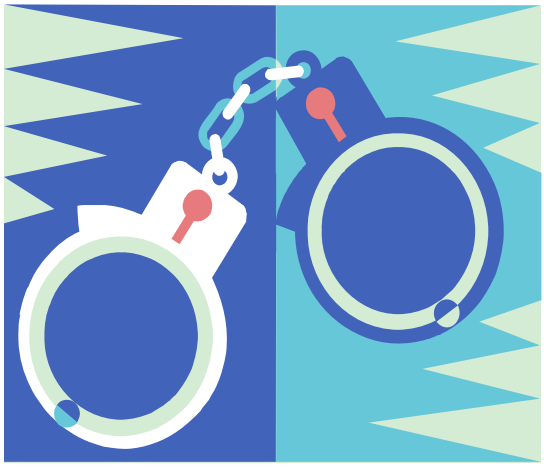

# "JUST PLAIN WRONG"

## Excessive Use of Restraints and Law Enforcement Style Devices on Developmentally Disabled Residents At The Minnesota Department of Human Services Minnesota Extended Treatment Program (METO) Cambridge, MN

**September 2008**


**Review Team Members: Regional Ombudsman: Arlene G. Wegener, Cheryl Turcotte, Chris Michel**



**Issued under the authority of the Ombudsman for Mental Health and Developmental Disabilities**

**Roberta Opheim, Ombudsman**

*State of Minnesota*

# S T A T E M E N T  B Y  G O V E R N O R  L U T H E R  W .  Y O U N G D A H L

## AT THE BURNING OF RESTRAINTS

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## ANOKA STATE HOSPITAL, OCTOBER 31, 1949

**It is just a little more than 250 years ago since mentally ill and other citizens were burned at the stake at Salem as witches.**

**A long period of time has elapsed since then. We discarded the stake but retained in our attitudes toward the mentally ill the voodooism, demonology, fears, and superstitions associated with witchcraft.**

**Tonight – Hallowe'en eve – we employ the stakes and fire for another purpose – to destroy the strait-jackets, shackles, and manacles which were our heritage from the Salem days.**

**As little as eighteen months ago all but one of our mental hospitals used mechanical restraints. Today most are restraint-free.**

**The bonfire which I am lighting tonight consists of 359 strait-jackets, 196 cuffs, 91 straps, and 25 canvas mittens.**

**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.**

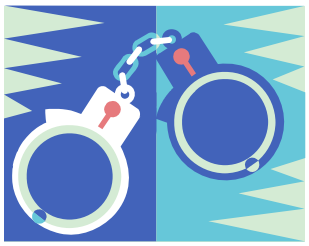
**By this action we say more than that we have liberated the patients from barbarous devices and the approach which those devices symbolized.**

**By this action we say that we have liberated ourselves from witchcraft – that in taking off mechanical restraints from the patients, we are taking off intellectual restraints from ourselves.**

**By this action we say to the patients that we understand them – that they need have no fears – that those around them are their friends.**

**By this action we say to the patients that we will not rest until every possible thing is done to help them get well and return to their families.**

**We have no easy job. The roots of demonology are deep. We have burned one evidence of this tonight. We must be on our guard that it does not creep up in other forms – that what the bonfire symbolizes tonight will carry on in public thinking until every last thing is done to make the state hospital truly a house of hope for these most misunderstood of all human beings.**



# Executive Summary

The Minnesota Extended Treatment Options (METO) is a program operated by Minnesota's Department of Human Service's State Operated Services Division. It is licensed as a 48 bed residential program for persons with developmental disabilities. The program was established after the closure of the Cambridge State Hospital and was designed to serve citizens with developmental disabilities who have some of the most challenging behaviors, including those that may have been involved with the criminal justice system or those who have lost their less restrictive community placement.

In April of 2007, the Office of Ombudsman for Mental Health and Developmental Disabilities received a complaint about the use of physical restraints on these disabled citizens that included the use of metal, law enforcement style handcuffs. In addition, concern was raised by family members that if they did not authorize the use of such restraints, they or their loved one would be subjected to retaliation.

Over the course of the next year, the Office of Ombudsman conducted a systematic review of the treatment provided at the program as well as the laws, rules and quality assurance mechanisms that were applicable to the facility. The agency interviewed clients, family members, facility staff and management, county social service case managers, experts in the field of developmental disabilities and interested stakeholders to gather information about the program and its practices.

What the Ombudsman found was a program that was established with a good foundation and lofty goals but had slid into a pattern of practice that used restraints as a routine treatment modality in far too many cases. Generally accepted best practice standards indicate that restraints should only be used in a situation where there is imminent risk to the client or others and only for as long as the risk is present. In addition, the use of restraints is a matter of Civil and Human Rights.

Current best practice standards focus on positive behavioral supports, which includes assessing the purpose of the behaviors and finding positive alternatives for the individual to employ.

In the course of the review, the Ombudsman found that 63% of the residents who were in METO at the time of the Ombudsman's review had been restrained. Most of those who had been restrained had been restrained multiple times. One of the most egregious of the cases revealed a client who had been restrained 299 times in 2006 and 230 times in 2007. One example of reason to place a resident in restraints included "touching the pizza box." When the Ombudsman examined what alternatives had been tried to avoid the use of restraints our agency saw that many times no alternatives were attempted. In some cases the length of time the person was in restraints exceeded the facility's own guidelines.

In addition to practices of the facility, the Ombudsman looked at all of the various agencies who had protective obligations for these clients or responsibility to serve as a checks and balances over the actions of the program. For a variety of reasons, those checks and balances failed to protect the clients served by the program or turned a blind eye to the problem. It was not until the Ombudsman's Office started raising red flags that actions to identify and correct the problems began. The Minnesota Office of Health Facility Complaints (OHFC) issued a report with 99 pages of problems and citations. The DHS Licensing Division followed with a report outlining additional rule violations.

Since the completion of the investigative phase of this review, DHS has contracted with outside experts to assess and assist with the changes needed in the program as well as the system of care for individuals with developmental disabilities. The Office of the Ombudsman is encouraged by this step and will continue to monitor the program to ensure that meaningful changes are made to the benefit of the residents and the staff of the program.

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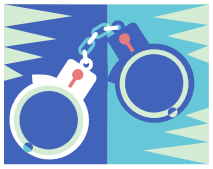


## ***Preface***

The Office of Ombudsman for Mental Health and Developmental Disabilities is authorized to produce reports that raise concerns and provide recommendations about the quality of services provided to some of Minnesota's most vulnerable citizens. The Ombudsman's statutory language states that the Ombudsman may investigate the quality of services provided to citizens and determine the extent to which quality assurance mechanisms within state and county government work to promote the health, safety, and welfare of citizens.

The nature of this review over the course of the past year has led to a number of rumors about this review. Specifically the Ombudsman received feedback that the program and others were of the belief that the goal of the Ombudsman was to see that the METO program is "shut down."

The Office of the Ombudsman wants to make clear that nothing could be further from the truth. METO was developed to meet a specific need for a resource to provide treatment to a small subset of the developmentally disabled receiving services for some of the most challenging maladaptive behaviors that have led to either criminal proceedings or a loss of a less restrictive community placement.

There is a desperate need to have an appropriate place with specially trained staff that is skilled in identifying the purpose of the behavior and what positive alternatives approaches may work for the client. From there staff need to execute treatment plans designed to provide alternative methods that would then result in a reduction in the maladaptive behaviors. METO needs to be a role model and consultant to the provider community on how to provide services to clients to reduce the discharge rate from community placements and allow the clients to be served in the least restrictive alternative. In the minds of many, METO is part of the "State Safety Net" for difficult to serve individuals.

Having said that, it is important that all programs comply with the laws and rules that govern their operation and with the spirit and intent of the law. All citizens of Minnesota regardless of their ability or disability deserve treatment with dignity and respect.

When the State of Minnesota is the provider of services, it rightfully deserves to be held to a higher standard in assuring that the human and civil rights of its citizens are protected. The goal of the Ombudsman in this case is to ask the facility to carefully examine its practices and revamp its programming to be consistent with generally accepted professional practices. In doing so, the program can become the outstanding facility we know it can be. Failure to take corrective action puts these clients at risk.

The Ombudsman also wants to clearly state that she understands that restraints are needed for extenuating circumstances. The Ombudsman believes that restraints are dehumanizing and present serious risks, not only to the person being restrained but also to the staff applying the restraint. The Ombudsman is aware of the research on the use of restraints and has conducted death reviews in Minnesota where the use of a restraint was part of the incident preceding the client's death. Much public outcry occurred and changes made after the Hartford Current, in 1998, published a series of articles outlining the risks with the use of restraints. It is the opinion of the Ombudsman that restraints should only be used as a tool of last resort— only when there is immediate risk of harm and only for the time needed to abate that risk.

If Governor Youngdahl declared we are "enlightened" in 1949, how did we get to this point in 2008?

***Legal Authority for the Review***

Under Minnesota Statutes 245.91-97, the Office of Ombudsman for Mental Health and Developmental Disabilities is created and charged with promoting the highest attainable standards of treatment, competence, efficiency and justice for persons receiving services or treatment for mental illness, mental retardation and related conditions, chemical dependency and emotional disturbance. Concerns and complaints can come from any source. They should involve the actions of an agency, facility, or program and can be client specific or a system wide concern.

Further, the Ombudsman is directed as to matter appropriate for review as follows:

MN Stat. § 245.94 Subd. 2. Matters appropriate for review. (a) In selecting matters for review by the office, the ombudsman shall give particular attention to unusual deaths or injuries of a client served by an agency, facility, or program, or actions of an agency, facility, or program that:

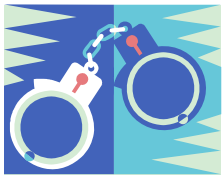
(1) may be contrary to law or rule;
(2) may be unreasonable, unfair, oppressive, or inconsistent with a policy or order of an agency, facility, or program;
(3) may be mistaken in law or arbitrary in the ascertainment of facts;
(4) may be unclear or inadequately explained, when reasons should have been revealed;
(5) may result in abuse or neglect of a person receiving treatment;
(6) may disregard the rights of a client or other individual served by an agency or facility;
(7) may impede or promote independence, community integration, and productivity for clients; or
(8) may impede or improve the monitoring or evaluation of services provided to clients.

## *Introduction*

For over 40 years, it has been the policy of this nation that persons with developmental disabilities have a right to receive treatment in the least restrictive setting. They have the right to achieve the highest attainable integrated life possible. Lawsuits filed in many states around the country in the 1970s and 1980s led to significant change in the quality of life persons with developmental disabilities had a right to expect. Society moved away from institutional warehousing of developmentally disabled citizens toward active treatment and support services based on the individual needs and wishes of the disabled person and their families.

## *Reason for the Review*

In April 2007, the Office of the Ombudsman was contacted regarding concerns for a person civilly committed to the Minnesota Extended Treatment Options (METO) facility in Cambridge, Minnesota. The complaint involved the use of four point restraints including metal, law enforcement style handcuffs and leg hobbles on a vulnerable adult.



