authenticated by: SHANNON TORBORG, PH.D/PSY.D., LP on 3/15/2013 at 03:56 PM

WR had not been seen by Dr. Miller, the Psychiatric Consultant, or Diane Miller, the Psychiatric Nurse Practitioner. I was informed that this was because WR was not admitted on any psychiatric medication, and there were no plans to consider the use of psychiatric medication.

END OF WR

JL

The following excerpt from "Minnesota Department of Human Services State Operated Services Diagnostic Assessment MSHS Cambridge" provides the summary of the reasons for JL's admission to MSHS-Cambridge. This report was prepared by Stuart Hazard, L.P.M.A./M.S.

MINNESOTA DEPARTMENT OF HUMAN SERVICES STATE OPERATED SERVICES DIAGNOSTIC ASSESSMENT MSHS Cambridge

Date of assessment: *8/5/2012* ***Date of admission:*** *8/1/2012*

Reason for initial referral: *[JL] was accused of robbing an adolescent male of his backpack, which contained video game discs and controllers, at gunpoint on 3-9-2012. [He/She] was arrested the following day for aggravated robbery and prohibited person possessing a firearm. ([JL] has previous violent a/o drug related felonies on [his/her] record and was currently on probation for check forgery). [He/She] was subsequently assessed and found incompetent to stand trial, and was committed to the Commissioner as a person with developmental disabilities pursuant to Rule 20.01.*

Prior to the interview, [JL] was informed of the relative lack of privacy inherent in a diagnostic assessment such as this one, and that several interests, [his/her] social worker, the court, and other treatment professionals, would have access to the results. [JL] restated these conditions in [his/her] own words, and said that he understood and accepted them.

Legal history: [JL's] arrest record goes back to at least 2002 and [he/she] was frequently in trouble for rule breaking and violence in school prior to that. Again, the reader is referred to Dr. Lovette's evaluation for a relatively complete listing and description of legal problems and challenging behaviors.

Diagnostic Impression *(explanation of above diagnoses. Clearly indicate the need for 24/7 supervision and intensive residential services that cannot be provided in a less restrictive setting. Note the specific functional impairments related to the developmental disability and co-occurring mental health condition which have had significant negative impact and impaired the individual's ability to reside in the community):*

[JL's] self-described symptoms of persistent anger and sleeplessness appear to be adequate descriptions of manic events. [He/She] does not endorse depressive events. However, anger is a consistent component of depression as well, and given [JL's] history, depression and self loathing might be driving the same feelings. At this time. [JL] is perhaps more than adequately medicated for a mood disorder, so discrimination by this writer would be speculative.

[JL] endorses both Cannabis and Alcohol dependence, stating that if [he/she] were not here, [he/she] would be engaged in using both. This is as likely what drive [his/her] previous criminal behavior as anger, for it seems a direct route to getting money for drugs. [He/She] had no previous event with the victim, and used the threat of permanent injury or death to avoid the need to use actual physical violence. Until such time as [JL] is ready to accept the responsibility of earning [his/her] total income via legal means, [he/she] poses a threat to the safety of the community.

[JL's] history and self disclosures indicate that significant abuse has been part of [his/her] past and given that anger is a consistent variable in [his/her] acting out, especially as a youth, it seems relevant to consider in [his/her] treatment planning.

[JL] has consistently recorded I.Q. scores in the mildly cognitively impaired range for [his/her] whole life since a child in school.

Although not here for long enough for these symptoms to be apparent at MSHS-CA, [JL's] history is rife with examples of [his/her] having no concern for the needs of others in [his/her] use of them. [JL] will be better able to deal with these aspects of [his/her] personality if [he/she] learns that better social skill use is to [his/her] personal benefit.

[JL] was exposed to a high lead environment for approximately six to seven years while living with [his/her] grandmother. Her home was condemned twice for this reason.

Given that [JL's] mother was using cocaine during her pregnancy it is well within reason to assume that she was also drinking. As [JL's] facial and dental features as well as skull shape also correlate with fetal alcohol effects, this should at least be considered a possibility when doing treatment and support planning.

While at MSHS-Cambridge, JL has been followed psychiatrically by Diane Lawrence, Psychiatric Nurse Practitioner, or Dr. Peter Miller at least monthly. The excerpts from Dr. Miller's Progress Note, dated 4/10/13, are as follows:

CURRENT DIAGNOSES:

I. Mood disorder NOS
II. Intellectual disability mild
Antisocial personality traits
III. Seizure disorder by records, (no medication or formal diagnosis)
Cannabis and alcohol dependence

Allergies: NKDA – PEAS, BEANS, CARROTS

CURRENT MEDICATIONS:

Seroquel 100 mg po AM (Increased on 1/26/13)
Seroquel 200 mg po HS (Increased from 150mg on 1/25/2012) (time changed to 10pm 3/29/13)
Trazodone 25 mgs po HS 10 pm discontinued 3/14/13
Zyprexa 10 mgs po HS discontinued on 10/19/12
Nicotine patch discontinued 11/27/12, lack of use

LABS:

8-14-12 HgbA1c-5.4, ALT 162,AST-61
9/4/12 ALT-52,AST-25 HIV neg, Hep B, Hep C neg
12/4/12 CMP-wnl

The Summary of JL's status, the Assessment, and the Plan as of that time was as follows:

PSYCHIATRIST NOTES (4/10/13)

SUMMARY:

Above notes have been reviewed. [JL] was seen along with [his/her] team today. Overall staff describe [him/her] as doing well. [He/She] tolerated the shifting of [his/her] Quetiapine to HS on 3/29/13. [He/she] has been sleeping well since the Trazodone was stopped on 3/14/13. We discussed [his/her] weight gain of about 20 pounds since admission. [He/She] has made some efforts to deal with this such as changing to diet pop. However, [he/she] also eats "king-sized candy bars" fairly often. [He/she] states that [he/she] only eats them "every in the blue," but staff report observing this at least on a daily basis on most days. [He/She] can continue to be quite demanding about staff and can get angry when [he/she] has to share job opportunities as noted above.

ASSESSMENT:

1. *Mood disorder with history of psychotic symptoms and aggression when not receiving antipsychotic medication.*
2. *After trials of a number of different agents, [JL] does seem to respond reasonably well to a moderate dose of Quetiapine and this makes sense as a moderately long term treatment. [His/Her] potential for aggression is quite significant and needs to be balanced with any efforts to further reduce the medication.*
3. *However, [he/she] also has had some weight gain as noted and will need to be working at both diet but particularly exercise to help reduce the ultimate risk of mortality. I did discuss the health risks to [him/her] of being overweight and [he/she] at least partially seemed to understand this.*

PLAN:

1. *No medication changes.*
2. *Patient education as noted above.*
3. *Will work with staff on an ongoing basis to help find a better placement for [him/her] ultimately.*

END OF JL

EB

The following excerpts from the Assessment prepared by Ronald Taylor, LICSW, provide an overview of the reasons that EB was admitted to MSHS-Cambridge.

MINNESOTA DEPARTMENT OF HUMAN SERVICES STATE OPERATED SERVICES
DIAGNOSTIC ASSESSMENT MSHS Cambridge

Date of assessment: *11/1/2012* ***Date of admission:*** *10/29/2012*

Reason for initial referral: *The historic Hennepin County and Genesis Group Home records indicate that [EB] had been living at Genesis, where a series of events took place on 9-18-12. The legal guardian and interdisciplinary team apparently felt that [he/she] was no longer safe to be currently placed in the community at the Genesis Group Home, and the group home reportedly discharged [him/her]. Their report describes [him/her] expressing verbal aggression, punching, kicking, throwing rocks at a person, damaging property, and reportedly walking into traffic, before walking to the sidewalk. Their report indicates that this action was interpreted as being suicidal. [EB] denies being suicidal during that incident. Reportedly police arrived and [EB] was transported to Mercy Hospital. Reportedly no physical injuries were sustained. {EB] was informed that the information [he/she] provides may be shared with team members, [his/her] guardian, [his/her] case manager, a court, or other authorized people, and that I am required to report it if [he/she] reports danger to self or others. [He/She] is informed that [he/she] does not have to answer questions, such as to not answer anything that [he/she] does not want to talk about. [He/She] says that [he/she] understands and reports to be willing to proceed. [He/She] denies having any questions. [He/She] participates and is brief in [his/her] responses.*

Legal history:

The record indicates that there has been a history of a 5th degree assault charge in August of 2010, and potential legal issues from the reported events of September 18, 2012. [He/She] reports that [he/she] is not aware that [he/she] will need to go to court for anything.

History of dangerous behaviors and risk factors (Include the precipitants and stressors for the individual that have a history of leading to violent/dangerous behaviors to the individual or others, such as triggering events like medical illness, loss of housing, grief over death, and issues that make them feel shame or despair): Reportedly there is a history of a 5th degree assault charge in August of 2010, and potential legal issues from the reported events of September 18, 2012.

Genesis Group Home records indicate that:

On 1/2/12 [EB] stated that [he/she] wanted to die and [he/she] was transported to Mercy Hospital emergency department, where [his/her] medication was reportedly increased. On 1/24/12, [EB] reported to be dizzy with chest pains, and reportedly received medication at Mercy Hospital for quick on-set pneumonia. On 4/24/12, [EB] appeared to try to choke [himself/herself] with [his/her] own hand, kicked a staff person, and grabbed a butter knife. Prn medication was reported to be helpful. On 4-25-12, [EB] stated that [he/she] didn't recall kicking staff or grabbing the knife. [He/She] stated that [he/she] had a demon talking to [him/her] that was telling [him/her] to kill [himself/herself] and others. [He/She] stated that the demon left [him/her] when the staff asked [EB] to sit down. Later on that date, [EB] called 911 to tell them [he/she]

wanted to kill [himself/herself] and others. [He/She] then grabbed a bat, and then put it down when asked to do so. [He/She] ran and was found holding a small wood saw up to [his/her] neck saying if the staff person came close [he/she] was going to cut [his/her] throat. [EB] put the saw down after prompting. The police took [him/her] to Mercy Hospital for a 72 hour hold to address medication changes. On 5-8-12, [EB] called 911 and he asked to go to the hospital, and stated that [he/she] wanted to kill [himself/herself]. [He/she] was assessed at Mercy Hospital and discharged back to the group home. On 5-10-12, [EB] tried to call 911, punched a housemate, eloped, and punched staff, threw rocks at staff, one of which struck staff. Police transported [him/her] to Mercy Hospital. On 6-10-12, [EB] punched staff, kicked, and twisted the staff person's hand. On 6-23-12, [EB] refused to turn down very loud music, started name calling, and stated that [he/she] wanted to kill [himself/herself]. Police took [him/her] to the Mercy Hospital emergency department. On 6-28-12, [EB] reportedly charged and hit a staff person four times. Police were called and [he/she] was transported to the Mercy Hospital emergency department. Intake records indicate that on 6-30-12, [EB] was admitted to St. Joseph's Behavioral Unit, where [he/she] attacked a security guard. [EB] was reportedly discharged to Hermantown Crisis where [he/she] was admitted on 7-26-12. On 9-18-12, events reportedly took place at Genesis Group Home, which are listed in the reason for initial referral. Hospital records indicate that there was crying, verbal threats, and a physical altercation at the hospital on 9-26-12. [EB] reported that [he/she] intentionally cut [his/her] right shoulder a few months ago, and reportedly did not need stitches for it.

Reported suggested factors in triggering include [his/her] family, getting upset over [his/her] housemates, if [he/she] doesn't get [his/her] way, if [he/she] doesn't like what the staff say to [him/her], or thinks that the staff doesn't listen to [him/her]. Other reported issues include if [he/she] thinks staff doesn't answer [him/her] right away, if [he/she] doesn't' earn [his/her] reward, or if [he/she] is being asked things that [he/she] considers [his/her] personal business. Reportedly [EB] has talked of suicide in the past, and the group home reportedly interpreted [his/her] actions of 9-18-12 as being suicidal. [EB] denies being suicidal during that incident.

EB has received psychiatric treatment from Diane Lawrence, Psychiatric Nurse Practitioner, and Dr. Peter Miller, the Consulting Psychiatrist. [He/She] was seen by one of them at least monthly. The most recent Psychiatric Progress Note is from Dr. Miller; the prior three monthly Progress Notes are from Ms. Lawrence. The excerpts from Dr. Miller's Progress Note, dated 4/10/13, are as follows:

CURRENT DIAGNOSES:

I: Schizoaffective Disorder bipolar type
II: Intellectual disability – mild
III Asthma; hypothyroidism; Hyperlipidemia

Allergies: Aspirin, Ibuprofen-contraindication while take Lithium, seasonal allergies

CURRENT MEDICATIONS:

Quetiapine 200 mg QID (increased on 3/15/13)
Perphenazine 2mg BID
Divalproex ER 1250mg BID (increased on 1/26/13)
Amitriptyline 10 mg HS
Trazodone 100mg HS
Hydroxyzine 50mg at noon (changed from HS to noon on 1/25/13)
Tricor 48mg Daily

Metformin 500mg BID
Zocor 20mg HS
Synthroid 150 MCG Daily
Claritin 10 mgs po daily
Lithium 300mg BID (increased on 3/15/13)

This Progress Note also contains a detailed history of EB's treatment with psychotropic medication, going back to 2006. The recommendations at that time were:

PLAN:

1. *We have arranged for a face-to-face meeting with the guardian for 5/1/13. At that point we can go over the above medication history and any further recommendations. Due to the Lithium level being low at 0.4, I initially was planning the Lithium but the guardian indicated she would prefer to wait until we had discussion as scheduled.*

2. *Staff will continue to monitor [EB's] potential for aggressive violence. We discussed today options to deal with this, including admission to a general psychiatric hospital. This would not require a commitment. The necessity for commitment has been a road block for admission to AMRTC at our unit for people with intellectual disability and mental illness.*

END OF EB

KC

The following excerpts from the Minnesota Department of Human Services State Operated Services Diagnostic Assessment MSHC-Camridge for KC provide an overview of [his/her] history and status at the time of admission to MSHS-Cambridge.

Date of assessment: *11/30/2012* ***Date of admission:*** *11/26/12*

Reason for initial referral: *Intake information from Faribault/Martin County, including court records and a report to the court by Gregory A. Hanson, Ph.D., L.P., Forensic Psychologist, on September 20, 2012, indicate that: [KC] was found to be a Mentally Ill and Developmentally Disabled person, as of October 3, 2012, in Martin County District Court, and in need of commitment. [KC] was committed to the custody of The Commissioner of Human Services of Minnesota for placement at such facility as the Commissioner may designate, for an initial period not to exceed six (6) months. Reportedly, [KC] can no longer reside at St. Peter Young Adult and Adolescent Program, Minnesota Security Hospital, where [he/she] has resided since July 24, 2012. Prior to the placement in St. Peter, [he/she] was being held at Minnesota Correctional Facility-Red Wing, where [he/she] had been transferred from Elmore Academy. Concerns have included aggressive behavior and property destruction. [His/Her] history indicates that on January 18, 2012, [he/she] apparently attempted to strangle [his/her] roommate with a belt, at Horizon Program, Elmore Academy. In the interview today [KC] is informed that the information [he/she] provides may be shared with team members, [his/her] guardian, [his/her] case manager, a court, or other authorized people, and that I am required to report if [he/she] reports danger to self or others. [He/She] is informed that [he/she] does not have to answer questions, such as not answer anything that [he/she] does not want to talk about. [KC] reports that [he/she] understands and reports to be willing to proceed. [He/she] denies having any questions. [He/She] participates and is brief in [his/her] responses.*

Legal history: *[KC] was found to be Mentally Ill and Developmentally Disabled person, as of October 3, 2012, in Martin County District Court, and in need of commitment. Charges of Terroristic Threats and Fourth Degree Damage to Property from a reported incident on July 1, 2012, were reportedly dismissed on July 24, 2012, upon the commitment order.*

Strengths and protective factors *(Identify both internal and external strengths/protective factors): [KC] can reportedly enjoy activities, can reportedly have times of associating positively with others, and reportedly has a very good sense of humor.*

Needs: *[KC] reportedly can use help in dealing with self-control and boundaries. [He/She] may find it helpful to have ongoing opportunities to talk with staff about [his/her] thoughts and feelings. Ongoing review of needs by the team is expected to provide additional information.*

Recommendations *(Prioritize areas to be addressed in treatment and indicate areas of treatment to be deferred until after discharge): Addressing anger management issues would appear to be beneficial. Illness and Management and Recovery components such as Coping with Stress, and Building Social Supports, and possibly others, as available, may be helpful. It is recommended that opportunities to talk with staff be provided. [KC] reportedly does better in keeping focus when a person is active in repeating or reframing questions when needed. [He/She] reportedly does better when spoken to in a calm voice and with patience.*

REFERRALS REQUESTED

Psychological testing: No
Psychiatric consultation: Yes
Neurological examination: No
Functional Behavioral Assessment: No
Medical provider: Yes
Other referral: No

Electronically authenticated by: RONALD TAYLOR, LICSW on 11/30/2012 at 03:28 PM

KC was seen by Diane Lawrence, Psychiatric Nurse Practitioner on 12/26/12. The following excerpts from the corresponding Progress Note, dated 1/12/13, indicate that the psychiatric diagnoses at that time were:

CURRENT DIAGNOSES:

Axis I: Cognitive Disorder NOS
Disruptive Behavior Disorder NOS
Rule-out Psychotic Disorder, NOS
Axis II: Mild Intellectual Functioning
Axis III: Seizure disorder (ill defined)
Hypothyroidism
Systolic ejection murmur
Medication induced constipation
Status post-surgical correction of Arnold Chiai malformation complicated by questionable postop meningitis requiring re-operation
History of near drowning episode
Status post tonsillectomy
Status post dog bite injury to scalp

KC's psychiatric and anticonvulsant medications at that time were as follows:

CURRENT MEDICATIONS:

Colace 100mgs po BID
Focalin XR 20 mgs po daily
Melatonin 5mgs po HS
Synthroid 75 mcg po daily
Tegretol XR 600mgs po BID
Topamax 200mgs po BID
Zyprexa 5 mgs po HS

The following entries provide an overview of KC's adaptation to the facility, at that time:

Discharge Plans: Discharge planning begins as soon as clients are admitted to MSHs. After initial assessments are completed a more detailed plan will be submitted to [his/her] county case manager outlining supports that will be needed so that [KC] can be served in a less restrictive setting.