***Human Rights Context***

In addition to being a treatment issue, the Office of Ombudsman views the use of restraints in a treatment program as a matter of civil and human rights as well a matter of dignity and respect. In this country, citizens are guaranteed the right to liberty. This includes the right to be free of restraints except in very limited circumstances. Civil rights laws assure that your liberty interests cannot be taken away without due process.

> ***Individuals with developmental disabilities in a state institution have a Fourteenth Amendment due process right to reasonably safe conditions of confinement, freedom from unreasonable bodily restraints, reasonable protection from harm, and adequate food, shelter, clothing, and medical care. Youngberg v. Romeo, 457 U.S. 307 (1982).***

Both Federal and State law protect the rights of citizens of Minnesota. In addition to the basic civil and human rights protected by the United States Constitution, Minnesota has statutes that protect the rights of persons receiving care and treatment in facilities governed by Minnesota laws or licensed by state agencies such as the Minnesota Departments of Human Services (DHS) and Health (MDH). These laws include the Patient Bill of Rights and the Resident's Rights under Civil Commitment. At the federal level, these rights are enforced by the Department of Justice (DOJ), Civil Rights Division under the Civil Rights of Institutionalized Persons Act (CRIPA) [1], which specifically covers facilities operated by government including prisons, jails, mental health and developmental disabilities treatment facilities and nursing homes. METO falls within the scope of this Act.

[1] http://www.usdoj.gov/crt

In reviewing previous findings of the DOJ, the Ombudsman makes note of quotes that express the essence of these rights. Following are two quotes that are often repeated in CRIPA reports:

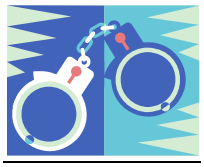
"Individuals with developmental disabilities in a state institution have a Fourteenth Amendment due process right to reasonably safe conditions of confinement, freedom from unreasonable bodily restraints, reasonable protection from harm, and adequate food, shelter, clothing, and medical care. Youngberg v. Romeo, 457 U.S. 307 (1982). See also Savidge v. Fincannon, 836 F.2d 898, 906 (5th Cir. 1988) (finding that Youngberg recognized that an institutionalized person "has a liberty interest in 'personal security' as well as a right to 'freedom from bodily restraint.'"). Determining whether treatment is adequate focuses on whether institutional conditions substantially depart from generally accepted professional judgment, practices or standards. Youngberg, 457 U.S. at 323. Residents also have the right to be treated in the most integrated setting appropriate to meet their individualized needs. See Olmstead v. L.C., 527 U.S. 581 (1999); Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12132 et seq.; Section 504 of the Rehabilitation Act of 1973, 29 U.S.C."[2]

*"The right to be free from undue bodily restraint is the "core of the liberty protected by the Due Process Clause from arbitrary governmental action." Youngberg, 457 U.S. at 316. Consistent with generally accepted professional practice, seclusion and restraints may only be used when a patient is a danger to himself or to others. See Youngberg, 457 U.S. at 324 ("[The State] may not restrain residents except when and to the extent professional judgment deems this necessary to assure such safety to provide needed training."); Goodwill, 737 F.2d at 1243(holding patients of mental health institutions have a right to freedom from undue bodily restraint and excess locking of doors violates patients' freedom from undue restraint); Thomas S. v. Flaherty, 699 F. Supp. 1178, 1189 (W.D.N.C. 1988), aff'd,902 F.2d 250 (4th Cir. 1990) ("It is a substantial*

***The right to be free from undue bodily restraint is the "core of the liberty protected by the Due Process Clause from arbitrary governmental action." Youngberg, 457 U.S. at 316***

[2] CRIPA Investigation of the Lubbock State School,December 11, 2006

*departure from professional standards to rely routinely on seclusion and restraint rather than systematic behavior techniques such as social reinforcement to control aggressive behavior."); Williams v. Wasserman, 164 F. Supp. 2d 591, 619-20 (D. Md. 2001) (holding that the State may restrain patients via mechanical restraints, chemical restraints, or seclusion only when professional judgment deems such restraints necessary to ensure resident safety or to provide needed treatment). Seclusion and restraint should only be used as a last resort. Thomas S., 699 F. Supp. at 1189.Similar protections are accorded by federal law. See, e.g., Title XIX of the Social Security Act, 42 U.S.C. § 1395hh, and implementing regulations, 42 C.F.R. Parts 482-483 (Medicaid and Medicare Program Provisions); 42 C.F.R. § 482.13(f)(3) ("The use of a restraint or seclusion must be . . . [s]elected only when less restrictive measures have been found to be ineffective to protect the patient or others from harm; [and] . . . [i]n accordance with the order of a physician . . . ."); 42 C.F.R.§ 482.13(f)(1) ("The patient has the right to be free from seclusion and restraints, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff.")."*[3]



***Details of the Review***

During the course of this investigation, the Office of Ombudsman interviewed:

Multiple clients and guardians;

DHS DD policy division staff;

DHS State Operated Services management;

DHS Licensing staff;

A former DHS psychologist;

Department of Health, Office of Health Facilities Complaints (OHFC) staff;

[3] CRIPA Investigation of the Connecticut Valley Hospital, Middletown, Connecticut August 6, 2007 Pages 9, 10.

Members of the Ombudsman's Advisory Committee;

Members of the Governor's Council on Developmental Disabilities;

Staff of the Minnesota Disability Law Center;

An Advocate for ARC;

The program physician,

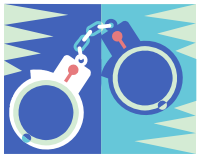
Program administrators,

Behavioral analysts,

Community providers,

County social service case managers and supervisors.[4]

In addition to the interviews, Ombudsman staff made multiple visits to the facility to observe activities and conduct chart reviews.



***Applicable Statutes, Rules, and Policies***

Ombudsman staff reviewed applicable laws, rules, and policies including:

42 U.S.C. § 1997 et seq. Civil Rights of Institutionalized Persons Act

Minnesota Statute 245.825 Aversive and Deprivation Procedures; Licensed Facilities and Services

Minnesota Rules, 9525.2700-9525.2780, Standards that govern the use of aversive and deprivation procedures with persons who have mental retardation or a related condition and who are served by a license holder

[4] The Ombudsman is careful not to indentify which interviewees provided which specific information. A hallmark of Ombudsman's work is confidentiality in order to assure frank responses from those interviewed.

licensed by the commissioner under Minnesota Statutes, chapter 245A and section 252.28, subdivision 2.

Minnesota Statutes 256.092 Services for Persons with Developmental Disabilities

Minnesota Rules 9525, generally referred to as the "Consolidated Rule for Persons with Developmental Disabilities"

Minnesota Statutes 245B.04, Consumer Rights

Minnesota Statute 144.651 Patient's Bill of Rights

Minnesota Statute 253B.03 Resident's Rights (under Civil Commitment)

National ARC policy statement on Behavior Supports

METO policies on the use of controlled procedures in behavior management

***System of Checks and Balances***

Statewide care for individuals with Developmental Disabilities has a number of systems involved, each with its specific roles. In the area of the use of restraints, each role is separate and intended to be a checks and balance system to prevent the inappropriate use of this type of programming. Included is a list of roles in this system.

1. **DHS Long Term Care's DD Policy Division** works to develop public policy and resource development to assure that persons with Developmental Disabilities have appropriate residential and treatment options to meet the needs at all levels in the least restrictive setting.
2. The **County Case Manager** is charged with finding appropriate residential placement with programming to meet the individual client's needs in the least restrictive setting. The County Case Manager is expected to be the primary advocate for the client.

3. The **Court System** determines whether a person should be civilly committed to the Commissioner for treatment at METO because it is the least restrictive setting to meet the client's needs.
4. The **DHS Licensing Division** is responsible for licensing the program to ensure that it is following all of the appropriate laws and rules required under the license (including rules on the use of restraints). Licensing's role is to assure minimum standards which are not the same as generally accepted professional practice.
5. The **MDH Office of Health Facility Complaints** is the designated agency responsible for inspection and enforcement of Federal Center for Medicare and Medicaid Services' (CMS) laws and rules governing ICF/MRs that are certified to receive Federal Financial Participation. MDH is also responsible for licensing Supervised Living Facilities, which includes the noncertified beds at METO.
6. The **Program Administrator** is responsible for seeing that the program operates according to the laws and rules that govern the program.
7. The **Program Clinical Director** assures that the program offers care and treatment that work and is consistent with generally accepted practice standards.
8. The **Program Behavioral Analysts** are charged with assessing the function of the maladaptive behavior and developing the plan of treatment.
9. The **Program Medical Staff** which includes the program physician and nursing staff who assure that the client's health needs are met and that the client's health conditions are not compromised by aspects of the treatment plan. They are specifically required to indicate whether or not restraints are contraindicated.
10. The **Hospital Review Board**, which consists of three members appointed by the Commissioner of Human Services to review both admissions and discharges of clients, and to hear resident concerns or complaints.
11. The **Client's Guardian** if the client has been appointed one by the courts. The Guardian is charged with promoting the client's best interest and with protecting the client's legal and civil rights.
12. The **Parents** or **Family**, if not the appointed Guardian, because they have the most knowledge about the client, his/her behaviors, and how the behaviors have been handled in the past.

Any one of these agencies or individuals has the ability and in most cases the obligation to raise concerns when client rights are violated or treatment plans are not adequate to meet the needs of these disabled individuals. The question raised in this review is how specific roles within the system are required to provide the checks and balance and a

level of protection could have turned the other way while these vulnerable individuals were being routinely restrained.

***Background***

Program Background

METO is a State of Minnesota operated facility that is licensed by the DHS Licensing Division as an Intermediate Care Facility/Mentally Retarded (ICF/MR). METO was partially the result of the closure of the Cambridge State Hospital after the state entered into a Federal Consent Agreement. The Agreement was the outcome of a lengthy Federal litigation about the conditions of care and treatment of the residents of the Hospital. The current program is licensed to serve up to 48 persons with developmental disabilities. METO was established in 1995 by the Minnesota Legislature.

*The Legislature directed DHS to "develop a specialized service model at the Cambridge campus to serve citizens of Minnesota who have a developmental disability and exhibit severe behaviors which present a risk to public safety."*

The Legislature directed DHS to "develop a specialized service model at the Cambridge campus to serve citizens of Minnesota who have a developmental disability and exhibit severe behaviors which present a risk to public safety."[5] METO was formally opened in 1999 on the grounds of the Cambridge State Hospital that closed the same year. The purpose of the program was to treat developmentally disabled citizens who may have engaged in actions which may be criminal or present a serious concern for public or client safety. The METO facility is operated under the forensic division of DHS State Operated Services (SOS). The physical plant

[5]www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_136574

includes eight new residential units in four, one story buildings. Each residential unit has a five-person capacity. Other buildings include remodeled buildings from the former Cambridge State Hospital. These house administration, health services, day/work programs and recreational facilities.