Notes:

[KC] continues to do well. Staff have noted that in the morning on a couple occasions, [he/she] appeared distracted as [he/she] looks around the house and whispers.

Request that [his/her] dosage of anti-psychotic be reviewed. [KC] is responding to internal stimuli and has been talking to [himself/herself], especially when [he/she] is alone in [his/her] room.

[KC] is now [his/her] own guardian. [He/She] turned 18 on 12/3/12. [KC] has a guardianship hearing in January, [he/she] will not need to be present for the meeting.

[KC] has been attending more groups: mini cores, IM&R, wellness, health education, job club, school and canteen. [KC] has also engaged in playing cards, watching movies, coloring word find and playing the Wii. [He/She] seems to prefer smaller groups and has been more social.

Medical:

(12/22/12) [KC] was seen by Keri Anderson RN, NP on 12/10/12. [He/she] is in good health and interacting clearly with her. [He/she] has a seizure disorder, grand mal and partial complex type. [He/she] is known to have nighttime seizures but it is not known when [he/she] last had a seizure. [KC] is monitored every hour currently. [He/She] has glasses at St Peter Eyecare center which will be sent to [him/her] here. [He/She] also had an echocardiogram while at St Peter and the report has been sent for. [KC] was seen by the dietician as [he/she] had been on double portion diet and this has been changed to regular.

KC was seen by Dr. Peter Miller on 1/9/13 and 4/10/13. The Progress Notes suggest that [he/she] was seen at least monthly by either Dr. Miller or the Psychiatric Nurse Practitioner.

There is no discernible difference in the structure of the Progress Notes prepared by these two psychiatric providers. The most recent Psychiatric Progress Note relates to Dr. Miller's 4/10/13 assessment. At that time, the prescribed psychiatric and anticonvulsant medications were:

CURRENT MEDICATIONS:

Colace 100 mgs po BID
Focalin XR 15 mgs po daily (decreased on 1/18/13)
Melatonin 5 mgs po HS
Synthroid 75 mcg po daily
Tegretol XR 600 mgs po BID
Topamax 200 mgs po BID
Zyprexa 10 mgs po HS (increased 3/15/12)

The following Summary, which was prepared by Dr. Miller at that time is as follows:

PSYCHIATRIST NOTES 4/10/13

SUMMARY: Above notes have been reviewed [KC] was seen with the staff in a team meeting. [He/She] appeared to be significantly better than at my last visit. [He/She – himself/herself] reported that [he/she] doing quite "good." When asked for details [he/she] said that is better in "all sorts of ways." [He/She] has more privileges, [he/she] is doing more, [he/she] is wanting to do more. Staff concur. They feel that there has been a definite improvement since increase in Olanzapine on 3/15/13 although there was also some increase in agitation and disruptive behavior after the reduction of [his/her] Dexmethylphenidate which was done on 1/18/13. [KC] has been going to school to work toward finishing high school. [KC] thinks [he/she] won't graduate until next year but [he/she] is enjoying some science related classes among others.

Staff reported that [KC] did have an additional seizure about a week ago, with somewhat different quality. It happened while [he/she] was up and walking out of the bathroom. Usually these happen while [he/she] is asleep or just waking up. [His/Her] mother reported to staff that [he/she] had one similar to this many years ago but has not had one like this lately. [He/She] was observed coming out of the bathroom with an odd look on [his/her] face, drooling, and staggering. [KC] was unresponsive but the duration was not noted. It was reported however that [he/she] did very quickly return to normal. There was no falling, no injury, no incontinence.

The Plan at that time was:

PLAN:

1. *Increase Topirimate to 225 mg twice daily in view of the possible increase in frequency or type of seizure symptoms.*

2. *Should this not be effective we would then also need to send [him/her] out to a neurologist for further assessment and advice on treatment.*

3. *We will also obtain serum basic metabolic panel to make sure we are not disrupting [his/her] bicarbonate levels with the increase in Topirimate.*

4. *After stabilization of the above, would consider further reductions in the Dexmethylphenidate, down to 10 mg daily for a couple weeks, 5 mg daily for a couple weeks, and then stopping. However, we need to be careful to not precipitate a need for further increases in Olanzapine, and to review this with [his/her] guardian as changes move along.*

END OF KC

JSH

The following excerpts from the assessment prepared by Jack Kasl, Ph.D./Psy.D., LP provide an overview of the reasons for JSH's referral to MSHS-Cambridge.

JSH has been followed psychiatrically by Diane Lawrence, Psychiatric Nurse Practitioner, and Dr. Peter Miller at least monthly. The most recent Progress Note from Dr. Miller refers to the 4/10/13 Progress Note. The relevant excerpts are as follows:

MINNESOTA DEPARTMENT OF HUMAN SERVICES STATE OPERATED SERVICES DIAGNOSTIC ASSESSMENT

Date of assessment: *6/10/2012* ***Date of admission:*** *6/5/2012*

Reason for initial referral: *[JSH] was hospitalized three times in the past several months for verbal and physical aggressions toward [his /her] group home staff. Prior to [his/her] admission, [he/she] was hospitalized for allegedly raping a male peer at [his/her] group home. Given [JSH's} behavior challenges, community placements would not accept [him/her] back in their settings. [He/she] remained at Hennepin County Medical Center until [his/her] admission to MSHS-Cambridge.*

Legal history: *[His/Her] adopted mother continues to be [his/her] guardian. [JSH] is civilly committed as a person with developmental disabilities.*

Recommendations (prioritize areas to be addressed in IRTS treatment and indicate areas of treatment to be deferred): [JSH] could benefit from a behavioral assessment of [his/her] challenging behaviors, as these behaviors prevent [his/her] placement at lower level of care. Educational and treatment components of group therapy such as Illness Management and Recovery and behavioral milieu programming can assist [JSH] in coping with [his/her] mood symptoms and behavioral problems as well as developing a healthy tolerance for less structured routines if they are preferred and desired for "important for" and "important to" living in the community. On-going medical supervision of [his/her] medications is essential.

CURRENT DIAGNOSES:

I. Pervasive Developmental Disorder, NOS
Conduct Disorder, Childhood-Onset Type
Mood disorder with bipolar and psychotic features

II. Intellectual Disability with Mild Cognitive Impairments

III. Bilateral Hearing Impairment
GERD
Fetal Alcohol Spectrum Disorder Prenatal Cocaine Exposure

Allergies: Clozapine – neutropenia (no re-challenge per records)

CURRENT MEDICATIONS:

Quetiapine 225 mgs po TID 8-12-8 (increased 01/09/13)
Haloperidol Decanoate 150 mgs IM q 2 weeks (last dose 4/5/13)
Haloperidol 5 mgs po BID 8-8
Divalproex 1000 mg po BID 8-8 (decreased 01/09/13)
Paroxetine 40 mgs po daily 8am (decreased to 30 mgs on 3/15/13 and increased back on 3/29/13)
Hydroxyzine 50 mgs po TID 8-12-4 (noon dose changed to 2pm)
Fiber tab 2 daily at 4 pm
Colace 200 mgs po daily at 8am
Protonix 20mgs po daily PRN

PSYCHIATRIST NOTES 4/10/13

SUMMARY: Above notes have been reviewed. [JSH] was seen with [his/her] team. They report overall [he/she] has been doing well. [He/She] did have increased agitation and anxiety after reduction in Paroxetine on 3/15/13. [He/She] has done better since the dose was returned to 40 mg daily. [He/She] has not had any significant problems in the last 10 days. [JSH] is handling frustration better but does still have some episodes related to planning [his/her] discharge. [He/She] had a monitoring meeting this morning and [he/she] reports that it went well. Staff later reported the same. In essence, [he/she] is near discharge. [He/She] has not been voicing any concern about voices and in fact today specifically mentioned the Haloperidol as having helped [him/her] with voices. [He/She] di make brief mention to "Trevor" being present in the room but apparently has not been saying anything about this recently at all probably for many weeks if not months.

PLAN:

1. *No medication changes at this point.*
2. *Support plan of the team to move toward discharge and transition to a situation more fully integrated with the community.*

END OF JSH

As evident from this information, all of the individuals resided in settings other than a community residence or their family home prior to their admission to MSHS – Cambridge.

The role of the Facility in the Minnesota system of care can further be defined by an analysis where individuals go when they are discharged from the Facility. The following list of ten most recent discharges was prepared by the Director of Admissions, in response to a request generated at the time of the review.

	DATE OF DISCHARGE	*DATE OF ADMISSION*	
N.K.	*10/26/2012*	*7/1/2011*	*MSOCS, Pine Island, MN*
J.R.	*11/6/2012*	*5/4/2012*	*MSOCS, Brainerd*
J.H.	*12/19/2012*	*12/11/2012*	*Benton County Jail, Foley, MN*
R.S.	*12/27/2012*	*12/21/2012*	*AMRTC, Anoka, MN*
R.T.	*1/2/2013*	*7/25/2012*	*Provide Care – Jackson, Pine City, MN*
M.B.	*2/4/2013*	*5/23/2012*	*Opal, Rosemount, MN*
P.I.	*2/4/2013*	*8/28/2012*	*Guardian's Home, International Falls, MN*
M.S.	*3/7/2013*	*2/20/2013*	*AMRTC, Anoka, MN*
B.R.	*3/12/2013*	*5/16/2012*	*Provide Care – Reagan, Rush City, MN*
A.K.	*3/21/2013*	*1/3/2013*	*Provide Care – Jackson, Pine City, MN*

In reviewing this list with the Director of Nurses, she indicated that the goal is for every individual to be discharged to a community residence. All of the individuals listed above had been discharged to such a residence, with the exception of the two individuals who were sent to the AMRTC that is located within the Regional Center in Anoka, MN. This unit is able to provide intensive psychiatric treatment. There is also one individual who was returned to a correctional setting.

Discharge planning was discussed during each of the interviews with the residents, which were also attended by at least one member of the Interdisciplinary Team. During each of these interviews (with the exception of JL, who did not consent to the interview), the topic of discharge placement was discussed. These discussions revealed that each individual was not only aware of the evolving plan, but was also a participant in the process. The progress of this planning varied according to the length of time that the individual had resided at the Facility. Those individuals who had been at the Facility for several months were, of course, more likely to have identified a specific community residence to which they had hoped to move; whereas, those that had been admitted within the past few months were less apt to have had a specific residence identified.

Based on these interviews, one of the primary impediments to this process was finding a suitable residential program within reasonable proximity to their family so that they could maintain contact.

2. HABILITATIVE TREATMENT/SERVICES

Are Habilitative Treatment/Services Appropriate?

The MSHS – Cambridge has gone through three substantial programmatic changes in the past several years. Historically, the facility maintained what is described as a very active vocational program, which included a number of options for individuals, based on their abilities, as well as their personal interests. Staff members who were employed at the facility in that era described these options as including a broad spectrum of vocational choices, ranging from gross motor activities, such as landscaping – to fine motor tasks, such as assembling and small machine repair. There were also opportunities for paid employment both at the facility and in the larger community. The staff members who worked at the facility in that era clearly felt a great deal of pride in that aspect of the services that were provided to the residents.

As the facility's census decreased over the years, it was difficult to maintain this extensive level of vocational programs. Approximately three years ago, the administration of the facility put into a place a rehabilitative model that was group based. The educational materials that guided the curriculum of this group-based model, had originally been developed to address the needs of individuals with psychiatric illnesses. The facility had recently replaced that system with a new curriculum that contains elements of material that the staff had successfully used in the past. Those members of the Treatment Team with whom I spoke felt that the new curriculum was more appropriate for the individuals that currently reside at the facility. Specifically, they felt that the modules directed toward anger management and health awareness were effective.

During the interviews with the individuals that currently reside at MSHS-Cambridge, I inquired as to their perception of these groups, as well as their attendance. The individuals appeared to have the highest regard for the module that was related to anger management, and also were more likely to participate in those activities. Although aggregate data on attendance was not available, my impression was that attendance ranged from *hardly ever* to *most of the time*, with an average of about 50%.

The three individuals who were under the age of 22 were provided education services during the week in the facility Administration Building. Of interest is the observation that all three of these individuals indicated that they attended these academic classes 100% of the time, and the staff who worked with them verified this. One of the individuals was working on his homework for this class on Saturday morning, before I interviewed him, and he was anxious to resume his work at the conclusion of the interview. The staff members with whom I spoke confirmed that these students attended the classes with the frequency that they had described, and that they always went willingly to the sessions, unless they were ill. When I inquired as to the reason for the difference in the perception that the residents had of these classes, as opposed to

the curriculum that is used on the Unit, I was told that the teacher who provided the educational classes was not only very innovative, but was also able to make the learning enjoyable, so that the students looked forward to attending the classes.

Many of the staff members with whom I spoke were also demoralized by their feeling that they were unable to provide the individuals with active treatment. This feeling was especially present in those members of the IDT who had been present during the era where the resources existed to provide more meaningful vocational activities.

In addition to the lack of vocational activities, the staff members also shared the perception that they were unable to provide any direction or structure to the individuals' daily activities, for fear that this might provoke an aggressive response by the individual, and that responding to such a response would incur the risk that they would be in violation of the Settlement terms of the lawsuit and related Court ruling. As a result of this, the daily activities of the residents were, essentially, unstructured, unless the individual was internally motivated to take part in an activity. During the 5/14/13 interview with the Facility Administrator, he indicated that although some staff members may have this reaction, it is not the perception of all of the staff.

As indicated above, the individuals who are admitted to MSHS have significant psychiatric illnesses that directly affect their ability to live in a less structured community setting. Many also have a history of negative involvement with the legal system, with some also having active Court involvement. At the time of this review, there were three individuals who were specifically committed to the facility on what are referred to as "Rule 20" commitments related to a finding of their being "Incompetent to Stand Trial" for outstanding criminal charges. The purpose of these commitments is to determine if these individuals can be restored to competency.

During the course of the onsite review, a request was made to view the printed curriculum for the educational material that the facility utilizes to achieve this goal. I was able to review this material in the context of the interview with a member of the Treatment Team and one of the residents at the facility who was under a "Rule 20" Court commitment.

I could not determine the number of pages in the printed curriculum, as each section was paginated separately, and there were several sections. I was able to estimate that the folder contained several hundred pages, as the thickness of the material, when placed flat on the table, is approximately between two to four inches high. The individual was able to show me how far he/she was into the material, and it was within the range of 20 pages. The Log Book, which documents the amount of time that a staff member spends reviewing the material with the individual, did not indicate a specific pattern of structured curriculum, and the list of the contacts could fit on one page of a handwritten sheet.

The status found "Incompetent to Stand Trial," but then referred to a facility to be restored to "Competency" essentially places the individual in a legal purgatory, as the

charges cannot be definitively resolved until they are either found to be “Competent” or “Incompetent” because they cannot be restored to competency. Thus, a more active structured approach to the resolution of this issue would potentially hasten the individual’s return to a more integrated setting.

An analogous situation exists with the risk evaluation and determination process. As indicated in the individual summaries above, each of the individuals who resided at MSHS-Cambridge has engaged in actions that have either actually or potentially posed an overt risk to others and/or themselves. In some cases, the Risk Assessment section primarily refers back to the earlier historical section, while in others, it appears to reproduce the list of dangerous acts that the individual has committed. Although this is important information, it frequently does not provide enough of the historical context to fully understand the precipitants of those acts. A thorough understanding of the historical context of those behaviors can provide useful data that will then inform the treatment program. The description of the list of the individual’s aggressive acts, without this important contextual information can understandably make community programs reticent to provide services to them, as it can appear that there is no way to effectively treat or manage them. A thorough Risk Assessment evaluation that takes into account the historical context for the individuals prior dangerous actions can often make those behaviors more understandable and potentially responsive to treatment.

The individual profiles, which appear in the first section of this report, indicate that the individuals who are admitted to the facility have serious psychiatric disorders in addition to their intellectual and developmental disabilities (ID/DD). These individual summaries also indicated that the psychiatric treatment for those individuals is provided via a monthly visit to the facility by either a Psychiatric Nurse Practitioner or the Psychiatrist with whom she works. Thus, once a month each individual is interviewed in the context of a meeting between the psychiatric provider and the individuals’ Interdisciplinary Team. The impression that I had from speaking on the phone with the Consulting Psychiatrist is that these monthly visits to the facility actually occur in the course of one day, and the subsequent interview with the Facility Director confirmed that was correct.

During the 5/14/13 telephone discussion with the Facility Administrator, he also indicated that the Psychiatric Nurse had recently accepted a position at another facility, and that the Consulting Psychiatrist would be providing all of the services until a replacement could be identified. Both the Psychiatrist and the Facility Director indicated that the Consulting Psychiatrist is available for telephone consultation when he is not on site.

The Progress Notes indicate that the psychiatric providers gather information from the team members that are then incorporated into the Progress Notes. It is not clear how much direction a Psychiatrist can provide to the Treatment Teams in the course of these monthly meetings. The frequency of psychiatric visits is similar to the standard that is commonly utilized in a regional treatment center for individuals with ID/DD. However, the individuals who are admitted to the facility present with a level of

psychiatric illness that is similar to that encountered in a psychiatric hospital. As noted above, many of the individuals have significant psychiatric and behavior disorders that have proven to be refractory to prior pharmacological and other forms of treatment.

Thus, the facility may want to consider increasing the frequency of psychiatric involvement to a level that is closer to the standard for a psychiatric hospital. The residents are also frequently on multiple psychiatric medications, which constitute polypharmacy. A comparison of each individual's psychiatric medications upon admission, with their most recent medications, indicate that little progress is made during these admissions to reducing polypharmacy, it is possible that more frequent psychiatric input could contribute to greater progress in reducing medications that may not be essential.

The individuals who are admitted to the facility also present with behavioral issues that could benefit from a thorough Functional Analysis, which could then be used to inform the Behavior Plan. The facility is hiring a new Director of Psychological Services. During the onsite interviews with staff members, I was told that this individual does have a doctorate in Psychology and is planning on implementing changes that would include a thorough Functional Analysis for the individuals for whom it would be appropriate. The Facility Director also indicated that this individual has considerable experience, which should prove valuable in the effort to provide more active treatment to the residents of MSHS-Cambridge.

In summary, one cannot conclude that active treatment and habilitative services are currently in place for the residents of MSHS-Cambridge. The implementation of measures that would constitute active treatment could, conceivably, shorten the length of time the individuals reside at the facility before they can return to a community residence. It was clear during the interview with the Facility Director that he is committed to enhancing the habilitative services that are available to the residents of MSHS-Cambridge, and it is hoped that the new Director of Behavioral Services will implement effective changes.

3. MOST INTEGRATED SETTING

Are Residents Served in Most Integrated Setting Appropriate?

The table below lists the residential setting where each of the individuals resided prior to their admission to MSHS-Cambridge.

INDIVIDUAL	PRIOR RESIDENCE
SW	Private psychiatric hospital
MR	Young Adult and Adolescent Program State Operated Intensive Treatment Program
WS	AMRTC-Anoka
LD	AMRTC-Anoka
JS	Private psychiatric hospital
WR	Hennepin County Jail
JL	Jail
EB	Private psychiatric hospital
KC	Young Adult and Adolescent Program State Operated Intensive Treatment Program
JSH	Private psychiatric hospital

These prior placements could all be considered to be more or equally restrictive to the MSHS-Cambridge facility. The circumstances that led up to their transfer also suggest that this placement was a reasonable decision, in light of the current options that are available to the Department. The current problems related to this factor derive from the deficits in habilitative treatment identified above. These deficits result in these individuals residing at the facility longer than might be necessary, if more active treatment options were available. The more detailed risk assessment that is described in that section of the report could also result in community residences being more open to developing residential services for them.

During the 5/14/13 telephone interview with the Facility Director also discussed the issue of the length of time that the individuals reside at MSHS-Cambridge after the IDT has determined that their clinical status has stabilized to the point that they could be returned to a community placement. He indicated that, since the Minnesota Extended Treatment Options (METO) program closed, and the MSHS-Cambridge program was opened in January 2012, 31 individuals have been admitted, and then discharged from the program.

The distribution of placements for those individuals is as follows: Small community group home setting (17); family of origin (2); correctional facility/jail (2). Other state-operated facilities, such as the intensive treatment at the Anoka Regional Center or

another MSHS facility (9); and one individual who was deemed competent and had no outstanding criminal charges, left the facility of his own volition.

One factor that complicates and can delay a MHSH-Cambridge residence to a community setting is the variable resources of the respective individual's county of origin, which is responsible for both developing and financing this program. The other complicating factor is the desire to locate a residence that is not only appropriate, but also in close proximity to the individual's family, so that relationships can be maintained. This discussion of least restrictive settings also raises the question as to whether or not a function of the MSHS-Cambridge could be carried out in more community residences that have security enhancement, such as door and window alarms. Mr. Jensen indicated that there are state- and vendor-operated programs that do have these security measures in place.

4. MEDICATION & BEHAVIOR

Is Use of Medication Appropriate?

There is no indication that psychotropic medications are overtly used to manage behavior or restrain freedom of movement. However, as noted above, the residents are often admitted on multiple medications from their prior placements, and the facility does not appear to make aggressive efforts to decrease these medications when the individual is stable.

There is no indication that prn medications are used for punishment, for the convenience of staff, or as a behavior modification technique. However, the Facility Director did indicate that the Psychiatrist can write an order that would allow a resident to ask for an extra dosage of a medication if they felt that it would help them. The decisions concerning these orders are made by the Psychiatrist, working in conjunction with the IDT and the individual. The facility staff can also offer this medication to the individual if he is becoming upset, but cannot force or coerce them to take the medication.

The forms that are used for the documentation of medication administration are similar to those commonly used in other facilities.

5. EMERGENCY RESTRAINT

Were Restraints Used Only in an Emergency?

I did not find any indication that emergency restraint is used at MSHS-Cambridge. However, in the discussion with the Facility Director, he indicated that there were six incidents in December, 2012, which required them to place 911 Calls to the local police for assistance. During the course of the discussion of these events, it became clear that these incidents were all related to two individuals. One of these had been admitted from the correctional system, and returned to jail, as he violated his Probation. The other individual was admitted after a prolonged stay of several days in a psychiatric emergency room, due to severe psychotic illness, with associated aggression. This individual was subsequently discharged to a more secure setting. Since January, there have only been three 911 Calls that resulted in the police coming to the facility. It is not clear if having the police arrive in response to a 911 Call is less intrusive than an emergency restraint applied in the facility. Obviously, this depends on the nature of the incident and the response of the police who arrive at the facility.

6. TRANSITION PLANNING

Is Transition Planning Properly Accomplished?

The facility indicates that “Discharge planning begins at admission” and the available documentation supports this assertion. This planning also includes the individual and their family. However, the Treatment Team frequently concludes that the individual is ready for community placement several weeks to months prior to the identification of a community placement that will accept them. The deficits identified earlier in this report contribute to those delays, as does the lack of a sufficient number of community programs that are designed to serve individuals with these profiles.

Minnesota Department of **Human Services**

June 4, 2013

David Ferleger
Archways Professional Building
413 Johnson St., Ste. 203
Jenkintown, PA 19046
Via email only – david@ferleger.com

Re: *Jensen et al. v. Minnesota Department of Human Services et al.*
Court File No. 09-1775 (DWF/FLN)

Dear Mr. Ferleger:

Thank you for providing your May 22, 2013, draft Status Report on Compliance ("Report") to the Minnesota Department of Human Services ("Department") for review and comment. The Department sincerely appreciates that time and effort expended by you – along with Drs. Fredda Brown, Linda Bambara and Edwin Mikkelsen – in the preparation of the Report.

The Department believes it has significantly improved the care and treatment provided to individuals with developmental disabilities, including but not limited to the individuals residing at Minnesota Specialty Health Services – Cambridge and MSOCS Transition Home (collectively "Cambridge"). However, the Department recognizes that there is still work to be done. As further discussed below, the Department is actively working to address the concerns raised in the Report, and strives to achieve and maintain substantial compliance[1] with the terms of the Settlement Agreement in the coming months.

This response provides information regarding the following: (1) the Department's establishment of a formal Jensen Implementation Team; (2) the adoption of best practices for the population currently served at Cambridge's campus-based facility; (3) the Department's approach to the Report's recommendations; and (4) the Report's non-compliant findings.

I. FORMAL JENSEN IMPLEMENTATION TEAM

To date, the Department has dedicated a significant amount of time and attention to achieving and maintaining substantial compliance with the terms and the spirit of the Settlement Agreement, and to ensuring that it meets the needs of the individuals with developmental disabilities in its care. However,

[1] The Court's April 23, 2013, Order requires the Department to reach "substantial compliance" with the terms of the Settlement Agreement. (Order, Apr. 23, 2013, p. 6.) The Court Monitor defines "substantial compliance" on pages 26 and 27 of the Report. However, the parties have yet to reach an agreement as to their understanding of the definition of "substantial compliance", and the Department reserves the right to contest the definition of this term.

in light of the Court Monitor's recent findings and recommendations, the Department finds it imperative that it increase the resources it dedicates to these goals.

- Accordingly, the Department has formed a formal Jensen Implementation Team. The Team will focus on formalizing the Department's Jensen Settlement Agreement implementation plan and implementation management system. Specifically, the Team will ensure that the Department fulfills its obligations under the Settlement Agreement, fully honors and implements the *Olmstead* principles, and consistently adopts and implements best practices.

- The Jensen Implementation Team's members include Jensen Compliance Officer Christina Baltes[2], Deputy DHS Commissioner Anne Barry, Direct Care Executive Director Steven Allen[3], Direct Care Executive Director Patricia Carlson, Cambridge Executive Director Steve Jensen, Compliance Office Special Projects Manager Mike Tessneer, Director of Disability Services Alex Bartolic, Internal Reviewer Dr. Richard Amado, Project Lead (*Olmstead* Plan) Rosalie Vollmar, Chief Compliance Officer Gregory Gray, Chief General Counsel Amy Kaldor Akbay, Legal Management Office Attorney Leah Flygare, the newly appointed Operations Manager (discussed below), and the newly appointed Project Manager (discussed below).

- Christina Baltes, RN, PHN, BSN, MA, QDOP/QIDP will manage and oversee the Jensen Implementation Team's work and the Department's overall compliance with the Settlement Agreement. Ms. Baltes will dedicate her time and considerable expertise to meeting the above-outlined goals.

II. ADOPTING BEST PRACTICES FOR THE POPULATION CURRENTLY SERVED AT CAMBRIDGE'S CAMPUS-BASED FACILITY

The Department is developing a plan to adopt best practices for the population currently served at Cambridge's campus-based facility, specifically, by developing individually tailored services and supports that safely support individuals in the most integrated setting. This plan will be created in collaboration with the Court Monitor, Settlement Class Counsel, Ombudsman Opheim, and Dr. Wieck. The Department will provide the aforementioned plan to the Court Monitor, Settlement Class Counsel, Ombudsman Opheim, and Dr. Wieck on or before June 30, 2013. In connection with these changes, the Department intends to repurpose Cambridge's campus-based facility so that it no longer serves individuals who are solely civilly committed as developmentally disabled.

III. THE REPORT'S OVERARCHING ISSUES, FINDINGS & RECOMMENDATIONS

The Department is actively working to address the concerns and implement many of the recommendations contained throughout the Report (*see* Report, pp. 31-134), some of which are discussed below. On or before June 30, 2013, the Department will provide the Court Monitor, Settlement Class Counsel, Ombudsman Opheim, and Dr. Wieck with a detailed action plan explaining how the Department will address these overarching issues, findings and recommendations. This action

[2] A copy of Ms. Baltes' resume is attached hereto.
[3] A copy of Mr. Allen's resume is attached hereto.

plan will include a list of specific tasks and deadlines, and will identify the person(s) responsible for addressing each recommendation.

IV. THE REPORT'S NON-COMPLIANT FINDINGS

The Report evaluates 93 (ninety-three) Evaluation Criteria ("EC"). The Report finds that the Department is compliant with 57 (fifty-seven) of the examined ECs and non-compliant with 31 (thirty-one) of these ECs. The Report did not rate the Department on 5 (five) of the examined ECs. The Department agrees with the Report's finding that the Department is compliant with 57 (fifty-seven) ECs. The Department addresses each of the Report's non-compliant findings below.

Administrative Criteria

1. *Timely Notice of Restraint (EC #32-38) and Timely Notice to Internal Reviewer (EC #41)*

The Report states that the Department inaccurately reported that it submitted all but one of the notices of restraint use to the necessary parties within 24 hours. (Report, p. 79.) Specifically, the Report asserts that – contrary to the Department's reports – the Department failed to timely report the use of restraints at Cambridge on four (4) separate occasions. (Report, p. 80.)

The Department acknowledges that it inaccurately reported untimely notices of restraint use to the Court. These errors were inadvertent and were in no way intended to mislead the Court, the Court Monitor, Settlement Class Counsel or any other individual. The Department sincerely apologizes for its errors. To clarify:

- The Department acknowledges that it failed to timely notify all parties of restraint use in January 2012 (notice was two days late to three parties) and September 2012 (although all parties received an email alerting them of the restraint use within 24 hours, the email's attachment was inadvertently omitted and provided four days later).
    - The Department's September 17 and November 19, 2012, status reports accurately report – and DHS Licensing issued two correction orders addressing – these two incidents. These correction orders were provided to the Court Monitor and the Court.
- The Department believes that the other two instances of alleged untimely notice cited in the Report were, in fact, documentation – rather than reporting – issues: according to the Department's records, although all parties received notice of the July 5 and 12, 2012, restraint use within 24 hours, staff failed to document the date and time of the provided notice to the satisfaction of DHS Licensing.

The Department acknowledges that more work needs to be done to ensure (1) accurate reporting of restraint use; (2) timely notice of restraint use to all identified parties, including but not limited to the Internal Reviewer; and (3) proper documentation of the provided notice.

- To facilitate the timely and accurate reporting of restraint use, the Department recently created a single reporting process and form. Cambridge began using this process and form on May 1,

2013. The Department will continue to monitor the effectiveness of this new process, and will revise it if necessary.

- The Department will continue to monitor staff's compliance with the new process to ensure accurate, timely and complete reporting of restraint use at Cambridge. Ms. Baltes, supported by the Jensen Implementation Team, will be responsible for this compliance monitoring.

- To ensure the timely dissemination of any Cambridge-related correction notices issued by DHS Licensing, the Department will request that DHS Licensing simultaneously issue its Cambridge correction notices to the Court Monitor, the Jensen Implementation Team, the Deputy DHS Commissioner, Cambridge Leadership, Settlement Class Counsel, Ombudsman Opheim, and Dr. Wieck.

2. *Replace "Mental Retardation" – DHS (EC #99)*

The Report states that – despite the Department's efforts to eliminate all references to "mental retardation" on its website – the Department's website continues to include such references. (Report, pp. 126-7.)

The Department agrees with this finding. Through its efforts to eradicate any mention of the term "mental retardation" on its website, the Department discovered the following:

- The website contains archived material that includes the term "mental retardation". This material cannot be edited.

- The website contains information from the federal register containing the term "mental retardation". This federal register information may not be omitted without compromising the website's usefulness and relevancy.