Facilities operating as an ICF/MR need to be licensed in Minnesota by DHS. The facility is governed by MN Stat. § 256B.092 and Minnesota Rules Chapter 9525 (Consolidated Rule).

In order to receive federal funding under the 50% federal match ICF/MR facilities also need to be certified by the Federal Center for Medicare/Medicaid Services (CMS) through the MDH. Several years ago, CMS determined that 36 of the beds did not meet the federal standards for certification. CMS opined the clients placed in those beds did not need an institutional level of care for their basic activities of daily living (bathing, feeding, clothing, toileting). Currently, 10 of the beds remain certified and 36 beds are not certified but the facility license remains as an ICF/MR. For all of the beds, regardless of certification, Minnesota requires that they be licensed by as a Supervised Living Facility (SLF) by MDH in addition to their DHS license.

The 2008 per diem rate for METO is $861. That cost is for each person residing at the program on any given day. That averages out to approximately $25,830 per month per client, an annual rate of $314,000. The majority of these costs are paid with state and county social service funds with 10 of the beds receiving partial federal funding.

Rule 40 Background:

In Minnesota, the term "Rule 40" refers to the rules that govern the use of aversive and deprivation procedures such as seclusion and restraints. Although we all use the old term "Rule 40," it was officially changed many years ago to Rule 9525.2700 – 9525.2810. The rule is established to govern how a program handles clients who have behaviors on

a regular basis that have escalated to a point where an aversive procedure was necessary to protect the client from injury to self or injury of others. The purpose of Rule 40 was not to promote the use of aversive and deprivation procedures, but rather to encourage the use of positive approaches as an alternative and to establish specific standards that must be met when other less restrictive alternatives have been attempted and proven unsuccessful. Rule 40 is a programmatic outline incorporated into the treatment plan with the agreement of the person or their guardian. This can be used as permission to use restraints on a planned but limited basis on clients who have behaviors that are challenging when all less restrictive alternatives have failed. The Rule 40 program is to provide systematic treatment where the treatment team identifies the problematic behaviors, what leads up to them, what function they fulfill for the person, and alternatives to redirect the person in a safe manner (prior to the need to use an aversive procedure). The final purpose of the Rule 40 program is to direct what type of aversive procedure that will be implemented if all other efforts have failed to produce a safe situation. The goal is to provide direct care staff with the tools to work with the client to develop skills needed to reduce or eliminate the need for the aversive procedure and for its safe application when needed. Rule 40 was never meant to be a blanket approval for routine use. The rule directs that the treatment team documents and observes how the plan is working. If the need for aversive programming continues, then a new approach should be developed by the treatment team. Behaviors are often a means of communication when the individual may not be able to adequately express their needs, wants or emotions. Plans should be developed by individuals trained in understanding what need the client is trying to fulfill through the behavior and then find a positive alternative for the client to get their needs met in a safe environment.

Rule 40 plans are to be reviewed to see if they are working and if not, the plan should be amended. The assumption would be that if there is a repeated need to use restraints frequently, then the plan is not working and something else should be tried.

## System Issue Background:

The initial concern brought to the Office of the Ombudsman in April of 2007 was concerning the treatment and aversive programming used by the staff at METO. The caller raised concerns about the METO treatment team's lack of regard for the legal guardian's authority to provide or withdraw consent for aversive programs. The caller also expressed what they believed to be threats and

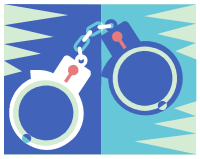
coercion by certain METO staff if they did not sign the aversive program developed by the behavioral staff. Further review of these concerns revealed that staff had been directed to use metal handcuffs and leg hobbles to restrain this person on a frequent and regular basis. Following discussions with all parties of this complaint, METO staff indicated in e-mail messages that they would honor the guardian's decision to revoke their consent for the aversive program, and would no longer use metal handcuffs to restrain persons. Due to the satisfactory resolution of the complaint, the Ombudsman's case was closed at that time.

In September of 2007, the Office of the Ombudsman received new concerns regarding another individual who had been civilly committed to METO. The initial concerns raised were regarding the general treatment of this person and once again, the use of metal handcuffs and leg hobbles to restrain them as part of a behavior program. There were additional concerns raised about the programming being of a very punitive nature instead of instructive and supportive. Based on the information received as a result of these two complaints Ombudsman staff decided to review several other files, chosen at random on September 28, 2007.

Following this initial review of several other records for persons residing at METO, concerns were raised regarding the possible widespread use of restraints, the type of mechanical restraints being used, the reasons persons were placed in restraints and the number and amount of time people were restrained. METO management explained the facility-wide process to Ombudsman staff during a previous visit to METO. It was explained that any person displaying their target behavior for two minutes who could not be redirected, is placed in mechanical restraints. Management stated that the use of mechanical restraints was preferable to manual restraints as it lessened the risk of injury to staff and clients and was the least restrictive way to manage behavior. Management, as well as other staff, stated that this was the only method to get person's behavior under control so they could be discharged to the community. Management and clinical staff echoed the statement that "national studies show the use of mechanical restraints are much safer" than

manual restraints.[6] The studies being cited only included restraints used by law enforcement to subdue someone in a life-threatening situation. None of the studies advocated the use of mechanical or manual restraint as part of a behavioral program.

Based on this preliminary review, the decision was made to initiate a full-scale investigation into the use of restraints at METO. METO management and the State Operated Services management were notified of the Ombudsman's intent to open an investigation. During the September 28, 2007, visit to METO, Ombudsman staff requested copies of documents from individual files.



***Process***

Systemic Review Process:

After determining that the use of metal handcuffs was standard practice, the Ombudsman expressed concern about such use in a treatment facility. Generally accepted practice in a health care setting would be to use soft wrist cuffs. Metal handcuffs are associated with law enforcement and criminals. They can be painful and cause injury. The Office of the Ombudsman initially contacted the DHS Licensing Division with concerns regarding the use of restraints at METO, based on the review of five records at the facility. It was the understanding of the Ombudsman that DHS Licensing was responsible for regulatory oversight of Rule 40 programs at the facility. The Ombudsman was

[6] Ball, H.N. (2005). Death in restraint: Lessons. ***Psychiatric Bulletin***, **29**: 321-323.NUNNO, M.A.,

HOLDEN, M.J. & TOLLAR, A. (2006). Learning from Tragedy: A survey of child and adolescent restraint fatalities. ***Child Abuse and Neglect***, **30**: 1329-1331. A web link to this study is: http://www.charlydmiller.com/LIB09/2006DecChildAdolescentRestraintFatalities.pdf

O'HALLORAN, R.L.& LEWMAN, L.V. (1993). Restraint asphyxiation in excited delirium. ***American Journal of Forensic Medicine and Pathology***, **14**, 289-295.

REAY, D.T., FLIGNER, C.L., STILWEL, A.D., et al (1992). Positional asphyxia during law enforcement transport. ***American Journal of Forensic Medicine and Pathology***, **13,** 90-97.

told that DHS Licensing would look into complaints regarding specific persons if those complaints were within their jurisdiction. However, Licensing informed the Ombudsman that they would not expand their review beyond the specific clients named regardless of what they found in those individual records. The Office of the Ombudsman provided the names of individuals and details of concerns for those five persons whose files had been reviewed in the initial visit to METO.

On October 29 and 30, 2007, forty individual records were reviewed by Ombudsman staff. During this visit to METO, Ombudsman staff met with the METO physician. The physician identified only one individual for whom the use of certain mechanical restraints and a takedown to a prone position would be considered contraindicated. The physician echoed METO staff in stating that mechanical restraints present less risk of injury to persons and staff and it was the least restrictive method to contain severe behavior that might cause harm to themselves or others.

The initial review of all records revealed that at least 65% of the persons at METO at that time had been restrained at least once since their admittance to the facility. Many were being restrained on a regular basis as part of a behavior program or on an "emergency" basis.

*Of the 40 records reviewed in October 2007*

***65%***

*of clients had been restrained*

***73%***

*of clients restrained, had been restrained multiple times*

***74%***

*of clients who were restrained multiple times, had over 10 uses of restraints*

*Highest numbers of restraints reviewed at that time included some who restrained more than 50 times each*

The records reviewed were a snapshot of clients in the program on October 29, 2007.[7] It was later learned that additional documentation of restraints were put in an archive file to keep the chart a reasonable size. Once the archives were reviewed, many more restraint uses were identified for some clients.

Upon admission to METO, each individual is given a physical exam. The admission physical exam form includes a statement to determine if the person

[7] See Appendix E

has a medical condition that would contraindicate use of restraints. The Ombudsman staff was unable to find an initial exam form in any person's record that did not allow the use of mechanical restraints. In reviewing the medical files there was documentation of individuals with asthma, seizure disorders, history of lung abscesses and other medical issues being cleared for the use of mechanical restraints. One individual had several lung abscesses and continued to be mechanically restrained in a prone position just days after being released from the community hospital for this condition.

This visit to METO also raised concerns regarding the reasons persons were restrained and the methods of restraint. Some persons were being restrained for what was termed aggressive behavior such as touching staff's shoulder, touching a pizza box that was being held by staff, talking about running away, and other behaviors that do not appear to meet any definition of aggressive or dangerous behavior. METO staff and management argued that these behaviors may not appear to be aggressive, but were precursors to dangerous behavior.

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. In at least one case, a client that the metal handcuffs and leg hobbles were then secured together behind the person, further immobilizing the arms and legs, reported it to the Ombudsman staff. 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, as they would not be able to use their arms or hands to break that fall. Others were being restrained on a restraint board with straps across their limbs and trunk. METO policies stated that a person was not to be restrained for more than 50 minutes. Ombudsman staff found numerous examples of documented incidents where after 50 minutes in a restraint, staff would continue the restraint but document it on a different restraint use form, sometimes with no indication that it was a continuation of the previous restraint.

*people were being routinely restrained in a prone, face down position and placed in metal handcuffs and leg hobbles*

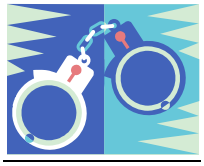
Documentation revealed that in most cases where restraints were used, the person was calm and cooperative about going into the restraint but began to struggle, cry and yell once they were in the restraints. In some cases, clients appeared to be conditioned to "assume the position" for the application of restraints where they would lie on the floor and put their hands behind their back without resistance. One client who was regularly restrained with metal handcuffs and leg irons stated that once the restraints were on he/she began to experience discomfort which led to crying, yelling and struggling against the restraints. The METO policy stated that a person had to be calm for 15 minutes before they could be released from restraints. During one METO visit Ombudsman staff requested that METO management place the handcuffs on them in a standing position with their hands behind their back. Ombudsman staff did not struggle at all during this time and had the handcuffs on for approximately 5-10 minutes. At that point, it became uncomfortable in the wrists and shoulders. The Ombudsman staff experienced discomfort in their wrists and shoulders for at least an hour after the use of the handcuffs. This raised further concerns for persons that would struggle when in this type of restraint.