- To ensure that its website remains accurate and timely, the Department permits multiple individuals to edit the website's content. Some of these individuals may inadvertently include the term "mental retardation" in their postings, particularly when pulling information from archived sources.

To address these issues, the Department will do the following:

- Include the following approved disclaimer language on the Department's home page and on the introduction of any search activity page:

> *The terminology used to describe People with Disabilities has changed over time. The Minnesota Department of Human Services ("Department") supports the use of "People First" language. Although outmoded and offensive terms might be found within documents on the Department's website, the Department does not endorse these terms*.

  - The Department will add this disclaimer to the Department's website on or before June 30, 2013.

- Conduct monthly audits of the Department's website to ensure that newly posted content does not contain the term "mental retardation". The first such audit will occur on or before June 30, 2013.

Instrumental Criteria

3. *Posting Rights (EC #72) & Rights Posting Understandable (EC #73)*

The Report states that although Cambridge posted the Health Care Bill of Rights in its facilities, the language and typeface of the postings "is not likely to be understandable in context". (Report, pp. 105-6.) The Report further faults the Department for failing to post the name and contact information of the staff members capable of answering treatment questions and inquiries on how to submit a complaint to the Office of Health Facility Complaints. (Report, p. 105.)

The Department agrees with the Report's findings and related recommendations. The Department is committed to ensuring that Cambridge residents and their families fully understand the residents' rights and how they can report concerns to the Office of Health Facility Complaints.

- In addition to the postings referenced in the Report, the Department also provides patients and their families and guardians with individual copies of the Health Care Bill of Rights.

- Cambridge will work with the Minnesota Department of Health and DHS Licensing to revise the existing postings to make them more readily understandable to residents and their families and guardians.

    - Cambridge will prominently display the revised postings on or before June 30, 2013.

- Cambridge currently has a laminated document available for review in each residence that explains how to raise concerns with the Office of Health Facility Complaints.

    - On or before June 30, 2013, Cambridge will (1) review this document to assess its understandability; (2) revise the document, if necessary, to make it readily comprehensible for residents and their families and guardians; and (3) prominently post the revised document in its facilities.

- The Department will consult with and provide a copy of the above-mentioned documents to the Court Monitor, Settlement Class Counsel, Ombudsman Opheim, and Dr. Wieck on or before June 30, 2013.

4. *Behavior Analyst Qualifications Met (EC #84A)*

The Report states that behavior analysts hired by the Department do not have the qualifications required by the Settlement Agreement. (Report, p. 110.)

The Department agrees with this finding.

- Currently, the demand for individuals with the behavior analyst qualifications specified in the Settlement Agreement far exceeds the supply of such individuals in Minnesota. To overcome these obstacles:

    - The Department will continue its efforts to recruit qualified individuals – locally and nationally – to fill these critical positions.

        - The Department will continue to operate a staffed recruitment booth at national events to attract qualified applicants.

        - The Department will actively explore other ways to attract additional qualified applicants, including but not limited to offering more competitive salary and benefit packages.

- In the meantime, the Department has – and will continue to – hire individuals with advanced degrees in psychology, special education, social work or other related fields, and with clinical experience serving individuals within the target population, to fill the behavior analyst positions.

    - After hiring these individuals, the Department provides them with supplemental training to augment their existing qualifications. As a result of this training, these individuals meet – or will soon meet – the Settlement Agreement's articulated qualifications.

- The Department agrees with the Report's suggestion that it work with educational institutions and other credentialing organizations to ensure that it has a supply of qualified behavior analysts in the future, and will explore how to best implement this recommendation in the coming months. In line with this recommendation, the Department is also currently exploring the possibility of establishing practicums, internships and post-doctoral placements that will help develop a larger pool of qualified behavior analysts.

5. ***Olmstead Recommendations Issued Timely (EC #86)***

As reflected in the Report, the Olmstead Planning Committee issued its public recommendations on October 23, 2012, over two weeks after the recommendations' October 5, 2012, due date. (Report, p. 115.) The Department agrees with this finding.

Although EC #87 is not yet rated, to briefly address the same, the Department fully intends to include the Court, the Court Monitor, and Settlement Class Counsel along with Sub-Cabinet ex-officio members (Ombudsman Opheim and Dr. Wieck) in the development and implementation of Minnesota's *Olmstead* plan (with the plan to be developed and implemented on or before November 1, 2013). With the input of the Court Monitor, Ombudsman Opheim, and Dr. Wieck, the Department is also in the process of securing additional experts to assist it in developing the substantive components and format of Minnesota's *Olmstead* plan.

6. *Rule 40 – Function and Product (EC #90)*

The Report criticizes the Rule 40 Advisory Committee for its struggles to reach a consensus and the delayed issuance of its recommendations. (Report, pp. 117-119.) The Report further states that "[c]onsideration by the Monitor of deficiencies in the committee's functioning or product, or elements of the Omnibus DHS Bill, is not ripe until the Committee finishes its work." (Report, p. 119.) The Report concludes by finding that as "the issuance of the Rule 40 report has been unduly delayed without a formal explanation to the Court or the Monitor", a finding of non-compliance is warranted. (Report, p. 119.)

The Department respectfully disagrees with the Report's finding that it is non-compliant with EC #90. The Settlement Agreement contains no deadline for the issuance of the Rule 40 Advisory Committee's recommendations (Settlement Agreement, p. 19), and due to the serious nature of the Committee's work and the diversity of opinions of its members, the Committee's work has taken longer than originally anticipated.

- The Committee is in the process of finalizing its recommendations, and anticipates that it will issue its final recommendations on or before June 30, 2013.

- The Department looks forward to reviewing and implementing these recommendations shortly after their issuance.

The Report also expresses concerns with the contents of the Omnibus DHS Bill recently passed by the Minnesota Legislature, and asks the Department to clarify the role, if any, of the Rule 40 Advisory Committee in shaping this legislation. (Report, p. 118.)

- The Omnibus DHS Bill affects a diverse group of individuals, including but not limited to those impacted by the Settlement Agreement.

- Committee members were invited to provide input into the contents of the Omnibus DHS Bill, and many members elected to do so. However, Committee members did not have the authority to approve or reject the contents of this Bill. Those giving input did so independently and not in their capacity as Committee members.

- Members of the Minnesota Legislature ultimately determined the contents and form of the Omnibus DHS Bill.

Quality of Life Criteria

7. *Olmstead Compliance (EC #2) & Cambridge Complies with Best Practices (EC #3)*

The Report states that Cambridge does not comply with the principles of *Olmstead*. (Report, p. 49.) The Report specifically faults Cambridge for a variety of shortcomings, including but not limited to its failure to consistently employ professional best practices in its treatment and care of its residents; its failure to prepare thorough Risk Management Assessments and Behavior Support Plans; and its sometimes delayed implementation of the Internal Reviewer's recommendations. (Report, pp. 49-54.)

The Department acknowledges this finding, and continues to diligently work to implement the foundational structures that align with the principles of *Olmstead*.

- As mentioned above, the Department recently created a formalized Jensen Implementation Team to assist with this implementation. The Team will focus much of its work on ensuring implementation of the *Olmstead* principles, and is in the process of creating a comprehensive implementation plan. On or before June 30, 3013, the Department will provide a copy of this implementation plan to the Court Monitor, Settlement Class Counsel, Ombudsman Opheim, and Dr. Wieck.

- The Department recently appointed a new Project Manager to serve individuals with developmental disabilities referred to Cambridge. This individual is responsible for systems, plan document quality, positive behavioral supports and "Person Centered" thinking continuity.

- The Department recently appointed a new Operations Manager to serve individuals with developmental disabilities referred to Cambridge. This individual is responsible for working with the Clinical Director and Project Manager to ensure the implementation of the *Olmstead* principles. Some of the Operation Manager's immediate tasks include improving the homelike atmosphere of Cambridge's facilities and ensuring that each resident has proper PCP assessments, functional behavior assessments, and plans that reflect "Person Centered" thinking and positive interventions.

- Within the past 30 days, the Department has also added staff at Cambridge. These staff members are trained in the areas of active treatment, rehabilitation planning and positive behavioral supports, and include a clinical director who holds a PhD in Educational Psychology, a MA in Applied Behavioral Science and is a Board Certified Behavior Analyst.

- To ensure staff are using a positive behavioral skill-set and to enhance their "Person Centered" approach to caregiving, the Department recently provided Cambridge staff members with additional, on-the-job training and direct feedback.

- Cambridge staff members are actively encouraging and facilitating residents' participation in Job Club, a program specifically designed to empower residents to obtain off-site work experience.

As mentioned above, the parties recently discussed adopting the best practices that would ensure that individuals are placed in the most integrated setting without the need for civil commitment to Cambridge's campus-based facility. This will be accomplished by reallocating resources to community-based services and repurposing Cambridge's campus-based facility so that it no longer serves individuals who are solely civilly committed as developmentally disabled.

8. *Cambridge Has Been Licensed (EC #1A)*

The Report states that as "Cambridge was not licensed for many months, and…the Court and Plaintiffs were not informed," a non-compliance finding for EC #1A is merited. (Report, p. 52.) The Department agrees with the Report's finding that Cambridge had a gap in licensure.

Cambridge is a dually-licensed facility:

- Cambridge holds a Department-issued license authorizing it to serve individuals with developmental disabilities. Cambridge has held this license without interruption since its inception.

- Cambridge also holds a Supervised Living Facility ("SLF") license issued by the Minnesota Department of Health ("MDH"). As highlighted in the Report and as acknowledged by the Department, Cambridge improperly operated without a SLF license until April 24, 2012. (Report, p. 6.) The Department has since rectified this oversight: since April 24, 2012, Cambridge has held a SLF license.

The Department recognizes the extreme importance of, and its legal obligation to maintain, proper licensure, and is committed to ensuring Cambridge is properly licensed now and in the future. In light of its successful efforts to correct this licensure oversight, the Department believes that it is now in substantial compliance with EC #1A.

9. *Zero PRN Chemical Restraint (EC #14) and Zero PRN for Behavior Control (EC #15)*

The Report does not allege that Cambridge violated the Settlement Agreement's prohibition on the use of PRN chemical restraints or PRNs for behavior control. (Report, pp. 65- 69; *see also* Mikkleson Report, p. 40 (stating "[t]here is no indication that psychotropic medications are overtly used to manage behavior or restrain freedom of movement" at Cambridge.)) Rather, the Report takes issue with how the Department reports the use – or lack thereof – of these PRNs at Cambridge. (Report, pp.67-69.) The Department respectfully disagrees with the Report's finding that the Department is non-compliant with ECs #14 and 15.

As acknowledged in the Report, Cambridge staff members do not use PRNs as a chemical restraint or for behavior control. Rather, these staff members conscientiously and consistently work with residents, teaching them the self-monitoring and self-regulation skills that they will need to effectively transition into the community.

To further clarify the Department's March 17, 2013, Status Report:

- During the reporting period covered by this report, there were zero instances of prohibited PRN usage.

- However, during this same time period, the Department did report that there were four instances when PRNs were administered.[4] These PRNs were administered not to manage behavior or restrict freedom of movement, but rather as a standard treatment or dosage to address the residents' conditions.

The Department revised its PRN-related procedures – specifically, Procedures 15904 and 15876 – in January 2013.

[4] Based upon the Department's November 2012 conversations with Settlement Class Counsel, Ombudsman Opheim, Dr. Wieck, and the Court Monitor, the Department has been reporting all use of PRNs since January 1, 2013, at Cambridge.

- The purpose of these revisions was to make these Procedures easier to understand and to implement in a consistent and appropriate manner.

- As recommended by the Report, the Department will reevaluate these and other procedures to determine if additional modifications to these Procedures are warranted.

- The Department welcomes any and all specific suggestions on how it might further improve these or other procedures to ensure accurate reporting to all interested parties.

10. ***All Abuse/Neglect Allegations Investigated (EC #26)***

The Report finds the Department non-compliant with EC #26 due to its investigation of a report of inappropriate sexual touching at Cambridge. (Report, pp. 75-76.) The Report characterizes the investigation of this incident as "cavalier". (Report, p. 76.)

Law enforcement personnel investigated the above-referenced incident at the time of its occurrence and concluded that no criminal behavior took place. However, despite this finding by law enforcement, the Department agrees with the Report's conclusion that the incident was insufficiently investigated by the Department.

- Based on the Department's preliminary investigation, the Department believes that the insufficiency of the original investigation is a staff performance – rather than systematic – issue. The Department has taken steps to ensure that the responsible staff member is no longer conducting this type of investigation.

- On or before June 15, 2013, the Department will retain an independent investigator to reinvestigate this incident and Cambridge's response to it. The Department will request that the investigator simultaneously provide his/her findings to the Court Monitor, Deputy Commissioner of Human Services, Settlement Class Counsel, Ombudsman Opheim, and Dr. Wieck.

The Department is committed to fully investigating each and every abuse and/or neglect allegation. The second incident referenced in the Report – specifically, the recent report of a client ingesting cleaning fluid (Report, p. 75) – is being diligently investigated by the Department. The Department will provide the Court Monitor, Settlement Class Counsel, Ombudsman Opheim, and Dr. Wieck with its findings upon the completion of the investigation.

11. ***Ensure Most Integrated Setting (EC #54); Actively Pursue Discharge with Transition Plans (EC #55); Family Actively Involved (EC #56); Person Centered Planning at Each Stage (EC #57); Resident Choice (EC # 58); Best Efforts for Placement Alternatives (EC #59); and Implement in Accord with Olmstead (EC #60).***

The Report asserts that the Department does not comply with the Settlement Agreement's Transition Planning requirement. Specifically, the Report states that although the Department has paid increased attention to transition planning, it has failed to (1) ensure the most integrated appropriate setting for each of its patients (EC #54); (2) actively pursue discharge with transition plans (EC #55); (3) ensure that each resident's family is actively involved in the transition planning (EC #56); (4) engage in person-

centered planning at each transition stage (EC #57); (5) work to honor each resident's choice (EC #58); (6) demonstrate its best efforts for placement alternatives (EC #59); and (7) implement transition planning in accordance with *Olmstead* (EC #60). (Report, pp. 89-92.)

The Department agrees that more work is needed regarding Transition Planning. In addition to the Department's past and current efforts, the Department will promptly address this matter as follows:

- Following extensive discussions in April and May 2013, Settlement Class Counsel, Ombudsman Opheim, Dr. Wieck, and the Department agreed that the Department should retain an outside consultant to specifically address transition planning.
    - This consultant – working in collaboration with key stakeholders – will be responsible for designing and assisting in the implementation of a new transition planning program that is consistent with the *Olmstead* principles, the Settlement Agreement and best practices.
    - The Department will work with Settlement Class Counsel, Ombudsman Opheim, and Dr. Wieck to identify a well-qualified consultant.
    - The Department will retain this consultant on or before June 30, 2013.
- Further, the Department agrees with the Court Monitor's recommendation that there must be state-wide training on Transition Planning that includes both State and County staff. The Department will address this recommendation, in detail, in its updated implementation plan that will be submitted on or before June 30, 2013,

12. ***Visitors Permitted (EC #66) and Private Visitation (EC #68)***

The Report opines that the Department failed to properly document the visitation restrictions imposed upon a Cambridge resident, thus rendering the Department non-compliant with ECs #66 and 68. (Report, p. 100.)

- The Department agrees that it failed to properly document the reasons for the visitation restrictions imposed upon Cambridge Resident JL, and was thus non-compliant with ECs #66 and 68.
    - In January 2013, Cambridge created a tailored Visitation Guideline for JL. Members of JL's team – including but not limited to JL (who acts as his own guardian) and his case manager – participated in the development of JL's Visitation Guidelines. These Visitation Guidelines were necessary to meet the needs of JL.
    - The rationale for these Visitation Guidelines was absent from JL's Individual Program Plan.
        - Cambridge will update JL's Individual Program Plan on or before June 7, 2013.

- The Department recognizes the importance of proper documentation, and will continue to train and monitor Cambridge staff on this issue.

The Report also raises concerns regarding the implementation of Procedure 15899 ("Involvement with Family, Guardians and Friends") at Cambridge, and the training provided on this Procedure. (Report, pp. 98-101.) The Report states that although this Procedure complies with the Settlement Agreement, it failed to specifically supersede non-compliant Procedure 15901 ("Client Care: Outings and Vacations for MSHS-Cambridge Clients"). (Report, pp. 99-100.)

- The Department agrees that additional work needs to be done to clarify and implement its visitation policies.
  - Cambridge staff received training on Procedure 15899 (effective date October 8, 2012) on October 3, 2012.
    - The Department provides on-going training to staff regarding Procedure 15899. These trainings occur annually and every time the Procedure is amended.
    - The Department sent a Cambridge-wide memo identifying the changes to Procedure 15899 on October 3, 2012.
  - Procedure 15901 addresses off-campus visits by residents, and thus covers areas outside the purview of Procedure 15899.
    - The Department will review Procedure 15901 to determine what modifications are necessary to bring this policy into compliance with the terms of the Settlement Agreement, and will make any necessary modifications to this Procedure on or before June 15, 2013.
    - The Department provides training to staff regarding Procedure 15901. These trainings occur annually and every time the Procedure is amended.

13. ***MSH – All Transfers Per Olmstead (EC #97)***

The Report states that the Department transferred three (3) individuals with developmental disabilities from the Minnesota Security Hospital to community placements on or before January 17, 2013. (Report, pp. 121-122.) The Report does not dispute that these transfers were appropriate; rather, the Report states that the Department effectuated these transfers without a person-centered plan and an *Olmstead* analysis. (Report, p. 122.)

The Department respectfully disagrees that this finding. The Department is committed to ensuring person-centered transfers that are consistent with the *Olmstead* principles, and believes that the above-referenced individuals moved to their new homes in a person-centered and *Olmstead*-compliant manner. For each of these individuals, the Department took the following actions:

- MSH worked closely with these three (3) individuals, county case management, the individuals' respective family support systems, the Ombudsman's Office, Community Support Services and

community program staff providers prior to, during and following these individuals' moves to their new homes.

- MSH staff met separately with each individual to identify the elements that were most important to him in a living environment, his goals for the future and how he enjoyed spending his time.

- Future community providers visited with each individual at MSH on multiple occasions.

- MSH staff accompanied two (2) of the three (3) individuals to visit the proposed new setting(s).

  - The third individual was unable to visit the proposed new setting without jeopardizing his clinical status. However, staff created a picture book for this individual. This picture book contained numerous pictures of the proposed new setting, and the various color and furnishing options for the individual's proposed new home. Staff then worked with the individual to identify his preferences, which were then reflected in his new home.

- MSH staff utilized a formal Residential Matching Tool to identify what was most important to the individual regarding the living situation, and to gauge how closely the proposed setting matched the individual's preferences.

- It is the Department's understanding that all three (3) of these individuals are doing well in their new homes.

The Department is committed to continually improving its transfer process.

- To assist the Department in this effort, the Department will – as recommended by the Report – retain an independent reviewer to conduct a review of these transfers. The Department will request that this reviewer simultaneously provide his/her findings to the Court Monitor, Deputy DHS Commissioner, Settlement Class Counsel, Ombudsman Opheim, and Dr. Wieck. It is the Department's intention to use the findings of this independent reviewer to further refine and improve its transfer process and ensure best practices are adopted and implemented.

* * * * *

The Department is committed to improving its systems of care, and sincerely appreciates the time and consideration invested in the Report's preparation and recommendations. The Department looks forward to continuing to work with the Court Monitor, Settlement Class Counsel, Ombudsman Opheim, Dr. Wieck, and the Court as the Department undertakes these improvements.

Please let me know if you have any questions or concerns regarding this matter.

Sincerely,

/s/ Anne M. Barry

ANNE M. BARRY
Deputy Commissioner of Human Services

Encs. Resumes of Christina Baltes and Steve Allen

cc. Mr. Scott Ikeda, Assistant Attorney General (*via email only*)
Mr. Steven H. Alpert, Assistant Attorney General (*via email only*)
Ms. Amy Kaldor Akbay, DHS Chief General Counsel (*via email only*)
Mr. Shamus O'Meara, Settlement Class Counsel (*via email only*)
Ms. Annie Santos, Settlement Class Counsel (*via email only*)
Dr. Colleen Wieck, Minnesota Governor's Council on Developmental Disabilities (*via email only*)
Ms. Roberta Opheim, Ombudsman for Mental Health and Developmental Disabilities (*via email only*)

June 4, 2013

Via E-Mail Only
Mr. David Ferleger
Ferleger Wealth Management, LLC
Archways Professional Building
413 Johnson Street, Suite 203
Jenkintown, PA 19046

Re: Jensen et al v. Minnesota Department of Human Services et al
Court File No: 09-CV-1775 DWF/FLN
Our File No.: 7400-001

Dear Mr. Ferleger:

On behalf of the Settlement Class, we provide the following comments to the Independent Monitor's May 20, 2013, draft Report to the Court. We respectfully request that the Monitor include this communication with its finalized report along with our enclosures.

We enclose Ms. Opheim and Dr. Wieck's comments on the Monitor's draft report.

The State Defendants Have a Long History of Non-Compliance and Failure to Properly Implement the Settlement Agreement

> The State of Minnesota further declares, as a top concern, the safety and quality of life of the Residents of the Facility. The State agrees that its goal is to provide these residents with a safe and humane living environment free from abuse and neglect. The State also agrees that its goal is to utilize the Rule 40 Committee and Olmstead Committee process described in this Agreement to extend the application of the provisions in this Agreement to all state operated locations serving people with developmental disabilities with severe behavioral problems or other conditions that would qualify for admission to METO, its Cambridge, Minnesota successor, or the two new adult foster care transitional homes.
>
> *Final Approval Order for Stipulated Class Action Settlement Agreement, Exhibit A, Stipulated Class Action Settlement Agreement* at 3.

At the outset, we emphasize that the Settlement Agreement is the agreed upon, Court-ordered baseline upon which DHS conduct must be measured. DHS, however, measures itself against the conditions that existed before the Settlement Agreement rather than the

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best practices in the Settlement Agreement to which it expressly agreed. Settlement Class Counsel has provided many items of information over the past several months to the Court Monitor relating to issues of concern and DHS non-compliance with regard to the Settlement Agreement. The Settlement Class expressly preserves, and does not waive, all of its rights and positions.

Notably, the Monitor's draft report does not reflect on the extremely important and extensive, time consuming process of repeatedly demanding and requesting information from DHS with regard to issues of concern and non-compliance and implementation of the settlement agreement. Our November 27, 2012, letter to the Court (enclosed) provided the Court with a comprehensive update of ongoing efforts over many months to understand the status of DHS and State of Minnesota compliance with the Settlement Agreement. Our November 14, 2012, letter to the Monitor, and November 14 email to DHS counsel, are two examples of hundreds of letters, requests and identified issues involving DHS non-compliance -- some of them summarized in our enclosed chart of requests involving non-compliance from January 2012 to November 2012, previously provided to DHS and to the Monitor.

On many occasions, the State Defendants (which include the State of Minnesota and the Minnesota Department of Human Services) promised to act or provide information and then failed to act or did not disclose its actions or information. The State Defendants' lack of candor and response to these concerns reflects their widespread failure to properly address the Settlement provisions to which they expressly agreed and a dangerous, cavalier approach to the issues of concern raised. This has led to a near complete breakdown of trust involving DHS stated positions, later found to be untrue, or partially false, or never conveyed, or subsequently, and secretly, contradicted by others within DHS or other State agencies.[1] Settlement Class Counsel has expended nearly 2,000 hours from the approval of the Settlement Agreement to date pursuing issues involving DHS non-compliance and ongoing concerns pertaining to the implementation of the Settlement Agreement. Hundreds of additional hours have been expended by Dr. Wieck and Ms. Opheim on these issues, and these consultants find themselves having to pick up

[1] Numerous examples abound, including repeated efforts by the DHS Mental Health Division/NAMI representatives resistant to the Settlement provisions involving restraint, *see* Settlement Class Counsel November 14, 2012, letter to Monitor (statement of Mr. Greg Cox, DHS, "On behalf of the mental health divisions, the providers, and NAMI and the entire mental health community I am here to say, 'No thank you' to your Rule 40 work.. The mental health community has adequate and appropriate rules that govern restraint and seclusion, any standard created by the Rule 40 committee would be duplicative and in conflict."); Minnesota Department of Health, an agency of Defendant State of Minnesota, stating that the Settlement Agreement does not apply to MDH; and DHS legislative group proffering a bill outside of the Rule 40 settlement process without adequate notice to the Court, Settlement Class Counsel or the Rule 40 Committee that specifically excepted people with developmental disabilities from prohibitions against restraint and seclusion.

the pieces of DHS failures in the Olmstead and Rule 40 Committee process to supply critical missing information and expertise, often with little or no time allowed for their input. For Settlement Class Counsel and the consultants, this process has devolved into a search for what is actually occurring rather than what DHS is disclosing to us, if anything.

The draft report also notes an incredibly understaffed effort to address implementation of the statewide Class Action Settlement Agreement, highlighted here as an obvious example of the absence of priority placed on the Settlement by DHS and the State. *See* Monitor draft report at 34 ("The DHS Central Office assigned Michael Tessneer as liaison and to coordinate Jensen compliance. For months, he had this role alone, and recently another staff person has joined him. Mr. Tessneer has no authority to direct compliance. For one or two staff, there is an overabundance of material to digest, communicate and track. Based on the Monitor's experience and knowledge of similar situations, this Central Office staffing is insufficient for the task.") ("DHS Quality Assurance has a single individual assigned to QA for Cambridge. Working alone, and making a circuit traveling the entire state, she is responsible for all the data collection for several institutions. She acknowledges the impossibility of this task and states that QA has "urgently" requested additional staffing, and that two new QA positions are in the works, but "the jobs have not yet been posted. In addition, and perhaps most telling, she has not been informed of the Jensen requirements and not been requested to track compliance." ("MSHS-Cambridge has a new Quality Assurance Plan (effective January 14, 2013), but no QA officer, minimal activity, and no focus on – and no mention of -- the settlement agreement in its 2012 minutes.")

The State of Minnesota and DHS Illegal Operation of MSHS Cambridge Facility Without a Supervised Living License

> 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 BehaviorSupports (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 Minn. Stat. § 252.025, subd. 7; and (5) notifyparents and guardians of residents, at least annually, of their opportunity to comment inwriting, by e-mail, and in person, on the operation of the Facility.
>
> *Final Approval Order for Stipulated Class Action Settlement Agreement, Exhibit A, Stipulated Class Action Settlement Agreement* at 6.

The Monitor's Draft Report, at page 6, states:

> MSHS-Cambridge requires a license issued by DHS and also by the Minnesota Department of Health ("MDH"). Cambridge operated in violation of the law for 10 months from its establishment July 1, 2011 until it was licensed by the Minnesota Department of Health April 24, 2012. DHS later called its lapse "inexcusable." During the four and a half months following the Court's approval of the settlement, the Court and Plaintiffs were not informed that Cambridge was not licensed. The settlement requires licensure.

Unbelievably, inexcusably, and in direct violation of Minnesota law, state rules, and the Settlement Agreement, DHS knowingly, and without notice to the Court or Settlement Class Counsel, allowed the MSHS Cambridge facility to be operated for 10 months without its required Supervised Living License. *See* Minn. Stat 144.50, subd 1((a)"No person, partnership, association, or corporation, nor any state, county, or local governmental units, nor any division, department, board, or agency thereof, shall establish, operate, conduct, or maintain in the state any hospital, sanitarium or other institution for the hospitalization or care of human beings without first obtaining a license therefor in the manner provided in sections 144.50 to 144.56; (b) A violation of this subdivision is a misdemeanor punishable by a fine of not more than $300; (c) The sanctions in this subdivision do not restrict other available sanctions."). *See also* Rule 4665.0300 FACILITY LICENSE; DHS February 1, 2013, licensing report (listing multiple violations).

A review of the documents comprising the Office of Legislative Auditor report and related sources shows that many State of Minnesota employees, including DHS and MDH employees, some in leadership and supervisory capacities, knew of this non-licensure issue and failed to disclose it. In its February 2013, Report, the Office of Legislative Auditor ("OLA") concluded the successor facility, MSHS Cambridge, "operated for about ten months before it obtained a necessary license from the Department of Health." OLA Report at 64. The OLA Report states:

> As we were reviewing the licensure status of state-run facilities, we found that:
>
> - **State-Operated Services opened a residential facility in Cambridge in 2011 without first obtaining the necessary approvals from the Minnesota Department of Health or the State Fire Marshal.**
>
> In mid-2011, SOS closed a 48-bed facility (Minnesota Extended Treatment Options) in Cambridge and replaced it with a new 16-bed facility in the same location. The new facility is licensed under DHS's residential services rule for

> persons with developmental disabilities and is the only SOS facility of this particular type.
>
> To ensure compliance with health and safety requirements, state law requires that license applicants (including SOS) document compliance with applicable fire and life safety codes, as well as health rules, when opening a new facility [citing Minnesota Statutes 2012, 245A.04, subd. 2a.]. But SOS failed to notify MDH or obtain the department's approval before opening SOS's new facility on July 1, 2011. Likewise, SOS did not notify MDH that it was closing Minnesota Extended Treatment Options on June 30, 2011. Staff at MDH told us they contacted DHS in Fall 2011 about renewing the license for Minnesota Extended Treatment Options. State-Operated Services staff did not respond until January 2012, when they submitted an incomplete application for the MDH license. It was not until February 2012 that MDH learned that one SOS facility had closed and a new one had opened—slightly more than seven months after the fact.
>
> Minnesota Department of Health officials told us they do not approve any supervised living facility license until both engineering and licensing staff at MDH as well as the State Fire Marshal have determined that a building is fit for occupancy. Health Department staff began obtaining the necessary licensing information and approvals from SOS and the State Fire Marshal, issuing the Cambridge facility its first supervised living facility license in April 2012 — almost ten months after the first residents had moved in.

OLA Report at 65 (http://www.auditor.leg.state.mn.us/ped/pedrep/sos.pdf#page=77) (emphasis supplied); *see also* Court Monitor's May 20, 2013 draft status report at 6, Ombudsman for Mental Health and Developmental Disabilities' May 7, 2013 *Comments Regarding the Jensen Settlement Agreement Compliance Issues*.

We have demanded from the State Defendants a listing of State employees with knowledge of the non-licensure and the substance of each employee's knowledge. We expect to receive additional information about the extent of the State and DHS knowledge on this critical issue. Such conduct, including the State and DHS silence and non-disclosure of this issue to the Court and counsel, and stating that DHS has fully complied with the Settlement, is misleading, and a misrepresentation of material facts. *See e.g. M H. and H. L. v. Caritas Family Services*, 488 N. W.2d 282,289 (Minn. 1992) (misrepresentation by affirmative false statement or by concealing or not disclosing certain facts that render the facts that are disclosed as misleading); *In re Hennepin County 1986 Recycling Bond Litigation*, 540 N.W.2d 494, 502 (Minn. 1995) (every contract contains an implied covenant of good faith and fair dealing); September 17, 2012, DHS Status Report to Court at 6 [Doc. 165] (December 5, 2011 through August 31, 2012) (stating status completed and compliant with Olmstead - no mention of non-licensure);

November 19, 2012, DHS Status Report to Court at 6 [Doc. 180] (September through October 2012) (status completed and compliant with Olmstead - no mention of non-licensure)

On this critical issue, it should be noted that Settlement Class Counsel, Dr. Wieck, and Roberta Opheim, the Ombudsman for Mental Health and Developmental Disabilities, repeatedly asked for information and sought clarification concerning DHS licensure of the MSHS facility. Some of these requests included:

> On November 6, in response to the DHS November 5 e-mail on licensing of Cambridge, we asked DHS to augment its response to address the several questions and concerns we have raised concerning the license in our July 5, 2012, e-mail, reiterated in our September 20 and October 8 communication to the monitor.

November 14, 2012,Settlement Class Counsel Letter to Monitor

> We conveyed ongoing concerns regarding the Cambridge licensure issue, and in our November 6 response to Mr. Tessner's November 6 e-mail on licensure, we asked that the DHS response be augmented to address the several questions and concerns we have raised concerning the license in our July 5, 2012, e-mail, reiterated in our September 20 and October 8 communication to the monitor. No response has been provided.

November 14, 2012, Settlement Class Counsel E-mail to DHS Counsel

> The MSHS Cambridge program is operating under a Supervised Living Facility (SLF) license issued by the Department of Health and a DHS program license (245b) which governs programs serving individuals with developmental disabilities. MSHS Cambridge does not carry an ICF/DD certification because it has been determined that most people in the target population for the program do not qualify for these services.

November 11, 2012, DHS E-mail to Settlement Class Counsel and Monitor

> By November 5, 2012, DHS will respond to Plaintiff's October 5, 2012 questions regarding the variance.