During the October 29 and 30, 2007 visit the Ombudsman staff obtained the names of the guardians for the persons whose files were reviewed on those dates. A release of information form was sent to the guardians so the Office would be able to obtain copies of documents from the individual files. The Office received approximately 50% of the signed releases back from guardians. Only one of the thirty-plus county case managers contacted the Ombudsman's Office to obtain more information about the investigation or discuss their concerns. Only one guardian contacted the Ombudsman's Office to express disagreement about the concerns raised concerning the use of mechanical restraints.

The analysis of the individual files, METO policies and procedures, and interviews with staff and management indicate a philosophy that has been established at the facility regarding the use of restraints. Management and professional staff defended this punitive restraint practice as the safest and least restrictive way to control individual's behavior. The Ombudsman has concerns about staff regard for individual rights or risks of this type of programming.

In addition to METO management and staff, three clients, six guardians, two case managers, one social service supervisor and DHS management were

interviewed or were notified of the concerns found in this investigation to that date. The Minnesota Department of Health, Office of Health Facilities Complaints (OHFC) was also notified of the Ombudsman's concerns at METO.



***Summary of Licensing Investigations***

Summary of the OHFC Investigation and Statement of Deficiencies

The MDH, Office of Health Facility Complaints (OHFC) division conducted an unannounced visit to METO on January 10 and 11, 2008, following information provided to them by the Office of the Ombudsman. The scope of the investigation by OHFC included not only persons residing in the ICF/MR certified beds of the facility, but also those persons who were residing in the non-certified beds, or SLF units. As a result of this investigation OHFC investigators found that fifteen 'Conditions' under the Federal regulations governing ICF/MR facilities were not met by METO. They issued a sixty-five page report to the Department of Human Services detailing the facts of those deficiencies. Federal regulations require that the service provider develop and submit a plan of correction for each deficiency in this portion of the OHFC report.

A separate investigative report by OHFC details the results of their investigation of complaints regarding resident rights in the SLF units at METO. In the twenty-nine page report issued by OHFC, the investigators provided evidence that the facility failed to meet the requirements under MN Statute 144.651, Subdivision 14, to ensure that residents were free from maltreatment, particularly from "unnecessary drugs and physical restraints." METO was given 40 days to correct this violation of State Statute or face monetary fines. The Office of the Ombudsman was informed that the deficiency report issued to METO by Office of Health Facility Complaints was one of the largest reports ever issued to a facility serving persons with developmental disabilities in Minnesota.

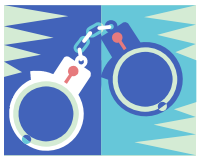
Summary of DHS Licensing Investigation and Correction Orders

DHS Licensing issued an Investigation Memorandum and Correction Orders on April 4, 2008 regarding complaints about the use of controlled procedures; in particular, mechanical and manual restraints at METO. DHS Licensing investigated allegations involving clients residing at METO, who are in both federally certified beds and non-certified beds. The DHS Licensing investigation's scope was limited to the four specific concerns or allegations raised by the Office of the Ombudsman on October 15, 2007. At the time of the October 15th meeting with DHS Licensing, the Ombudsman's Office had only reviewed a limited number of client records. More extensive reviews were conducted by Ombudsman staff in the weeks and months to come. The concerns raised by the Ombudsman's Office at this meeting were summarized and categorized into four allegations by DHS Licensing staff. DHS Licensing investigators determined that in three of the four allegations there were violations of MN Rules governing the use of aversive procedures. The fourth allegation was determined to be inconclusive. It should be noted that the fourth allegation concerned the complaints by two guardians of two clients residing in two separate residential units at METO that they were coerced into signing consent for the use of a controlled procedure on their wards. The investigators did not interview one of the two guardians.

DHS Licensing issued a Correction Order to the METO facility that contained six citations, which required corrective action. The citations included the following:

1. Failure to ensure that all the required standards and conditions for the use of controlled procedures were met.
2. Failure to submit data on the use and effectiveness of the controlled procedures to the expanded interdisciplinary team, the internal review committee, and the regional review committee on a quarterly basis.
3. Failure to obtain the required assessment information on persons who had a controlled procedure as part of their Individual Program Plan (IPP).
4. Failure to ensure necessary conditions were met when an emergency use of a controlled procedure was implemented on a client.
5. Failure to implement the program's own policy on the emergency use of controlled procedures.
6. Failure to "complete the required reporting and reviewing" of the use of emergency controlled procedures.

At the time of this report, there has been no follow-up information provided by DHS Licensing to indicate that METO has corrected the violations outlined in their Correction Order.



***Personal Stories***

Many individuals are adversely affected by the METO policies and procedures regarding the use of mechanical restraints. The following are just a few of the persons whose lives have been affected.

Person #1

This person has no family involvement in his/her life and has a private guardian who helps him/her make decisions on life matters. This is an individual who has the diagnosis of moderate mental retardation, schizoaffective disorder, pervasive developmental disorder, as well as numerous other physical issues including a seizure disorder and recurring lung abscesses. This person has challenging behavior, the most severe being injury to him/herself. He/she was civilly committed to METO after a community program was unable to provide the appropriate programming and support to maintain a safe environment. In discussions with this person's guardian, the Ombudsman was informed that this individual had a difficult and traumatic childhood and has presented a challenge to caregivers. It was explained that in order for the person to feel in control of his/her environment, he/she would display target behaviors to test the caregivers to see if they would initiate the consequences that the behavior program dictated they should do. This was a constant theme in this person's behavior. When this person was admitted to METO a Rule 40 procedure was developed that included no touching of any person without their permission. If this person touched any staff or peer three times in one hour, it is considered physical aggression. He/she would be placed on the restraint board or in a prone, face down position and handcuffed behind his/her back with a leg hobble placed on his/her legs. There was no

documentation of any behavior that could be defined as extremely dangerous or life threatening. Each time he/she was restrained, he/she would cry and yell for the majority of the time. In 2007, this person was restrained approximately 225 times for a total of over 130 hours. In 2006, documents revealed a similar number of restraint uses for the same reasons. Of those 225 plus times in 2007, restraints were only used four times for self-injurious behavior and seven times for hitting or scratching staff or a peer. Nearly 160 of those times he/she was restrained it was for merely touching a staff or an object being held by staff or bumping into someone. Some of the other reasons listed for the use of restraints were: "touching pizza that staff was holding," "threw wash cloth at staff," "spitting at staff," and "touching staff's walkie-talkie." There were several incidents when the person was released from a restraint, that he/she would immediately touch the staff person and be placed back into restraints.

While interviewing this person on his/her residential unit it appeared that he/she was controlling the environment by watching for staff's reaction to any move he/she made. This person was pleasant and personable to Ombudsman staff but constantly asked about getting out of METO and going to a community group home.

Person #2

This person is a young adult in his/her twenties who has a developmental disability and autism. This individual has a supportive family that is active in his/her life. The family members are vocal advocates for their loved one and are always working to get the best services for him/her. Prior to being committed to METO, this person was residing in the community at a state operated group home. According to records, he/she was taken by staff of this community placement to a shopping center. The person became extremely agitated from the external stimulus and began to display behavior that was self injurious that the staff could not control. The staff called the police rather than remove the person from this environment. Police took the individual into custody but quickly determined they had detained someone with severe disabilities that they were not prepared to care for in a community jail.

The group home refused to take the person back and law enforcement officials were forced to find a hospital placement for him/her. The person was subsequently committed to METO from an acute care hospital as there were no

alternative placements available in the community at that time. Staff immediately began to use metal handcuffs and leg hobbles to restrain him/her when he/she displayed behaviors that were deemed to be antecedent to more severe self injurious behaviors. There did not appear to be other methods of programming discussed or considered. Typical behaviors displayed by this person that resulted in restraints include: spitting, becoming agitated (there was not a clear definition of this behavior) and other behaviors that are not unusual for this person to display when their environment is over stimulating or stressful for him/her.

Concerns were also raised about staff training in the treatment of persons with autism. There was also a complaint about certain METO staff members attempting to coerce the guardians of this individual into signing the authorization to use mechanical restraints. The guardians indicated that they were told by one METO staff person if they did not sign the Rule 40 authorization, METO staff would request that the Court review the guardianship (implying the guardians would be removed & replaced) and METO would obtain a court order for the use of restraints. The guardians stated that they felt they had no choice but to sign the authorization for the Rule 40. Following a review of this individual's record and discussions with staff at METO, county case managers and family, the concerns raised were substantiated by the Ombudsman's Office. The guardians rescinded their authorization for a Rule 40 program and the clinical director agreed to stop using metal handcuffs and leg hobbles on this individual. Although the Rule 40 program was discontinued, the restraints were used multiple times on what staff documented as an "emergency basis." The records indicated that those emergency uses were for behavior that was indicative of someone with autism who is stressed out and over stimulated by their environment.

Several months later the individual was discharged from METO to a crisis bed to await a placement being developed by a community licensed facility. The clinical director at METO refused to authorize a voluntary stay when the MR commitment was completed in November 2007. The family was concerned about the stress of two residential moves for their loved one in such a short time. The clinical director provided the following reasons for not authorizing the voluntary stay in a memo to the county case manager: "The majority of [his/her] behavioral episodes have been reactions to disruptive peers… Another barrier to my consent is the fact that the guardians are in open

disagreement with the METO program and its care of their ward. I cannot conceive of a competent guardian who would consent to voluntarily assigning care to a clinician whose personal and professional credibility they attack at every opportunity. I believe my consent to voluntary treatment of [this person] would pose unacceptable risk to me, the program, and the Office of the Commissioner."

*"The majority of [his/her] behavioral episodes have been reactions to disruptive peers… Another barrier to my consent is the fact that the guardians are in open disagreement with the METO program and its care of their ward. I cannot conceive of a competent guardian who would consent to voluntarily assigning care to a clinician whose personal and professional credibility they attack at every opportunity. I believe my consent to voluntary treatment of [this person] would pose unacceptable risk to me, the program, and the Office of the Commissioner."*

The family expressed concerns that the clinical director did not express these reasons to them directly and that he appeared to be more concerned about his own reputation than the well-being of the client.

Since his/her discharge from METO the family has noted a difference in their adult child, stating he/she blossomed and has had very few issues with behavior. The family attributed this difference in behavior to the person not being restrained and that the person was provided with choices in their daily life, something they indicated was not the case at METO. However, the family indicated that their child was afraid to leave the new facility to attend day programming due to fear of having to return to METO. They also indicated that their child continues to express fear at being returned to METO.

## Person #3

This person is also a young adult in his/her twenties who was committed as Mentally Ill and Mentally Retarded to METO from a state operated facility. He/she has the diagnosis of severe Fetal Alcohol Syndrome, mild developmental disabilities, Intermittent Explosive Disorder and other

neurological problems. The records indicate that he/she was committed to METO for aggressive behavior toward staff, suicidal ideation and attempts to run away from the community residential program. Within days of his/her admittance to METO there is documentation of the use of metal handcuffs and leg hobbles in a prone position. Reasons given were yelling at staff; showing anger towards staff when told he/she could not go to church; for "interfering in peer's program"; throwing and tipping over a chair; telling staff he/she wanted to run away; not staying within eye sight of staff after receiving medication and similar incidents. Multiple times the documentation reports that prior to the use of the mechanical restraint the person was calmly watching television or eating a snack. There were two incidents in which he/she was attempting to harm themselves or a peer. There is little noted in the documentation that indicated why this person would suddenly attempt to hit staff. The person's parents report that he/she does not have a history of hitting staff or other physical aggression unless he/she feels provoked by something staff have said or done.[8]

The parents/guardians attempted to raise concerns regarding the person's treatment related to his/her fetal alcohol syndrome with little success. The parent/guardian was told that staff are to treat the behavior that got the person committed to METO, and the method of treatment was to restrain the person. The guardian stated that efforts to provide information that might be helpful in the treatment of the client were not readily accepted by staff. The guardian stated that when they began to question the use of restraints, the response by METO staff was an attempt to severely limit visitation by the parent. The parent/guardian would only sign a Rule 40 program if it were to be used for a room time-out. A review of the person's record indicated that staff continued to use mechanical restraints on what they documented as "an emergency" situation. The documentation did not indicate life threatening or severe behavior prior to the use of the mechanical restraints in these situations.

[8] It is important to note that this does not mean that staff intended to provoke the client but instead it is reflective of how the client may process certain events or actions of others. This could then assist in possible treatment plan options.

## Person #4

This individual is in his/her twenties and was removed from his/her home as a toddler due to parental abuse and neglect. He/she has been given the following diagnoses: mild mental retardation, major depressive disorder, oppositional defiant disorder-nos, antisocial traits, borderline personality disorder, and microcephaly. This individual has several alternative procedures included in his/her Rule 40 program, such as the use of an ice pack to be placed on his/her face, education group and talking with staff. The person's Rule 40 program calls for the person to be placed in a face down, prone position and the use of metal handcuffs and metal leg irons to restrain him/her. This procedure is used even if the person is cooperative and calm prior to being placed in the restraints. In the past year, this person has been restrained with the metal handcuffs and leg irons approximately 25 times for a total of 629 minutes, or an average of 25 minutes for each restraint. Multiple incidents where this person was restrained were because of attempted property destruction or threats to staff or attempts to kick or hit staff. While interviewing this person on his/her residential unit, the Ombudsman staff saw bruises, both old and new, on this person's wrists and ankles from the use of these restraints. The person stated that he/she has fewer behavior incidents than he/she did before and that the staff changed his/her program from the use of leg hobbles to leg irons because he/she was able to get out of the leg hobble restraint. It was clear that this person understood what behavior led to the use of restraints. Yet it is unclear if the person was always able to willfully control their own behavior due to their mental health issues and cognitive processing disabilities.

***The person's Rule 40 program calls for the person to be placed in a face down, prone position and the use of metal handcuffs and metal leg irons to restrain him/her. This procedure is used even if the person is cooperative and calm prior to being placed in the restraints.***

## Person #5

This individual is in his/her thirties and was civilly committed to METO in the spring of 2007. Prior to his/her commitment to METO the person resided in a group home in the community managed by DHS State Operated Services. This

person has been given the following diagnoses: schizoaffective mania, severe mental retardation, static hydrocephalus, history of head concussion secondary to trauma at age 4, history of benign heart murmur, psychomotor retardation, and a history of a seizure disorder. He/she has many challenging behaviors including self injurious and pica behaviors.

A discharge summary from the MSOCS crisis home lists this person's diagnosis as "moderate-severe mental retardation, hydrocephalus, seizure disorder, scoliosis, and behavioral dyscontrol." In the 18 weeks while at the crisis home this person displayed 104 incidents of verbal aggression, physical aggression, property destruction, and self-injurious behavior. The staff at the crisis home wrote clear and concise recommendations for behavioral intervention in their discharge summary that was provided to METO staff. It stated in part, "Two person escorts and manual restraints using the basic come along and arm bar to give staff a chance to exit the area were used with some success to maintain the safety of others. [The person] does not calm successfully when restrained and [he/she] retaliates immediately if able to do so. Turning [him/her] away from the exit and releasing [him/her] simultaneously while leaving the area would give [him/her] time to calm." The recommendations go on to say, "Mechanical restraints were not attempted due to safety issues, the number of staff needed to do so safely, and [his/her] need to pace and use tactile stimulation to calm and relax, would not be available if restraints were used."

During the first six weeks at METO, documentation indicates a baseline of 1132 incidents of physical aggression, self-injurious and pica behaviors. Between 9/1/07 to 11/29/07, 1420 incidents of those same behaviors were documented in this person's record at METO. From the date of admittance to METO until August 14, 2007, this person was being restrained both manually and mechanically, including the use of soft handcuffs and leg hobbles in a prone position, and being placed on the restraint board. On August 14, 2007, this method of restraint was discontinued following a spiral fracture of the person's left arm. Since that time staff have used a restraint belt with attached soft handcuffs. The person is allowed to move about the living area while in this type of restraint. In the six months since the person was admitted to METO he/she has been mechanically restrained over 120 times, most of those times for 50 minutes each.

***Facility Revisits***

On March 20, 2008, Ombudsman staff made an unannounced visit to METO to review several residents' records. This visit and record review was precipitated by the citations and facility response to citations from the Office of Health Facility Complaints (OHFC). The Ombudsman's Office was optimistic that major changes had taken place in the area of programming and patient rights. Four records were reviewed, including progress notes through March 19, 2008. Two records were reviewed of persons residing in the ICF/MR units and two records from persons in the SLF units. Three of the four records are persons whose stories are detailed in the Pertinent Facts and Findings section of this report.

The first record reviewed resides in an SLF unit, where regulatory oversight by OHFC is limited to the Patient Bill of Rights. Ombudsman staff found no changes to this person's Rule 40 program and determined through documentation that this person had been mechanically restrained 23 times from February 10, 2008 to March 17, 2008. Some examples of the reasons this person was restrained, were as follows: touching above the shoulder, touching staff's walkie-talkie, throwing milk at staff, grabbing at staff, threw napkin holder at staff, and threw a "piece of a rag" at staff. There were incidents documented where physical aggression was listed as the reason for the restraint, but the physical aggression was not always defined in clear terms. For example, in one case the staff simply wrote that the client aggressed against another peer by throwing an object at them. The staff did not chart what that object was, which could make a difference in how staff might intervene in the situation.

The second record reviewed was that of a person residing in an ICF/MR unit at METO. The ICF/MR units are closely regulated by the MDH and the program can be sanctioned for violations that are not corrected. This person's Rule 40 program indicated only one minor change since the OHFC citations had been issued to METO. The minor change did not involve the criteria for the use of the mechanical restraints. Note that this person had been restrained over 125 times in the months just prior to the OHFC visit. A review of the progress notes indicated only two dates in February where the person was restrained. There were no restraints documented in the month of March for behavioral issues. The documentation prior to February of 2008 was extensive in

regard to this person's negative behaviors and the need for restraints. There are many notations of negative behavior in the March progress notes in the person's record. However, there is only one written note of how this negative behavior was dealt with by staff. This person's file stated that the staff had received approval from the METO Human Rights committee at the end of February to place a camera in this person's room to observe him/her during a restraint procedure. The reason given for the camera was that the person, while in restraints and in their room, would become agitated and aggressive toward the staff observing the person in restraints.

The third record reviewed was that of a person who resides in an SLF unit. There were no changes to this person's Rule 40 program that allows room time-out only and no changes to the Individual Program Plan. This person had been manually restrained seven times in February and those were documented as "Emergency Restraints." The person, when interviewed, described the restraint procedure as being told to lie down on his/her stomach with four staff holding his/her arms and legs. There was no documentation of any restraints in the month of March. Further review of the record indicated that during the month of March, the person slept most of every day for three weeks, with little or no staff intervention.

The fourth record reviewed was that of a person with a developmental disability and is deaf. This individual resides in an ICF/MR unit. The person has an approved Rule 40 program that requires staff to manually and mechanically restrain the person when target behaviors identified in the program are evident. The program was used on a frequent basis until several weeks before this review. No restraints were documented during the month of March.

It can be concluded that there have been drastic changes in the way programs are initiated in the ICF units, however there remains little change in the programming methods in the SLF units.

***Personal Story Updates***

These updates are based on information obtained from April 24, 2008 to present.

Person #1

This person remains at METO, residing in the same living unit (SLF). His/her programming has not been altered significantly and he/she continues to be restrained on a frequent and regular basis for behaviors outlined in this report.

Person #2

This person was discharged from METO late 2007 to a crisis bed in the community while he/she awaited a permanent placement. This person's adjustment from METO to the community was somewhat difficult in that he/she was constantly "checking" with staff and family to make sure he/she didn't have to go back to METO. Staff at his/her permanent placement reported that he/she has a great deal of anxiety about leaving the group home for any new destination, as he/she believes he/she may be taken back to METO. In the beginning of placement, he/she had to constantly be reassured that he/she was not going to be taken back to METO. His/her guardians report that the trained staff in his/her current residence provide him/her with choices for activities each day, which was not the case at METO. This has led to a reduction in the person's anxiety level and the behavior exhibited at METO.

*Staff at his/her permanent placement reported that he/she has a great deal of anxiety about leaving the group home for any new destination, as he/she believes he/she may be taken back to METO.*

Person #3

This person currently resides at METO (SLF), however is slated to be discharged within weeks to his/her parent's home. Due to the advocacy of his/her guardians and others, this person no longer has a Rule 40 program that includes the use of metal handcuffs and leg hobbles. The guardians have informed the program that they are not to use mechanical restraints. They have told METO staff that they may use manual restraint and room time-out only in emergency situations where there is possible imminent, grave harm to their child. This person continues to communicate that he/she "hates" METO because he/she has been abused there by staff takedowns and the use of mechanical restraints.

Person #4

This person remains at METO in the same residential unit (SLF) as in January of 2008. His/her individual program plan, including his/her Rule 40 program, have not been altered to change the use of metal handcuffs and steel ankle cuffs as part of his/her program.

Person #5

This person remains at METO in the same residential unit (ICF/MR). Following the investigation by the Department of Health (OHFC), METO changed their restraint policy, which does not allow metal handcuffs to be used in the ICF/MR units. This client continues to be restrained with a waist belt that has soft cuffs attached to it. Documentation in the client's record indicates that recently, the internal Human Rights committee at METO has approved the use of a video monitor in this person's room to monitor him/her while he/she is in restraints.