October 24, 2012, Monitor Decision Notes

> **2. License Variance**. Plaintiffs raised specific concerns in a July 20, 2012, e-mail to DHS counsel, attached to a September 20, 2012, e-mail to the monitor with

material included in Plaintiff's October 8, 2012 e-mail to the monitor regarding the variance. Plaintiffs are requesting Defendants' response "a few days" before the October parties meeting. Would Defendants pleased provide that response by midday on October 22, 2012.

Monitor October 24, 2012 Agenda , Parties' Meeting

Licensure of the MSHS Cambridge facility:

In our July 5, 2012, e-mail to DHS counsel, previously provided to you as an attachment to our September 20, 2012, e-mail, enclosed here, we asked several questions and stated:

> We have concerns and questions relating to the current license for the Cambridge facility. The Settlement Agreement provides:
>
> 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 Minn. Stat. § 252.025, subd. 7; and (5) notify parents and guardians of residents, at least annually, of their opportunity to comment in writing, by e-mail, and in person, on the operation of the Facility.
>
> We understand DHS received a license variance for Cambridge, effective January 3, 2012, license number 804294. We do not have any record of being notified of this variance, asked for input concerning it, or what the variance means. Please advise if DHS issued the variance for Cambridge. Did DHS work with federal licensing authorities for people with developmental disabilities concerning the variance. How does it allow Cambridge to vary from the licensing requirements for serving people with developmental disabilities. Is it a new category. How does the variance facilitate Olmstread compliance. Is it equivalent to ICF/DD certification allowing for federal auditing and inspections, and the protections of the federal bill of rights for people with developmental disabilities. How does the variance compare with METO's prior license as a supervised living facility. How does it compare with crisis respite service licensing, and day

> training and habilitation licenses. Please advise why Cambridge was not licensed as a Residential Facility for Individuals with Developmental Disabled under DHS and a Supervised Living Facility under the Minnesota Health Department.
>
> Initial review of the variance documentation brings up several additional concerns involving inconsistency with the Settlement and little reason provided to support the licensing variance (e.g., length of stay for some residents is longer than stated 90 to 180 days, most integrated setting not mentioned, failure to adequately reference psychotropic medication and chemical restraint prohibition; incomplete safeguards for internal reviewer and external reviewer; locked doors; no listing of admission criteria; nothing listed for reporting incidents; short term plan discussion for mental illness, mental health professionals but not specific to people with developmental disabilities; discharge planning inconsistent with "transition planning" required by settlement, etc.)

We have not received any response to these questions and concerns. We reiterate our request for this information, and the questions and concerns about the Cambridge license referenced in our September 20 e-mail to the monitor. Without receiving this information, preferably a few days before the next meeting, it will be difficult to have a meaningful dialog on the subject.

October 8, 2012 Settlement Class Counsel E-Mail to Monitor (citing July 5, 2012 e-mail to DHS Counsel)

> We would like to receive a response to the licensing concerns involving Cambridge as expressed in our July 5, 2012, e-mail to counsel, enclosed. This is an important issue. The license for the facility drives the description of rights, protection of rights, and type of programming that people at MSHS-Cambridge receive. We understand the idea of IRTS was proposed and not accepted because it was not a license for people with developmental disabilities and the settlement required the successor program to return to its original purpose of serving people with developmental disabilities with severe behavioral issues.

September 20, 2012, Settlement Class E-mail to Monitor

From July 1, 2011, when MSHS first opened without a Supervised Living License (and earlier when it knew the license was required but decided to proceed to open Cambridge without it), to July 5, 2012, when Settlement Class Counsel began asking about the Cambridge licensure, throughout numerous letters, e-mails and meetings inquiring about the licensure status of the successor facility to METO, Defendants DHS and the State of

Minnesota had multiple opportunities and were obligated to provide Settlement Class Counsel, the Court and Monitor with notice of their operation of MSHS Cambridge without the required Supervised Living License. This is a fundamental, substantial issue of inexcusable DHS non-compliance, and breach of good faith and fair dealing, which highlights the DHS record of non-disclosure involving the real status of implementing the *Jensen* Class Action Settlement Agreement.

The DHS Rule 40 Settlement Agreement Process Has Failed

The Rule 40 process driven by DHS has been an abject failure with DHS repeatedly refusing to include the suggestions and consensus of committee members, unilaterally writing its own narrative, excluding the committee, and then taking the incredulous position that the current narrative represents the views of the committee. Settlement Class Counsel has provided dozens of communications to DHS and the Court Monitor on these issues, including letters to the Court objecting to the DHS driven Rule 40 process as well as the DHS Olmstead Committee process and its failure to include the committee members and conduct in creating "recommendations" that were never provided to the committee members to discuss, edit, change and agree upon.

Settlement Class Counsel has reiterated the Settlement Class position with regard to the current Rule 40 narrative:

> In follow up to the April 2, 2013, comments from Ms. Santos, below, we reiterate that the Settlement Class does not support any provision of the Rule 40 narrative that is inconsistent with, or in violation of, the Settlement Agreement. The latest proposed narrative seeks exceptions for the use of certain mechanical restraint. The parties to the Jensen Settlement Agreement have agreed there will be no use of mechanical restraint for the Facility as defined in the Settleemnt Agreement. Nearly one year ago our office and Mr. Tessner presented to the Rule 40 Committee urging that the Committee follow the guidance of the Jensen Settlement Agreement to prohibit the use of mechanical restraint which reflects best practices. As we have repeatedly conveyed, the definition of Prohibited Techniques in the Settlement Agreement was reached by consensus between the parties with active assistance from the consulting experts. Mike Tessner and I were asked by DHS to present the Settlement Agreement provisions to the Rule 40 Committee as the Committee was off track and needed a solid understanding of the Agreement as a predicate for its work. We viewed then, and now, that the Prohibited Techniques section, like other sections of the Settlement Agreement, as a best practice developed provision that should be present throughout the State/DHS facilities.

The Rule 40 process ordered by the Court in approving the Settlement Agreement has been replaced by the DHS unilateral intention to include restraint and seclusion provisions in its narrative and in proposed legislation that it has sought to hide from the Rule 40 Committee and Settlement Class Counsel. Our many prior communications to DHS and the Court Monitor highlight other objections and concerns relating to the Rule 40 narrative and DHS process. The Rule 40 process, driven by DHS over the objection of Settlement Class Counsel and others, including the consultants, has failed miserably.

DHS Unilateral Omnibus Bill Amendment Violates the Civil Rights of People With Developmental Disabilities and Class Action Settlement Process

> "No patient in the Anoka State Hospital is in restraint. Those restraints were removed from the patients not by administrative coercion, but by the enlightened attitudes of the superintendent, staff, employees, and volunteer workers of the Anoka State Hospital. They were removed as the hospital‟s answer to witchcraft."
>
> *October 31, 1949, Governor Luther Youngdahl*
>
> "Documents in individual records revealed that people were being routinely restrained in a prone face down position and placed in metal handcuffs and leg hobbles."
>
> "Some individuals were restrained with a waist belt restraint that cuffed their hands to their waist. An individual with an unsteady gait was routinely placed in this type of restraint, putting that person at risk of injury if they should fall. Others were being restrained on a restraint board with straps across their limbs and trunk."
>
> "[I]n most cases where restraints were used the person was calm and cooperative about going into the restraint but began to struggle, cry and yell once they were in the restraints. In some cases, clients appeared conditioned to „assume the position‟ for application of restraints where they would lie on the floor and put their hands behind their back without resistance."
>
> *Just Plain Wrong, Ombudsman for Mental Health and Developmental Disabilities Minnesota* (September 2008)

The Court, in its April 25, 2013, Amended Order [Doc. 212], cited the DHS omnibus bill expressly allowing for restraint and seclusion of people with developmental disabilities:

> ["T"he Court has learned there is an omnibus DHS bill moving through the state legislature. Surprisingly to this Court, and without explanation or notice to the Court as to its relationship to the Settlement Agreement, it appears that DHS has proposed a ban on all restraint and seclusion, EXCEPT for individuals with developmental disabilities.

Amended Order at 5.

Incredulously, the DHS bill unilaterally sought the continued abuse of people with developmental disabilities by allowing mechanical restraint and seclusion to be used on them in violation of their rights while disparately preventing these abusive procedures against all other populations in the bill. The Jensen Class Action lawsuit was predicated on eliminating such abuses which DHS and the State of Minnesota used against people with developmental disabilities (*see* Just Plain Wrong report). The Settlement Agreement that resulted from the lawsuit protects people with developmental disabilities from the restraint and seclusion, the same abusive procedures the State Defendants determined to put into the DHS bill.

The DHS omnibus bill amendment language was submitted in secret, in derogation of the Rule 40 Settlement process, without notice to the Court, Settlement Class Counsel, the consultants, or the Rule 40 Committee, in violation of the civil rights of people with developmental disabilities. After DHS was called out on its offensive language, it sought to change its legislation, again without notice to Settlement Class Counsel, after DHS, in the April 30 court ordered party meeting attended by the DHS deputy commissioner, compliance officer, DHS counsel and other DHS representatives, expressly agreed to provide the proposed amendment to Settlement Class counsel. DHS provided the information only after it was made aware that the Ombudsman had notified our office about the amendment status. These recent issues stand out as examples of DHS efforts to act without regard to the Settlement process or the rights of class members or others affected by its conduct.

At the court-ordered party meeting on April 30, DHS agreed to provide Settlement Class counsel with copies of the omnibus bill and its proposed amendment to the bill to correct the offensive language. DHS did not provide the information it expressly agreed to provide. On Friday late afternoon, May 3, Settlement Class Counsel learned from the Ombudsman that DHS was interacting with the conference committee to urge passage of its proposed amendment at a committee meeting that evening. Our office responded on May 3 with the Settlement Class position concerning the DHS proposed legislation, and again conveyed this position to DHS on Saturday, May 4, following DHS insistence that the amended language allowing restraint and seclusion of people with developmental disabilities during a several month "transition" basis is best practice. We have repeatedly conveyed our position over the past several days, stating:

> The Settlement Class objects to any legislation from DHS that is inconsistent with the Settlement Agreement, including any proposed transition period during which people with developmental disabilities are left unprotected against restraint and seclusion or any disparate treatment of people with developmental disabilities in the legislation.

> The legislative language in the bill DHS seeks to address before the conference committee was not properly vetted nor recommended by the Rule 40 Committee as required by the Settlement Agreement nor did DHS appropriately notify the Rule 40 Committee and Settlement Class Counsel of its intent to move forward with the legislative changes outside of the Settlement Agreement process. The transition period described is not consistent with the Settlement Agreement's prohibition against restraint and seclusion, is not best practice, nor is it consistent with the best practice approach taken by DHS to immediately eliminate mechanical restraint following the approval of the Settlement Agreement.
>
> We do not believe the DHS proposal to address the omnibus bill language adequately addresses the concern of the Federal Court in its recent Order (enclosed):
>
> > Finally, the Court has learned there is an omnibus DHS bill moving through the state legislature. Surprisingly to this Court, and without explanation or notice to the Court as to its relationship to the Settlement Agreement, it appears that DHS has proposed a ban on all restraint and seclusion, EXCEPT for individuals with developmental disabilities.
>
> We again ask that If DHS is attending a meeting or otherwise interacting with the conference committee that DHS please convey the Settlement Class position in this regard and please provide the conference committee with a copy of this communication.

Over the repeated objections of Settlement Class Counsel, and in direct violation of the Settlement Agreement, the DHS legislative position advocated the expressed, intentional disparate treatment of people with developmental disabilities in violation of their civil rights, allowing them to be mechanically restrained without qualification, possibly in leg irons and shackles, while other populations would be protected against such abusive civil rights violations.

Most recently, DHS leadership has sought to advance its unfounded position that allowing people with developmental disabilities to continue to be mechanically restrained for a "transition" period constitutes best practice. Settlement Class counsel continues to repeatedly object to such abusive positions, including a "transition" period hidden within the DHS omnibus bill and not deleted by DHS after it expressly promised to remove language that excepted people with developmental disabilities from being restrained and secluded. In the recent party meeting, DHS leadership and counsel could not even advise Settlement Class Counsel whether the omnibus bill precluded any type of mechanical restraint, what safeguards, if any, the facilities using restraint and seclusion on people with developmental disabilities were employing, or a listing of the types of restraints

used. While promises were made to provide this information to Settlement Class Counsel no such information has been provided, nor do we expect DHS to follow through on its promise based on its past non-performance

In its haste to pass an omnibus bill, DHS has significantly, and wrongly, compromised and violated the civil rights of people with developmental disabilities and their families – the population of citizens the Settlement Agreement expressly protects, and which the State and DHS as parties to the Settlement Agreement also expressly agreed to protect. The State Defendants acted in direct derogation of the Settlement Agreement, citizens with developmental disabilities and their families protected under the Agreement, the Rule 40 process, and without adequate notice to the Court or Settlement Class Counsel.

Olmstead Committee Process

> *"Institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life."*
>
> *Olmstead v. L.C., 527 U.S. 581, 600 (1999)*

Settlement Class Counsel repeatedly objected to the DHS Olmstead Planning Committee process and its failure to develop a proposed plan or any consensus recommendations. DHS ignored the Settlement Class concerns, and those of the consultants, focusing instead on its own internal agenda. Ultimately, a set of recommendations were issued by DHS, held out as the work of the committee, when the committee was never provided with a proposed final document to review and consider. DHS again ignored objections and placed the recommendations on its website and cited to them as the work of the committee. DHS finally agreed to remove the document from its website but until recently did not issue any disclaimer to the document and has refused to remove any of the pages to it, including the offensive and incorrect preface and other objectionable pages.

* * *

The Court's April 25, 2013, Amended Order [Doc. 212] referenced the January 28, 2013, Governor's Executive Order creating a subcabinet. The Monitor's December 13, 2013 Formal Recommendation to the Parties, copied to the Court, reported that during the December 11, 2012, Status Conference, Anne Barry stated the DHS Commissioner intended to recommend to the Governor a subcabinet to formulate an Olmstead Plan. The Monitor's Formal Recommendation included items the Monitor believed should be included in the Governor's Executive Order. On December 14, 2012, Settlement Class advised the Monitor that the Settlement Class was in agreement with the proposed

subcabinet approach to the Olmstead issues with certain revisions: (1) Settlement Class Counsel be allowed to attend and participate in the sub-cabinet consulting group meetings; (2) All meetings pertaining to the sub-cabinet group, consulting group or any other related meetings are open to the public and that the sub-cabinet expressly complies with the Open Meeting Law; (3) The subcabinet begin its work no later than January 15, 2013, retain the expert assistance no later than February 1, 2013, and present the Olmstead Plan to the Governor no later than October 1, 2013; and (4) Settlement Class retain all rights to relief under the Jensen Settlement Agreement and applicable law including but not limited to all rights to bring a Motion to Enforce the Settlement Agreement before the Federal Court.

On January 25, 2013, the Monitor asked Mr. Tessneer to forward a draft of the proposed Governor's Executive Order. On January 29, 2013, our office received a copy of a press release regarding the Executive Order. On January 29, 2013, a consultant advised Mr. Tessneer and Ms. Barry that the Court was aware of the Executive Order announcement and that DHS should write to the Court advising of the Executive Order and DHS's plans concerning it. On January 29, 2013, the Monitor sent an email to Ms. Barry advising her that he was pleased to see the Executive Order and expressing concerns regarding that day's subcabinet meeting including his recommendation against using a 30 page assignment chart based on extracts from the Olmstead Committee report without noting the acknowledged incompleteness of the Committee report, to be completed by someone in a variety of agencies, without education or a deep understanding of Olmstead and the report; and encouraging approval to use an experienced consulting group for the subcabinet.

On January 29, 2013, we wrote to the Monitor reiterating the Settlement Class previous position, agreeing the chart should not be distributed, and stating our approval for an "experienced consulting group" to develop a process to elicit information from agencies and stakeholders. On January 30, 2013, Mr. Tessneer sent Mr. Ferleger and our office a copy of the Executive Order which our office assumed had also been conveyed to the Court by DHS -- an order from the highest executive for Defendant State of Minnesota pertaining directly to an issue governed by a Federal Court Order, and the DHS deputy commissioner was also encouraged to provide it to the Court. On February 13, 2013, Mr. Ferleger sent Dr. Wieck and Ms. Opheim an email for presentation to the subcabinet involving the definition of disabilities and stating, "I look forward to meeting you and I want to let you know that, as the Court's Independent Consultant and Monitor in the Jensen case, I appreciate and encourage the work of the sub-cabinet on the Olmstead Plan. This Plan is very important to implementation of the Court's order approving the settlement."