***Program Positions Throughout the Review Process***

Throughout this investigative process the Ombudsman's Office has discussed with METO management and staff, a METO hospital review board member, DHS State Operated Services management, and DHS Disability Services Division policy staff the grave concerns regarding the use of restraints on persons committed to METO as a programmatic treatment method. There were many statements made by all parties associated with METO in defense of this practice. The staff and management of METO were adamant in their conviction that this method of "behavioral therapy" was the only method that could work on the individuals at their facility.

Comments were made that the Ombudsman and others did not understand the nature of the clients who were placed at METO. The Ombudsman was told that many of the clients would be in jail if they were not in METO. During the many discussions with METO or DHS management regarding the use of restraints on persons at that facility, Ombudsman staff have been told repeatedly that the individuals at METO are "the most difficult and dangerous" persons to serve. Another staff described them as the "worst of the worst." The staff insinuated that most of the persons at METO came there through the criminal courts following the committing of a serious crime.

During the January 8-9, 2008 visit to METO, only five of the forty people committed to the facility had come through the criminal court system. These five individuals were under a Treat to Competency Order (Rule 20.01).[9] The five individuals all had diagnoses of mild to moderate developmental disabilities with other diagnoses of mental illness, chemical dependency or traumatic brain injury. A thorough review of the five persons' records indicated that only one

[9] While there were five under 20.01 (Treat to Competency), there may have been others whose civil commitment was prompted/preceded by a Rule 20. Under Rule 20, if a person is found incompetent and the charge is a misdemeanor, the charges are usually dismissed and civil commitment proceedings are initiated. Those cases would show up as a straight civil commitment. More serious crimes (i.e. Gross Misdemeanor and Felony charges) usually result in a Treat to Competency.

of the individuals had been restrained in any way since their admittance to METO. The person had been manually restrained twice. All five records show individuals who are compliant with treatment and tasks they are directed to do by staff.

The documentation in the individuals' records and statements made about these five people by staff appears to contradict the statements made by METO and DHS management regarding the number of persons being committed to METO through the criminal courts and also that those persons are the most difficult to serve. The program was portrayed as a place where clients who have committed crimes are placed when they are not appropriate for prison, including those who were not competent to stand trial or able to understand the nature of their actions. These were individuals who would be committed there by a criminal court as a result of a Rule 20 assessment.[10] During the course of the review, the Ombudsman discovered that those placed there as a result of a Rule 20 represented only 10 – 15% of the clients served by the program. In fact it is striking to the Ombudsman that those who were there because of criminal court Rule 20 proceedings were less likely to be restrained than those who had been civilly committed. The Ombudsman does acknowledge that the numbers regarding criminal court commitments may not tell the full story because some individuals that have been civilly committed may well have been diverted from criminal court.

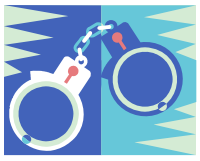
The program also expressed a belief that when guardians would not authorize the use of restraints or limited their use in some way, that the program was between a "rock and a hard place." It was further explained that this lack of authorization left the program unable to keep the client and staff safe and made staff unable to treat the client to the point where they could be returned to a less restrictive setting in the community. It was clear that the program believed that use of restraints was the only treatment method for difficult behaviors which is contrary to the generally accepted practice of positive behavioral supports.

Other comments made by staff indicated that it was the belief of the program that it was the fault of the client that they were in the program. Certainly it was the behavior that got the person admitted to the program, but it is not their fault

[10] MINNESOTA RULES OF CRIMINAL PROCEDURE WITH AMENDMENTS EFFECTIVE JULY 1, 2008; RULE 20

that they have a developmental disability that impairs their executive reasoning function.

One of the points made was that these individuals are not really DD but have mental illness because the clients are high functioning and have the ability to form intent. This implies that it would be acceptable to use these aversive practices in a residential mental health facility. However, if this were a facility for persons with mental illness, they still would not be able to routinely use restraints. There is no provision for the use of restraints comparable to Rule 40 in the mental health system.



***Commentary/Analysis***

The words and phrasing used by all parties connected to METO were similar or identical, indicating a problem often referred to as "group think," where the message is so ingrained and the leadership philosophy so strong that independent thinking is neither utilized nor tolerated among members of the group. This puts the facility at risk of no one seeing potential problems within the program or the corrective measures that might be needed. The language takes on the characteristics of a "mantra." The following is an attempt to examine some of the standard responses provided to the Ombudsman.

"Worst of the Worst"

Statements referred to the persons served at METO as the "worst of the worst," the "hardest to serve," "the most dangerous," and "the most behaviorally challenged." The use of this wording is demeaning and signifies a lack of respect for the persons at METO as individuals. Residents need to be seen as individuals with their unique abilities and challenges, needs, wants, hopes and desires.

## "It's the client's fault they are at METO"

Other statements made by METO and DHS individuals laid blame on the individuals themselves for being sent to METO. It was the individual's failure in the community, the individual's behavior, or the individual's unwillingness to comply with their care givers that resulted in them being committed to METO. First, all the persons at METO have mental disabilities that may not afford them the ability to reason and learn appropriate behavior on their own. By examining the recent history of many of these individuals prior to their commitment, it was sometimes the inability or unwillingness of the caregivers in the community to spend the time, energy and effort to provide appropriate treatment and supports to the person. For example, one individual with severe autism had community caregivers who appeared to panic when they did not know how to calm this individual who had become over-stimulated and began to harm himself/herself in public. For persons with autism, there can be a hyper-sensitivity to stimulation which is a hallmark feature or symptom of this disorder. The residential staff apparently did not have supports necessary to assist this individual and therefore called the local police for help. Law enforcement took this individual to jail and quickly realized they had a person with severe impairments they were ill equipped to manage the person in their correctional facility. If the residential staff had been provided with the appropriate training and supports from their management, they may have handled the situation differently and the individual may never have spent those long months at METO. Was this the individual's failure? Did the individual form reasoned intent to engage in maladaptive behaviors? Clearly this was not the case. The behavior may have been inappropriate to the situation or environment but the individual did not have the ability on their own initiative to choose to overcome those behaviors. If they were capable of making these changes on their own, there would not be a need for a placement in a specialized facility at a cost of $861 per day. Cost effective treatment can be done but it takes active, positive redirective programming, something this individual appears not to have received at the time of this incident.

Another example of "blaming the individual" is the situation of a person who resided in a crisis home for at least eighteen weeks (designed to be short-term placement) before being committed to METO. Because a placement was not found or developed in the community, this person ended up in METO. It should be noted that this individual's behavior was managed considerably

better in the crisis home without restraints. In fact, the professional staff from the crisis homemade specific recommendations to METO not to use restraints on the individual because it would not allow him/her to calm him/herself. (Please see Person #5's story in this report.)

These are just two examples appropriate for this report. Once again, it is clearly the responsibility of the professionals within the service delivery system to develop programs and services that are positive in nature and provide the necessary supports for individuals with developmental disabilities.

The Ombudsman's Office recognizes that some individuals receiving services have challenging behavioral issues, and that at times of immediate risk of injury to themselves or others, a person may have to be briefly restrained or removed from their environment to prevent an injury. Using restraints such as metal handcuffs, leg hobbles, leg irons, and restraint boards as a behavior tool to teach an individual not to engage in certain behaviors can be a violation of the individual's rights. It is ineffective in teaching appropriate behavior, and just plain wrong. If individuals are being restrained over 200 times in a year, shouldn't this be indication that the aversive, punitive programming isn't working?

## "It is not safe to keep him here" (Retaliation)

Some guardians of persons committed to METO learned that to raise questions about the use of restraints or other punitive methods of behavior management could lead to subtle and not so subtle retaliation from staff. Visiting times with the client and contact with staff became limited and information about their ward became difficult to obtain from METO staff. In one case, an individual's guardian refused to allow the use of mechanical restraints on their ward when he/she engaged in typical behavior associated with his/her autism. The guardian offered referrals to sources that could provide alternative behavioral methods for persons with severe autism, but these offers were ignored by METO staff. When the individual's commitment was coming to end and it appeared that the community placement would not be available for approximately a month after the end of the commitment, the guardian asked that the person remain at METO for that month. The guardian expressed concern about the stress put on the ward if they should have to move twice during such a short period of time. The guardian's request was never directly responded to by

METO staff. In correspondence to the person's county case manager, the clinical director wrote that he would not agree to this temporary, continued stay. He cited that the client had been ready for discharge for many months (the documentation at METO did not support this statement) and he would not allow him to stay beyond the end of the commitment. He went on to say, "I cannot conceive of a competent guardian who would consent to voluntarily assigning a clinician whose personal and professional credibility they attack at every opportunity. I believe my consent to voluntary treatment of [the client] would pose unacceptable risk to me, the program, and the office of the Commissioner."[11]

The Ombudsman's Office could not find any documentation that the guardians attacked this professional's credibility either personally or professionally. The guardians stated that they believe the decision by the clinical director and his false statements about them attacking his credibility are in retaliation for their refusal to accept mechanical restraints as the appropriate behavior therapy for their ward.

## "Rule 40 allows the use of restraints"

The practice conveyed to Ombudsman staff by program staff at varied levels gave the impression that it is acceptable to restrain clients routinely. The Ombudsman disagrees.

Rule 40 (9525.2700-9525.2810) states that its purpose is "not intended to encourage or require the use of aversive or deprivation procedures." It is intended to "encourage the use of positive approaches as an alternative to aversive or deprivation procedures." The rule also requires "documentation that positive approaches have been tried and have been unsuccessful as a condition of implementing an aversive or deprivation procedure."

What did occur was an immediate use of mechanical restraints for "target behavior" that was documented as "emergency use" until a Rule 40 program was written by clinical staff. Under Rule 40 standards for Emergency Use of Controlled Procedures, there are three standards that should be met to use this procedure.

[11] E-mail from the Clinical Director to the County Case Manager.

A. Immediate intervention is needed to protect the person or others from physical injury or to prevent severe property damage that is an immediate threat to the physical safety of the person or others."

B. The individual program plan of the person demonstrating the behavior does not include provisions for the use of the controlled procedure."

C. The procedure used is the least intrusive intervention possible to react effectively to the emergency situation."

Documentation in individual records where an emergency use of controlled procedures was implemented indicated that at least two of these standards (A and C) were not met before it was used on a person. One example of this is a person slamming a door several times. This clearly did not meet the definition of possible severe property damage. Another example is a person talking about running away. There was clearly no immediate danger of injury to this person or others by the threat of running away. In these two examples, it is illustrated how the line of what is considered an "emergency" was blurred to restrain someone for any negative or target behavior even when they did not have approval of the guardian.