DHS has set up a subcabinet through executive action but never bothered to provide Settlement Class Counsel with the committee agendas, meeting minutes, meeting dates or anything relating to the subcabinet, nor has DHS asked Settlement Class Counsel for any input or suggestions for the subcabinet. DHS provided some of this information to our office on May 6 after we advised DHS in the April 30 party meeting that none of these items had been provided. From our view, the creation of an Olmstead plan is again delayed by DHS and State of Minnesota failures to act promptly, leaving the heavy lifting for the consultants on short notice to correct incomplete and unprofessional efforts, and finding excuses for the State Defendants' ongoing failure to engage on an absolutely critical provision of the Settlement Agreement that, if implemented properly, will provide positive, life changing opportunities and protections for thousands of people with disabilities and their families. Given the passage of time from the December 2011 Court approval of the Settlement, ongoing delayed action by DHS, and ongoing failures to communicate and take the issues seriously, we anticipate that the State Defendants will not complete an Olmstead Plan on time, or will rush to create one without appropriate expert input in its drafting and will label it a consensus plan similar to what DHS did regarding the Olmstead Committee recommendations.

Ongoing DHS Violation of Third Party Expert Panel Requirement

A third party expert panel required to be in place since January 2012 is still not in place, without any real explanation and in derogation of the promises made by DHS in the Settlement Agreement and afterwards. Our October 4, 2012, letter to DHS counsel reaffirmed the Settlement Class longstanding position that DHS must adhere to its promises. DHS counsel also expressly informed the Court in a chambers conference that DHS would comply with the third party expert provision, In addition, the Monitor's October 24, 2012, Decision Notes state that DHS was to have provided a list of third party C.V.s, by November 1, 2012, and that DHS expected to have a pool of people for the expert panel within 30 days (by November 24, 2012). The Cambridge facility, moreover, continues to operate under a policy, CLIENT CARE THERAPEUTIC INTERVENTIONS AND EMERGENCY USE OF PERSONAL SAFETY TECHNIQUES (Exhibit A to the Settlement Agreement), which states:

> As soon as reasonably possible upon the emergency presenting, but no later than 30 minutes after the emergency begins, the responsible supervisor shall contact a Third Party Expert from a pre-approved list. The expert shall be consulted in order to obtain professional assistance to abate the emergency condition, including the use of positive behavioral support techniques, safety techniques, and other best practices. If the scheduled qualified Third Party Expert is not immediately available, 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 Third Party Expert or medical officer shall be documented in the resident's medical record

As we have noted, the Cambridge facility continues to operate outside of best practices including excessive and improper response to incidents, improper use of 911 emergency services, failed reporting, and insistence on the use of PRNs despite their preclusion. More the ever, the third party expert panel is needed to assist the implementation of best practice positive behavioral supports and to properly handle incidents involving residents

Excessive and Improper Use of Emergency Calls, PRNs and Chemical Restraint

MSHS Cambridge staff has used excessive 911 emergency calls, PRNs and self serving reporting of incidents involving residents at the facility. Required training was not done, yet DHS claimed it had complied with the Settlement Agreement. After DHS was called out by the monitor and others DHS said it would do the training but has not confirmed its completion. Settlement Class Counsel objects to any finding that the Cambridge facility is properly utilizing PRNs or 911 emergency notification, or that it has properly complied with all training requirements. We rely on the many cited previous letters, e-mail communications, reports of the Ombudsman and other investigative agencies on such issues.

As one of many examples, in our October 4, 2012 Amended Letter to the Court (enclosed) cited to the Ombudsman for Mental Health and Developmental Disabilities September 28, 2012, Report, In the Review of: MSHS-Cambridge Replacement Program for the Former METO Program:

- There is a general concern that the programing provided for the clients deviates from the original purpose of the program as outlined in the empowering legislation for METO or the subsequent Settlement Agreement that described the conditions of any successor program. This was and is to be primarily a program for individuals with a developmental disability with serious behavioral and legal issues, regardless of what other co-occurring conditions these clients may have.

- There is concern that there is a lack of vocational/habilitation programing that has clearly has always been a hallmark policy of this state for persons with developmental disabilities.

- There is a concern that chemical restraints appear to be used based on the PRN use of psychotropic medications and other medications used to deal with agitation.

- There is concern regarding the lack of medical staffing and the use of HSS staff for medication monitoring including first dose or PRN medication, given the number of complex medications that many clients are prescribed. There is concern as to whether HSS staff members are trained on monitoring for the very serious side effects that can accompany use of PRN antipsychotics.

- Also arising out of concern for the medical coverage is the issue of using the local Cambridge Medical Center when a client is out of behavioral control. While on first look this might appear to be logical, however the Cambridge Medical Center's Director of Behavioral Health is the same person who was the Clinical Director at METO during the time of excessive restraints and the person who would decide what protocols the Medical Center will use when the MSHS clients are at the medical center. In addition, it was the understanding of the Ombudsman that the special unit at AMRTC was supposed to provide those services needed when the MSHS – Cambridge clients were in need of acute behavioral stabilization.

- There is a concern that the Internal Reviewer is not being utilized as intended in the Jensen Settlement Agreement. We question why the facility under federal monitoring is allowed to reject or modify recommendations.

- Charting continues to remain a significant concern.

- Our office remains concerned that despite the agreement that this program would not be developed as an IRTS, all indications point to the program operating as if they are. Just because the DHS Licensing laws, rules and variances for persons with developmental disabilities under 245B are silent on medical staffing, day habilitation by the program and other issues does not mean that this is the right approach for the population that is to be served in this program.

September 26, 2012, Report of the Ombudsman at pp. 8-9 (cited in October 4, 2012 Amended Letter to Court)

Based upon available information, including the September 26, 2012, Report of the Ombudsman, which followed the Ombudsman's Just Plain Wrong report identifying the widespread abuse of residents through the use of programmatic restraint and seclusion at the METO facility, which was the subject of the Jensen class action lawsuit upon which the Settlement Agreement is predicated, we notified DHS that we believe the MSHS-Cambridge facility is engaging in the use of Chemical Restraint in violation of the

Settlement Agreement and that the Cambridge staff have not been properly trained as required by the Settlement Agreement.

Settlement Class Counsel has not received adequate information to date that counters the Ombudsman's finding or our conclusions in this regard, or that the civil rights of the residents of the Cambridge facility are adequately protected against such abuses.

Internal Reviewer Recommendations

The Internal Reviewer set up through the Settlement Agreement issues monthly reports, which we understand have not been followed in many instances. We also understand that MSHS-Cambridge administrator Stuart Hazard was writing a rebuttal to the these recommendations. We have urged a complete investigation of these issues.

Transition Planning

We do not believe that DHS is engaged in proper transition planning for residents consistent with Olmstead and the Settlement Agreement. We have urged a complete investigation of this critical issue, including the Cambridge facility's attempt to have residents execute waivers for transition compliance.

DHS Recording the Phone Conversations of Residents

The monitor raised the issue of the DHS unilateral decision to record the conversations of residents to which DHS is not a party and apparently without the resident's permission or knowledge. DHS has not notified Settlement Class counsel of any waiver request to record resident phone calls nor have we been provided with any transcripts or recordings of any phone calls. This information should be promptly provided by DHS.

Settlement Class Counsel has objected to the requested waiver and the recording of any resident phone calls. We have urged that the monitor promptly investigate this issue including whether DHS has violated the civil rights of residents, the Patient Bill of Rights, and Minnesota and Federal law relating to recording of conversations.

Request for Intervention by Department of Justice to Assist Implementation of the Settlement Agreement

Based upon the present situation as understood by Settlement Class Counsel, we urge that the Monitor's report include a recommendation that the Department of Justice be contacted to assist in the implementation of the Settlement Agreement. The ongoing conduct of DHS and its continuing non-compliance, including material misrepresentation of its licensing status and Settlement compliance, further reliance on DHS to properly and

timely implement the Settlement Agreement places at risk the Settlement Class and the rights of people with developmental disabilities affected by the Settlement Agreement.

We also urge that the Court's jurisdiction be extended for a period of one year to allow for the appropriate implementation and enforcement of the Settlement Agreement.

The Settlement Class expressly preserves, and does not waive, all of its rights and positions.

Thank you.

Respectfully,

JOHNSON & CONDON, P.A.

/s/ Shamus P. O'Meara

Shamus P. O'Meara
SPO:me

Enclosures

State of Minnesota
Office of the Ombudsman for
Mental Health and Developmental Disabilities
121 7th Place E. Suite 420 Metro Square Building, St. Paul, Minnesota 55101-2117
Voice: 651-757-1800 or Toll Free: 1-800-657-3506 TTY/Voice – Minnesota Relay Service 711
"Giving voice to those seldom heard"

OMBUDSMAN COMMEN TS REGARDING THE DRAFT STATUS REPORT ON COMPLIANCE OF THE COURT MONITOR UNITED STATES DISTRICT COURT DISTRICT OF MINNSOTA CIVIL NO. 09-1775 (DWF/FLN)

JUNE 4, 2013

I have reviewed the draft Report on the Status of Compliance, prepared my David Ferleger, Independent Consultant and Monitor in the Jensen Settlement agreement. After review of the document, The Office of the Ombudsman for Mental Health and Developmental Disabilities is in substantial agreement with the substance of the text of the report except for those items that will be articulated further in this document.

In the report the Monitor divides compliance into three different types:

- Administrative
- Instrumental
- Quality of Life

In reviewing the report the Ombudsman was struck by the number of issues that were categorized as Instrumental that the Monitor rated as in compliance and the number of items under the Quality of Life that were rated as non-compliance. I call particular attention to the concept that the category of Instrumental as being a precedent to or foundational for Quality of Life requirements. While I generally agree with the text of the report and the recommendations, I am concerned that if items classified as Instrumental are a precedent to or foundational to the quality of life, how the monitor could conclude they are in compliance when those foundational issues have not resulted in an improved quality of life for the individual served by the Department of Human Services?

The following are a list of comments that I would make regarding various items in the Monitor's draft report.

- On page 5 there is a graphic depiction of issues of compliance that the Ombudsman believes could be misleading. A simple glance at the chart would lead you to believe that the department is making significant progress towards compliance. However the graph lacks context. There are a number of technical items for evaluation that are Administrative or Instrumental that do not clearly reflect whether any of that work

made any difference to the quality of life. It does not adequately reflect that Quality of Life should be weighted in value. This chart is a simple numerical chart that weighs whether or not the program contacted the Medical Director in a timely manner, equal to such important criteria of whether or not the program is operating consistent with the principles of Olmstead.

- On page 11-12 there is a table depiction of compliance for which I would make the same comments as above.

- On page 53, EC 4 Cambridge serves only eligible individuals. While the program will only serve individuals who have a developmental disability and who present behaviors that that could be dangerous to the public, the programs seems to have restricted admission for some individuals who would be qualified. There appears to be confusion about who is appropriate for admission to the program.

- On page 61, EC 10 & 11. Again it seems contradictory that the program follows the policies when the incident reviews clearly indicate the confusion about when and when not to use an emergency restraint. As to the issue of the use of chemical restraints, the rating seems inconsistent with the report regarding medication use beginning on page 65.

- On pages 70-72 the report evaluates the role of the Third Party Experts. Specifically on page 72 it list the program is in compliance with items related to consultation with this provision because the settlement alludes to contacting the Medical Director in lieu of the third party experts when the expert is not available. I disagree with the finding of compliance because I believe that DHS is not in compliance with the spirit and intent of the settlement agreement. While they may have been in some form of technical compliance by placing the alternative call to the medical director, this alternative was not envisioned to be a permanent solution to the role of the third party expert. Use of the medical director was supposed to be until the expert panel was secured or if for some reason the expert could not be reached. DHS has become comfortable with this solution such that they have failed to solve the problems with finding qualified third party experts making the entire third party expert section of the agreement useless. While I have great respect for the Medical Director, Dr. Radke, he is still part of the same organization structure as the program and is not external to or independent of the program covered by the settlement agreement.

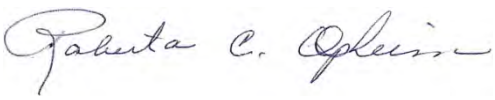
- On page 76 the monitor rates the program as in compliance with Referrals to the County Attorney under the zero tolerance of abuse or neglect. The monitor states this is because there have not been any specific perpetrators identified. I would respectfully contend that there should be no rating on this issue because it is not possible to know if they would make a referral in the future. The rating shows compliance but above the page notes that it is not possible to rate.

- On page 77 and 78 the monitor rates the reporting as being in compliance. Again this is a technical compliance. However the Ombudsman has observed that the information reported is often incomplete as to the antecedent behavior and the efforts at positive redirection. This is clearly reflected when you review the Internal Reviewer's assessment.

- On page 84, the monitor rates the program in compliance under EC 42, Internal Reviewer Consultation. Again, I would stress that there is consultation with the Internal Reviewer but it does not result in an approved plan of care. Even if the recommendations are accepted, there does not seem to be any timely follow up. While they may be in technical compliance, if the consultation is a foundation for the quality of life issue and the quality of life is not changed or improved, then I would challenge the finding of compliance. The program appears to go through the motions of consultation but misses the spirit and intent behind the consultation.

In summary, the Ombudsman remains concerned the major accomplishments envisioned in the Jensen Settlement Agreement has not resulted in the improved quality of life envisioned for persons with developmental disabilities in the 17 months the agreement has been in effect. While efforts continue, I remain concerned that insufficient progress has been made or will be made by the time the court is scheduled to discontinue its' oversight. I would respectfully request that the monitor request the court to extend the length of time the court retains its oversight authority if we are to see true transformation that was the promise of the agreement.

Respectfully Submitted,



Roberta C. Opheim
Ombudsman

Minnesota Governor's Council on Developmental Disabilities
Comments Regarding the Draft Status Report on
Compliance of the Court Monitor
United States District Court, District of Minnesota
Civil No. 09-1775 (DWF/FLN)

June 4, 2013

Part One—Executive Summary /Compliance Grid—Pages 4-12

1. Strengths of this section:

   A. Provides a succinct summary of the findings of the lengthier report.

   B. Examines the issues of the Cambridge facility in detail and provides overall recommendations including:

      1. The Minnesota Department of Health Supervised Living Facility license issue.
      2. Lack of an implementation plan for compliance with the Settlement Agreement.
      3. Implementation-related management problems.
      4. Olmstead plan problems.
      5. Rule 40 problems.
      6. County case management issues.
      7. Rule 20 commitment problems.
      8. Facility conditions such as the lack of habilitation, environment, interaction, useless information, day services, no functional behavioral analyses, most integrated setting, and the future of MSHS-Cambridge.

   C. Highlights the onsite findings of the three experts (Mikkelsen, Bambara and Brown) which bolster the report's findings and conclusions.

   D. The caution about paperwork is a wise addition.

2. What could be improved in this section:

   A. Compliance determination may need additional context. A lot of information is placed in a table which leads to truncated phrases; these phrases may not capture the provisions completely. A disclaimer may be needed cautioning the reader to view Part Four of the report for the complete wording of the provisions.

Part Two—Cambridge, Past and Present - Pages 13-18

1. Strengths of this section:
   A. The history section is helpful background.

   B. The "length of stay" calculation is also helpful information and should be tracked in future reports.

   C. A brief history of past licensing problems experienced at METO since its inception and how these were resolved would also be helpful.

2. What could be improved in this section:

   A. Consider placing all demographic information in this section. Summarize the lengthy sections about individual residents from the Dr. Mikkelsen report and insert here, highlighting those sections that pertain specifically to the Settlement Agreement. Who is currently living at all facilities—Cambridge, Anoka, St Peter, and SOCS group homes (successor facilities)? Include reason for admission, length of stay, goals, medications, Rule 20 and other commitment status; and clarify if any admissions are voluntary.

   B. The OLA Evaluation Report on State Operated Services discussed the costs of state services exceeding national averages (pages 23-24) and that information could be cited here.

Part Three: The Nature of this Report - Pages 19-29

1. Strengths of this section:

   A. Provides an overview for the reader and sets up the longer section entitled Part Four.

2. What could be improved in this section:

   A. Page 20—please indicate that there have been two status reports submitted by DHS to the court but those reports did not go through any review and comment period. Indicate the time periods covered by those status reports.

   B. Page 21 – the areas not covered by this report have not been fully identified. The court order stated “all parts of the agreement.” Clarify what parts of the Settlement Agreement will be covered in future reports.

   C. Page 21 – The statement is made that the current report “does not attend to the history.” Some items raised by settlement class counsel could be included in this report. The 145+ email exchanges were summarized by provision and were submitted previously.