In other situations, it becomes clear that the rigidity of the policies and procedures regarding restraint use is beyond the scope of any reasonable person's standard of when a restraint might be needed. One example of this is an incident where a person was excited by the fact they had their annual IPP meeting on a cold autumn day. The meeting was being held in the administration building, about a hundred yards from their residence. The person was told to put on a coat before leaving the residence for their meeting. The coat was in the laundry so the person left the residence without a coat. Staff rushed after the person, physically restrained him/her on the sidewalk, and when calm, brought him/her back to the residence. Once in the residence the person was placed in mechanical restraints and not allowed to go to their annual IPP meeting. As documented, this restraint was implemented for not following staff commands to wear a coat. Many people learn best how to dress after they experience the discomfort of being cold. In other words, we learn from our own mistakes. Unless the person's decision is immediately life threatening, the person should have some rights of self-determination and free choice. Use of a

restraint in that case was not the only method of handling the situation. There were a number of alternative options that could have been considered.

A review of records at METO showed a lack of individualized behavior programs. The difference in the behavior programs appeared to be the named "target behavior" for which the restraints would be used on the person. Ombudsman staff was informed by METO staff and management that staff had been trained to allow only two minutes of any "target behavior" for an individual. If the person did not stop the "target behavior" within this time frame, they were automatically placed in mechanical restraints, per their Rule 40 program. It was rare to find any documentation that staff attempted any less intrusive method to stop a 'target behavior.' In most incidents when staff were asked to document lesser intrusive methods or procedures tried before the restraint was used they wrote, "N/A" or "None." In other cases, they charted "redirected client" but without any detail about the redirection so it could be evaluated for why it was ineffective. It is unclear why the staff of the facility appears to believe that it must be "all or nothing" with regard to the use of restraints.

## "This program is a nationally recognized program"

Repeatedly the Ombudsman's Office heard from staff at METO, DHS and others associated with METO that the METO program was considered a nationally recognized program because of their achievements in the reduction of maladaptive behavior in individuals with developmental disabilities.

The Ombudsman's Office has learned through examination of documents that the success of a behavior program is directly linked to a reduction in the use of restraints on a person for target behavior. For example, if a person was restrained 50 times in the first six months of the year and only 30 times in the second six months of the year, the mechanical restraint program was said to be an effective program in reducing maladaptive behaviors. Documents obtained during this investigation indicate this is an incomplete evaluation of program effectiveness. For example, one document clearly indicated that staff was directed to reduce the use of restraints on one person to make it "easier for the person to be placed in the community." There was no indication that there was a reduction in "target behaviors" for this person at the time of this directive to

staff. When use of restraints are suddenly discontinued, the statistical appearance is that the program has dramatically reduced target behaviors.

Another example of this perception of programmatic success is a person who has been discharged from METO, who had an aversive Rule 40 program that required staff to restrain him/her for behavior that was typical for a person with autism. The guardian rescinded approval of this program. The guardian determined that the program was being used on their ward for behavior that he/she could not necessarily control and that the method of restraint was metal handcuffs and leg hobbles used in a face-down, prone position. When the Rule 40 program was discontinued, the documentation for this person indicates an almost immediate reduction in the "target behavior" for which the person was being mechanically restrained. It is unclear if the target behaviors had been reduced or that staff were not documenting those behaviors because there was no longer a Rule 40 program that required this documentation.

## "This is a relatively short-term program"

The original concept was that the METO program would be an interim placement until the behavior could be treated and the client returned to the community. Short term might be nine to 18 months, although it would be based on the client's individual progress. However, a review of the records indicates that many of the clients have been there for years, including individuals who had been there for three, four, seven, and eight years. One resident been there for over 25 years.

METO becomes their home, a place where they feel safe, respected and valued. At least one of these individuals had been restrained between 200 and 300 times per year for the last two years. It is difficult to conceive the client's quality of life. For the taxpayer cost of $ 314,265.00[12] per year, the client and the public have a right to expect better from the professionals who provide treatment.

## Checks and Balances in the System

A question raised earlier in this review is how all of the persons and programs within the system who are required to provide a level of protection to their clients could have

[12] DHS Bulletin #07-77-01

missed that these vulnerable individuals were being routinely restrained. The Ombudsman found generally complacency and a negative view of "what can we do" when we have no other options. Through examination of the various systems of checks and balances, the Ombudsman found a system under stress. It confirmed the philosophy that when everyone is responsible, then no one is accountable. From a policy division standpoint, the Ombudsman saw a system that has evolved over time, a system that is required to serve very complex needs within limited or diminishing resources.

There are not sufficient facilities with the capacity to handle the most difficult to serve individuals. When resources are limited, there can be cutbacks on staff training in community facilities. The state used to set aside funds that could be used to "enhance" the existing funding to find appropriate options for those with higher needs so that they did not need to remain institutionalized. These "enhanced" and "triple enhanced" waiver slots were held by the State and were therefore not dependent on what county a client may be from. This method gave way to pooling of all waiver dollars for a county and allowing the county to manage their funds within their pool of slots.

When county case managers sought placements, they found it challenging to find providers able to treat those with difficult needs. Counties were unwilling to pay for the staffing needed by the facilities to meet these needs. According to some in State Operated Services, the state still runs certain crisis services in name, but the counties are unwilling to pay the real cost of maintaining the professional staff needed to be available for crisis situations. Case managers sometimes carry large caseloads and difficult clients require a lot more of their time and energy. When a case manager is faced with a client in a failed placement, an open bed at METO can be an attractive alternative to developing alternative resources. Despite the expectation that the case manager is to be an aggressive advocate for their client, they generally are not clinical experts in this type of treatment. Sometimes they are willing to relinquish responsibility to METO knowing that someone else is providing for their client. Case managers indicate that their other work demands do not allow for full knowledge of what happens on a day-to-day basis. Case managers told us that they knew about the use of restraints but were not aware that they were law enforcement tools. Once they became aware of this, they expressed concern about the practice.

When parents and guardians raised concerns, case managers were afraid to "rock the boat" because of the limited options for alternative placements. Many of the family members went along with whatever the professionals proposed because they believed the professionals were the experts. Even if family members did not like the practices,

they were afraid to question them because the family members did not have the skills, ability and resources to meet the person's needs at home. As well, the person was "court ordered" to be at METO. For those who attempted to be assertive or even aggressive on behalf of their ward, program staff sometimes described them as "difficult" or "interfering with treatment." They were viewed as part of the problem. The Ombudsman was told about situations where the facility and sometimes the county would imply the need to go into court to question their role as guardian. One family member indicated that he/she would routinely bring up concerns reported to him/her by their ward, even concerns about how other residents on the unit were treated. The client called the family member at one point and said not to do that because his/her treatment would get worse after that. Although unrelated, the client said they had a search of all the rooms on the unit. The client had a piece a paper on which the family member had written the telephone number of an outside advocacy group. The client reported that the contact information was taken from the room and the client was worried about retaliation so was never going to complain again. While DHS licensing may not have been able to substantiate retaliation in reported cases, there was a sense of fear along with a strong sense of unease expressed by some of the family members.

## Where was Licensing?

When issues were raised about the treatment methods used, the program staff responded that if the problem was so bad, Licensing would have taken appropriate action.

Until recently, the MDH had a prominent role in overseeing ICF/MRs as well as the DHS Licensing Division. After the Consolidated Rule took effect, an interagency agreement was implemented, delegating the responsibility of investigations to DHS. In 2007, the CMS informed Minnesota that the interagency agreement did not meet Federal expectations. MDH then resumed their investigative role at METO for the beds that were federally certified as well as those licensed under the department's rules for SLFs.

Both MDH and DHS licensing division informed the Ombudsman that they had not been aware of the metal handcuff use and had not received any complaints. DHS made it clear that while they had some concern about the type of devices being used, there was nothing in the rule that limited the type of material that the restraint could be made. DHS went on to indicate that their reviews focused on whether or not the program had appropriate Risk Assessment Plans and Individual Treatment Plans. DHS also reviewed Rule 40 plans for the necessary elements. These included the guardian

signature authorizing the use of restraints. Licensing generally did not second-guess the clinical judgment about when to implement restraints. They emphasized that Minnesota Rules are only the minimum standards, not necessarily optimal standards.

Once Licensing became aware of the concerns, they did respond by conducting investigations within their regulatory scope and issued findings and citations to the facility.

In discussing these issues with parents, Licensing indicated that many clients did not know where to complain or were afraid to complain. Case managers reported to the Ombudsman that actual practices of the facility were not discussed at the team meetings. They reported that at the meetings, the facility generally reported the progress and any changes in the treatment plan. At least one case manager indicated that he/she did not ask any questions of the facility staff or challenge treatment decisions but was disturbed when they learned about the metal handcuffs.

Finally, the HRB indicated that it rarely met with clients but relied on reports from the staff.

## Penny Wise/Pound Foolish

In one case, it was reported that the community service provider had been doing a good job with the client and liked having the client in their home. However, because some of the behaviors were challenging they needed to add on another staff member for additional supervision purposes. When the provider requested an increase of the client's waiver allocation to cover the cost, the county denied the request. It was at that point that the facility said that without the extra staff, it would no longer be able to serve the client. The client was placed in the hospital and then in a state operated crisis home. From there the client went to a community setting where he/she had problems. The crisis home said he could not return. The client was then committed to METO at a cost of $861 per day. However, at METO, the county is only required to pay 10% of that cost and state pays the balance for the majority of the beds. While the clients are at METO, they lose their eligibility for waivered services. There is no guarantee there will be a slot when they are ready to return to the community. Under the county's waiver pool, those funds remain in the pool available for other waiver recipients. However, it is the Ombudsman's understanding that most of those discharged can be reestablished on a waiver when they leave.

The Ombudsman questions the rejection by the county of the additional staff person and the sending of the client to METO, where costs are significantly more.

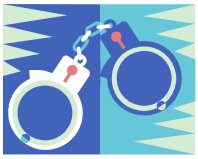
***Ombudsman Conclusions***

After a careful review of the information gathered and thoughtful consideration, the Ombudsman concludes that:

- There is an abundance of research and evidence that positive practices can work to alter challenging behaviors.
- Positive interventions are the generally accepted standard of care for persons with developmental disabilities.
- There is a legitimate place in the spectrum of care for a facility envisioned by METO's empowering legislation.
- METO currently has a program-wide practice of routine use of restraints employed as a basic treatment modality. This practice embodies a deeply ingrained philosophy of care.
- Staff members of the facility believe that their clients will not get better if they do not use this form of treatment.
- The practice of using restraints is practiced widely and is anticipated with every admission. This is evidenced by the standard check off on the admission form that there are no contraindications to the use of restraints.
- The facility plans are not sufficiently individualized except for what constitutes "target behaviors" that would precipitate restraint use.
- The facility's documentation surrounding the incidents of restraint use is not adequate to evaluate what alternatives were tried.
- The treatment plans were not routinely reviewed for the effectiveness of the Rule 40 program nor were they amended when the current plans were not producing results.
- Despite all the concerns raised, the program only discontinued restraint use in the two units that are certified and eligible to receive federal funds. The program

stated that the reason for the change was that federal rules were more restrictive and did not allow for it. There is no indication that the change was because of any acceptance that this practice is a problem or that they intend to change their practice in the other six units.