D. Consider truncating the description of Dr. Mikkelsen, Dr. Bambara and Dr. Brown in this section. Refer the reader to their CVs in the Appendix.

E. The conclusions of Mikkelsen, Bambara and Brown may not fit here without additional context.

F. Consider mentioning overall related or collateral quality of life issues in this section. For example, in the recitals of the Settlement Agreement, there is a declaration about the safety and quality of life of the residents of the facility and that the goal of the state is to extend this provision to all state operated locations. Based upon the OLA report about State Operated Services and based upon the Minnesota DHS Inspector General report about Maltreatment, greater attention is needed to prevent abuse and neglect. The Zero Tolerance policy was effective 9/18/12 which was nine (9) months after the Fairness Hearing (December 1, 2011). If you cross reference to Page 54 of the OLA report there is an uptick in number of reported incidents. This trend in increased number of incident reports could be included here.

G. Future compliance issues that could be reviewed:

- Indeterminate commitment status of people with DD
- OLA-SOS report findings
- Under-spending of the waiver
- Restoration to competency programs and most integrated setting
- Prevention of abuse and neglect

Part Four: Findings and Recommendations - Pages 30-128

A. Format and Overarching Issues - Pages 30-38

1. Strengths of this section:

a. Repeats the Executive Summary (pages 4-12) to reinforce the major points.

b. The Minnesota Department of Health email exchanges highlighted here help explain what happened.

c. The Future of Cambridge section does offer an opportunity to begin discussion of future service development.

2. What could be improved in this section:

a. In the area discussing the Minnesota Department of Health SLF waivers—the waivers could be listed and the reasons why DHS asked for the waivers.

b. Implementation Management—this area could be improved by noting the amount of effort by the settlement class counsel in raising issues since the Fairness Hearing.

c. The Olmstead section does not mention that the original Committee issued a plan but it was incomplete and the Subcabinet is a second effort.

B. EC 1-4 Closure of the METO Program, Olmstead, Best Practices, Licensure and Parent Notification - Pages 39-54

1. Strengths of this section:

a. The description of person centered planning and person centered thinking provides good background.

b. The description of positive behavior supports is an up-to-date synopsis of current thinking.

c. The overview of conditions at Cambridge summarizes observations that have been made since December 2011. These conditions address the email exchanges by settlement class counsel requesting information about the license, the lack of habilitation, the purpose of the program, and concerns about program direction and administration. For example, on October 22, 2012, DHS responded that it was DHS's intent to refer all Cambridge residents to community based vocational services. Based on this current report that action did not happen.

d. One of the photos included in this report is reminiscent of 1973 exhibit photos in the Welsch case.

e. The description of data collection should cause some immediate action on behalf of the Department. This type of data collection should end if it is not producing anything useful and wasting staff time.

f. The facts listed in this section are well organized.

2. What could be improved in this section:

a. It is difficult to determine what is preventing habilitation/active treatment from occurring at Cambridge.

b. It is difficult to determine if IMR has ended or not.

c. Strengthen the connection between the recommendations on page 53 and the content of this section regarding forms, inaccurate information being collected, licensing issues, Olmstead principles and positive approaches that should be followed.

C. EC 5, METO closure and guardian comment - Pages 55-56

1. Strengths of this section:

a. Summarizes that surveys have been undertaken.

2. What could be improved in this section:

a. Does not describe what input/feedback was received and how that feedback was used to improve the program.

b. Does not capture all other communication methods that individuals and families have used to offer feedback on how to improve the program such as complaints, phone calls, etc.

c. Suggestions could be offered to improve the response rate of the survey approach.

d. The point of this provision was improving the connection between the program and individuals/families/guardians.

D. EC 6-28, Prohibited techniques - Pages 57- 76

1. Strengths of this section:

a. The discussion beginning on page 67 is helpful and lays out the issues about the PRN protocols, the challenges, and the practices.

b. Page 75 - It is helpful to describe the pro forma inquiry/investigation of the alleged sexual abuse that occurred according to Fact #3. The Department did respond to the monitor which was a positive action.

2. What could be improved in this section:

a. The facts on page 57 do not mention the 911 calls and the use of the police. Were handcuffs ever used? If so, note that fact in this section.

b. Page 59, reconsider whether to include the staff quotation about forcing a person to go to group and causing a behavior, resulting in a federal judge who is upset.

c. Page 65—Compliance with this provision is disputed. The settlement class counsel may have been quoting what was found by others, such as OMHDD, Licensing or the court monitor on an earlier visit (see Fact #3, page 65).

d. Page 70—The third party expert facts are not complete. Names have been suggested to DHS, but there continues to be an impasse.

e. Page 71—Reconsider assessing non-compliance with EC 16, 17, and 18.

f. Pages 73-74: - This section could be strengthened with a few more facts about the Medical Officer Review, such as has he always been called within 30 minutes of the

restraint beginning? How many times was he reached compared to other designees when the Medical Officer could not be reached? Were the calls documented by the Medical Officer? Is the Medical Officer called when the staff members call 911?

g. May need to clarify that this provision means that the staff are supposed to reach the Medical Officer within 30 minutes; the 30 minutes does not apply to the length of time someone is restrained.

h. Page 74—Reconsider assessing non-compliance with EC 25 unless the court monitor has reviewed written documentation of the calls prepared by the Medical Officer.

i. Page 75 - Zero tolerance policy was adopted on 9/18/12; that needs to be added to Fact #1.

j. Page 69, Can the monitor provide a recommendation on improving or increasing clinical staff levels? Dr. Mikkelsen suggested that there may not be enough psychiatrist visits given the medication levels.

k. Page 67, Clarify the following, "Was chemical restraint used at any time at a local hospital?"

l. Pages 75-76,Clarify what happened during the "Mr. Clean" incident. This may need further discussion in a future report.

m. On Page 60, there is a quote about "Someone's going to get killed." Should the court monitor include a recommendation to address this fundamental concern expressed by staff?

n. On February 27, 2013, the court monitor asked about video recordings at the facility and the following questions are a follow-up to that inquiry:

(1) Were any of the incidents at the facility taped and/or recorded?
(2) If so, did the court monitor receive any copies of the recordings?
(3) If not, will the court monitor pursue the recordings?

o. Dr. Miller was asked to review all of the medication levels and the official report may have been a single page or single email. Can the monitor ask Dr. Mikkelsen to review that one page summary to determine if it adequately addressed the concerns raised by settlement class counsel in a series of email exchanges? I believe that Dr. Miller said there was no evidence of chemical restraint. According to Exhibit 11 in the Appendix the last PRN occurred in October 2012, has that been verified?

E. EC 29-39, Restraint Reporting - Pages 77-82

1. Strengths of this section:

a. Page 77 provides a good step by step description of the improvements made in documentation at the facility.

b. Page 79, Recognition that the DHS status reports to the court may have contained inaccuracies.

c. Page 79, Recognition that the DHS Licensing reports documented the lack of compliance with reporting requirements.

2. What could be improved in this section:

a. The recommendation on Page 80 could be improved by mentioning settlement class counsel concerns about this topic as documented in the email exchanges.

b. Page 77 - Clarify if there were any modifications to the original reports being filed at MSHS-Cambridge as first discovered by the court monitor during an earlier visit.

F. EC 40-53, Internal and External Reviewer - pages 83-88

1. Strengths of this section:

a. This section highlights some of the issues raised by settlement class counsel in email exchanges about the internal reviewer process and the failure of MDH to be in compliance about the external reviewer provision.

2. What could be improved in this section:

a. This section could be improved by describing the rebuttals that a previous administrator wrote in response to the internal reviewer reports. That issue has since been resolved.

b. This section could be improved by discussing the need for quicker action to be taken based upon the internal reviewer reports. A fast track plan could be written as a 30/60/90 day action plan.

c. The discussion of the external reviewer is incomplete. This section does not reflect the failure of the MDH to hire an external reviewer. Deadlines were missed. Considerable time was spent by Roberta Opheim and Colleen Wieck, and so it was not a matter of the parties unable to reach agreement.

3. Additional facts or clarifications needed about timeliness, quantitative and qualitative indicators:

a. Page 87 - "although there have been disputes regarding timeliness and completeness of DHS responses…." It might help if more facts were presented here. The email exchanges have been summarized and are available for inclusion in this report. If they were reviewed factually it appears that many questions have been asked and few

answers given. This court monitor report does provide some answers to those inquiries.

b. Failure to have an external reviewer led to confusion about reports to the court. As a result, two DHS status reports were submitted to the court without a review and comment period.

G. EC 54-60, Transition Planning - pages 89-93

Strengths of this section:

a. This is a very well written section and the facts appear to be complete and accurate.

2. What could be improved in this section:

a. Page 90, Fact #7 could be improved by adding "According to Dr. Mikkelsen," and then provide the quote.

b. It could be mentioned that the Cambridge staff had added the transition planning provision from the Settlement Agreement to the signature page and made it appear that, by signing the document, the facility had complied with this provision. That type of "work around" should be discouraged by the court monitor.

c. Page 92 - Recommendation #16: Can this recommendation be rewritten to stand alone such as by adding a phrase to the first sentence that clarifies “in the area of transition planning,” or “in the area of providing person centered planning and practices,” or “in finding the most integrated setting for individuals with complex needs?”

d. Page 93 - Recommendation #19: If there is a recommendation about training, be very specific in terms of directing training resources at a specific audience, providing a start and end date for training to occur, specifying the exact topic and the level of competence desired in those being trained.

e.. This may be beyond the scope of this review, but the early intervention and diversion document for St Peter could also use the transition planning language from the Settlement Agreement.

f. The settlement class counsel raised issues about transition planning repeatedly and there was no response. This current report helps answer the questions that were raised.

H. EC 61-73, Other practices, pages 94- 107

1. Strengths of this section:

a. Pages 98-101, The review of the visitor policy provides new information about current policies and practices compared to the Settlement Agreement. The recommendations will help clarify the visitor policy and practices.

b. Page 104, The review of the bill of rights section provides new information about current policies and practices compared to the Settlement Agreement. The recommendations contained in this section will bring the facility in compliance.

c. Dr. Mikkelsen quotes from a program brochure in his report; that contradicts DHS' email response on 2/8/12 that stated the end of any program brochures.

2. What could be improved in this section:

a. Pages 94-97, Was a review conducted of the training against the best practices standards? Did Bambara and Brown perform this review? If not, perhaps they could be asked to do such a review.

b. Pages 94-97, It should be noted that this entire section was in non-compliance and did not meet the deadlines, did not meet the requirements of all staff, and that staff did perform restraints without the training that was required. There is a history of email exchanges about the training sections of the agreement and this report confirms those many issues raised by the settlement class counsel.

c. According to the most recent DHS licensing report dated February 1, 2013, one staff member received training in "restraint and seclusion" during the summer of 2012. Did the court monitor find evidence of that course?

d. Page 96, Competence has not been assessed, but should be covered in future reports.

e. Page 96, Recommend assessment of non-compliance for EC 63, 64, and 65.

f. Agree with Recommendation #20 on page 96 that calls for another review of curricula specifically when the staff members are telling the independent experts that they are unsure of what to do. Something is missing and it could be supervision rather than a lack of skills or knowledge on the part of the employees.

g. Page 99 - General issue #6: Settlement class counsel at one point alleged that there were instances of denial of visitation but no specific information was provided. That information is contained in a staff log sheets. The staff logs were summarized and submitted to the court monitor separately from this document.

h. EC-67 visitor full access is assessed as compliant. The SLF license issued by MDH stated that there are certain areas that are locked. Are visitors really allowed in all parts of the homes? The February 1, 2013 DHS Licensing report also noted various locked areas.

i. Page 102 - Fact #2: The Admissions Bulletin was not issued on 12/31/12; it was unsigned and released one month later. The Admissions Bulletin contained in the exhibit section is signed.

j. This section states that there is no marketing, but Dr. Mikkelsen quotes from a brochure about the program in his report. That contradicts what this section says. If you do a Google search of METO or MSHS-Cambridge you can find several businesses that advertise this facility. Efforts should be undertaken to remove the facility from these other websites.

I. EC 74-100, CSS, Olmstead, Rule 40, Language pages 108-128

1. Strengths of this section:

   a. Even though CSS may not be a requirement, it helped to include a description of these provisions. CSS is a critical function and needs to be highlighted for the important role they play.

   b. It is very helpful to have the Behavior Analyst issue described because it has not received the attention it deserves.

   c. The Olmstead discussion is accurate.

   d. The OLA report can be used to strengthen this section. The OLA had a lengthy discussion of Olmstead issues and had made recommendations about Olmstead.

   e. The OLA report also discussed indefinite commitment of individuals with developmental disabilities. The monitor may want to address that issue in future reports.

   f. The Rule 40 discussion is accurate. The court monitor admonishes the Committee but equal concern should be addressed to those staffing the Committee.

2. What could be improved in this section:

   a. Reword Fact #1 on page 110 to describe all the ways that CSS serves people. Perhaps list out all the ways that CSS serves as a resource.

   b. Page 113, facts about Olmstead—it could be mentioned that the first Olmstead document was incomplete and that is the reason for the appointment of the Subcabinet.

   c. Page 114, Fact #7—please consider adding in the deadline that the Court set in the April 23rd/ 25th order. The new deadline is November 1, 2013.

d. Page 115, discussion—should all the criteria for an Olmstead plan be listed—measurable, effective, working, and implemented.

(1) This report answers the questions raised by Settlement Agreement class counsel in a series of emails about the Olmstead process.

(2) That exchange included information about the lack of review and comment; the release of the report to lobbyists before committee members, the lack of recommendations addressing waiting lists and other key issues.

e. Page 120, (EC 89-93, Rule 40) recommendation #39 - could be strengthened by stating that the Rule 40 report will be judged against the terms of the Settlement Agreement including best practices, the Association of Positive Behavior Supports, Person Centered Planning, and the Olmstead principles, etc.

f. Page 120, EC 93 - Is there any way to verify that there have been no Rule 40 exceptions at MSHS-Cambridge? Is it possible for the monitor to compare the resident records with the documents submitted to the DHS Rule 40 lead person?

(1) The OLA report describes the Rule 40 issues and the lack of a single policy on the use of restraint and seclusion.
(2) The OLA described the lack of debriefing for people with developmental disabilities and their families compared to other groups after a restraint had occurred. Can that insight be added to this current report?
(3) The OLA described the need to develop sound policies and practices regarding the use of restraint and seclusion.
(4) The OLA recommended a senior administrator to monitor and oversee restraint and seclusion practices.

g. Page 122 (EC 94-98, Minnesota Security Hospital and Anoka) - The section about St. Peter could be improved by adding in direct quotes from the OLA report about St. Peter and people with developmental disabilities.

(1) For example—Pages 15-17 – the OLA described the overall compliance records compared to other licensed facilities.
(2) The OLA report described conditions at St Peter and their concerns about people with DD at that facility.
(3)The OLA Exhibit 3.4 showed the type of incidents reported at state facilities from 2007 until 2012.
(4) The OLA described the licensing violations that have been reported elsewhere in this current report.

h. Perhaps the court monitor would consider contacting the OLA staff members to ask about their review of disability status and admission status for all the people with developmental disabilities at St Peter.

i. Page 123 - EC 97: It should be noted somewhere that the deadline was missed for transferring residents from St Peter. The deadline was December 1, 2011 and that deadline was not met. On October 8, 2012 two men with DD and committed solely as DD were discharged from MSH. On October 26, 2012, the settlement class counsel inquired about the status of two other individuals. On November 15, 2012, DHS said that the inquiry had been responded to fully.

j. On September 20, 2012, settlement class counsel requested information regarding whether people with DD are entering Anoka. No response was received.

k. Page 124 - Were timelines met for Anoka? Was this independently verified?

l. Page 126 (EC 99-100, language)—Can it be noted that the MR terminology was updated in 2005 by the State Legislature? This is not a new issue but an issue of implementation. Can it be noted that the rules must be updated not just legislative language? EC-100 - This step in the process means another year of work because the Revisor in Minnesota will update all rules in 2014. Can it be noted that when individual resident records are reviewed the terminology is loaded with the MR terminology and not just the DSM diagnostic status but throughout the individual descriptions? Implementation of this provision must continue.

FINAL SECTION: Recommendations - Pages 130—134

1. It would help if this recapitulation stated that the recommendations appear in order of appearance from the body of the report.

2. Any references to policies, procedures, and DHS Bulletins need to be identified accurately if this part of the document stands alone. Each recommendation should stand alone if read separately from the rest of the report.

3. Side headings and groupings of recommendations would help.

4. Priority ranking of recommendations by the monitor would help.

Thank you for the opportunity to provide these comments.

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