- The facility did agree to look for alternative restraint devices that are safe and more acceptable in a health care setting.
- Inappropriate use of restraints can constitute abuse under Minnesota's Vulnerable Adult Act.
- It is the opinion of the Ombudsman that certain practices have violated the human and civil rights of some clients.
- The system as a whole fell complacent in their roles to protect these vulnerable Minnesotans.
- There are not sufficient facilities in the community that are able to handle clients with intensive support needs and it is not clear who is responsible for their development.
- The clients who are at METO are not the "worst of the worst." There are many existing examples of clients with challenging behaviors who are living in the community and are successful when given the appropriate supports by well-trained support staff.



***Recommendations***

- DHS should immediately begin a comprehensive review of the policies, procedures and practices at METO.
- METO should immediately discontinue the use of restraints in any form except when eminent risk of harm is present.
- All staff should receive training in positive behavioral programming, rights of clients, documentation and other training as identified in any program evaluation.
- METO should establish an overarching approach to the use of restraints that applies to all clients regardless of what type of licensing covers any given unit. Human rights are universal and every client has the right to be treated with dignity and respect.
- METO should begin discharge planning for any client who has resided there for more than two years, with adequate safeguards to minimize the stress of transition.
- METO should begin a practice of developing a therapeutic alliance with family members and guardians, even those who may disagree with the program. There should be recognition of the legitimate role and responsibilities of these individuals and understanding that they are critical in the future success of the clients.
- DHS should look for opportunities to divert clients with less challenging behaviors to alternative resources in the community. If none exists, State Operated Community Services should look at developing those services.
- DHS should begin a process of evaluating why there are not adequate resources in the community and why they are not being developed.
- Clarity of who is responsible for developing these resources should be sought. Is it the state or the county? Who is responsible and how can they be held accountable?

- DHS should evaluate whether or not more could be done to support community providers in order to prevent the loss of an existing placement.
- DHS should evaluate the funding methodology to assure that there is a designated reserve to draw upon in that small percentage of cases where the standard methodologies are not appropriate.
- DHS Licensing should consider revising its policy of limiting its investigation to only those specific items identified in a complaint when their investigation reveals a pattern of practice that may reveal that other clients are affected and licensing rules are being violated.
- County case managers should become more active participants in their client's plan of care and should be encouraged to challenge practices to assure that all reasonable methods have been tried before any restraint is to be used.

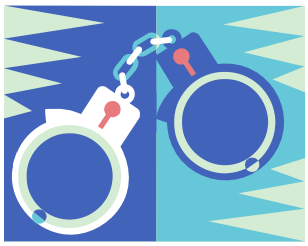
## ***In Closing***

It appears as if the METO program has lost sight of its original vision and mission. Minnesota has fallen back on the failed practices of the past that led to the necessity of a Federal Consent Decree. Without immediate and substantive change, the state is at risk of further federal intervention. METO clients deserve to receive treatment and supports that fully incorporate them into the fabric of our communities as equal and participating members. Those who know and work with these citizens know how much they contribute and how much they enrich our lives. These citizens deserve better and the taxpayers of Minnesota deserve more effective use of their resources.

## ***Addendum***

The Ombudsman is aware that during the time this report was being finalized by the Ombudsman, METO and DHS have embarked upon a process to address concerns raised in this report.

# REPORT APPENDIX



A. Responses from DHS

   1) DHS State Operated Services
   2) DHS Licensing Division

B. OHFC Citations

C. DHS Citations

D. Informational Web Sites Links

E. Table of Restraints on Initial Site Visit

# Appendix A1

# DHS State Operated Services Response

Minnesota Department of **Human Services**

August 8, 2008

Roberta C. Opheim
Office of the Ombudsman for
Mental Health and Developmental Disabilities
121 7th Place E. Suite 420, Metro Square Building
St. Paul, MN 55101-2117

Re: Your Correspondence Dated July 14, 2008, re: Ombudsman's July 2008 (Draft) Report Regarding the Use of Restraints in the Minnesota Extended Treatment Options Program

Dear Ms. Opheim:

This correspondence is in response to the referenced draft report compiled by your office. The report includes the Ombudsman's concerns regarding the use of restraints on disabled individuals at the Minnesota Department of Human Services' (DHS) Minnesota Extended Treatment Options (METO) Program.

The METO program and its dedicated staff constitute a vital and effective asset for individuals with developmental disabilities who present a risk to the public. METO has emerged as a pivotal component of the forensic services network, filling what had been a serious and persistent void in the continuum of care. In an effort to continue to provide and improve upon the quality services we provide, METO undertakes internal quality assessment and improvement efforts, including program reviews completed by outside experts.

One such review was recently completed by four national experts in the field of developmental disabilities who spent three days reviewing the METO program and patient charts. These consultants possess particular expertise regarding patients who exhibit challenging and aggressive behaviors. In addition, the METO program has been the subject of various reviews by the DHS Licensing Division, Minnesota Department of Health's (MDH) Health Compliance Office and Office of Health Facility Complaints ("survey agencies").

The Ombudsman's July draft report is a synopsis of program areas that had been referred to the survey agencies as needing improvement. Consequently, prior to the release of the July 2008 draft report, METO had already begun to satisfactorily address or resolve concerns raised by the Ombudsman. At the completion of an ongoing, comprehensive review and revision of program policies and procedures:

- The consultants will issue a report in early fall with recommendations;
- METO will develop a plan of action in response to the recommendations;

- The consultants will return in 12-18 months to assess progress on the action plan.

In addition, the actions below have already been taken by METO in response to citations issued by the survey agencies.

Comprehensive Review and Revision of Policies, Procedures and Practices at METO

METO has completed a comprehensive review and revision of its policies, procedures, and practices. The process resulted in substantive changes to facility policies and procedures affecting:

- Safety Planning for Community Activities,
- Emergency Use of Controlled Procedures (Manual & Mechanical Restraint),
- Use of Controlled Procedures in Behavior Management, and
- Staff and Client Conduct.

METO has trained staff and implemented these revised policies and procedures.

Consistent and Limited Use of Restraints

In February 2008, METO established (1) a uniform policy and procedure to be applied to all units, regardless of the type of applicable licensing regimen, regarding the use of restraints, and (2) an aggressive goal and timetable that all staff will be trained by March 1, 2008, and that goal was met. Under the new policy and procedure, METO has discontinued the use of restraints in any form except when imminent risk of harm is present.

Staff Training in Positive Behavioral Programming and Other Relevant Areas

In addition to new employee training and annual refresher training, specific training regarding behavioral management principles was provided to all METO staff in February 2008. This training included a segment regarding the change in policy on the use of restraints and the dangers of restraints. The training also included information on client rights to freedom from unnecessary restraint and other restrictive interventions. To further METO's mission to provide positive behavioral programming, METO is currently looking at various behavioral training curricula; METO is committed to purchasing a positive behavioral management program that will best serve its population.

Admission, Transition Planning, and Discharge

METO's policy and practice is to begin discharge planning upon admission. In practice, discharge planning begins even earlier, with detailed discussions with a prospective client prior to, and when possible weeks before, admission. Additional relevant considerations include:

- METO admission procedures have been strengthened to ensure county case manager involvement earlier and throughout the process.

- Assessment and treatment plans are now more focused on issues related to commitment and barriers to discharge, as opposed to long-term training and supports that are best delivered in a community-based setting.

- The DHS METO Admissions Bulletin has been revised to emphasize that placement at METO is intended to be interim and time-limited, rather than permanent.

- The practice of pre-admission discharge planning was greatly enhanced within the last year by the addition of a member of the DHS Disability Services Policy Division to the METO Admissions Committee. That person's role is to provide a liaison role between METO and the Disability Services Division and support regional staff as they work with counties to help facilitate timely discharge back to the community.

As a result of the preceding focus on maintaining and improving the discharge planning component of the METO program, in the past year alone, four out of nine clients at METO who had a length of stay exceeding two years have now returned to the community.

Involving Family Members, Guardians, Patient Advocates, and Others

METO recognizes the central importance of involving family members in the treatment process, regardless of legal (guardianship) status, in a variety of ways:

- Upon admission the facility fully discloses its policies and procedures related to positive behavioral supports and emergency restrictive interventions. Disclosure includes photographs of mechanical restraints. The family is asked to discuss any concerns regarding restrictive interventions so that appropriate alternatives are identified.

- Family members and others involved in a patients care are provided copies of client bill of rights and METO's policies and procedures relating to client rights, and are invited to tour the campus and interview staff prior to their person's placement.

- Guardians are key members of the Interdisciplinary Team. Treatment with psychotropic medications and/or restrictive interventions can only occur with the consent of the client or guardian.

- Involvement, input, and recommendations from interested third parties, including outside consultants, past service providers, patient advocates, and others is also encouraged, afforded serious consideration METO staff, and implemented when appropriate.

Identifying and Developing Alternative Community Resources

DHS' State Operated Services (SOS) Division and METO have been working collaboratively with the DHS Disabilities Services Division, the policy division, to clearly identify those clients who meet METO admission criteria and to require community crisis management services to work diligently to

to find community placements for those clients who do not meet METO admission criteria.

- METO has worked with Minnesota State Operated Community Services to develop alternative community placements. The first such home will be available in the fall of 2008.

- METO Staff collaborated with DHS Disabilities Division to sponsor a community crisis conference to focus on the unmet need for community crisis services by county and state providers with the goal of avoiding the need for clients to be admitted to METO.

- The METO Admissions Bulletin has been revised to include the following information:

  - Crisis Management Services: In an effort to avoid the need to initiate commitment proceedings, clients who are being *considered* for admission to METO should be referred to a community crisis management service to determine the appropriateness and availability of alternative care and/or placement.

  - Persons who do not meet METO's admission criteria but who have been committed to the Commissioner will be admitted to a Minnesota State Operated Community Services home, until such time as an appropriate community placement can be secured.

There have also been steps taken to evaluate and increase the capacity of community providers to meet the needs of individuals, in order to avert use of crisis services. As examples:

- The Disability Services Division coordinated with Aging and Adult Services Division this year to conduct an analysis of county capacity in order to identify service gaps, and influence the development of services to meet those gaps. This expanded the previous "Gaps Analysis" done by counties for people who are aging, to include people of any age with disabilities. The analysis of the findings is underway, and will lead to targeted technical assistance efforts by Disability Services Division staff with counties who are responsible for developing community service capacity.

- The Disability Services Division has been evaluating the array of services available through the four disability waiver programs to determine if changes are needed in the definition of any services and/or provider standards to assure people have access to appropriate services.

- The Disability Services Division intends to add crisis services to the CADI and TBI waivers, in addition to the DD waiver. This will allow individuals who do not qualify for ICF/MR level of care to receive needed crisis intervention services as well as short term residential support when necessary through other waiver programs. The provider standards for crisis services are being revised to include competencies with positive behavioral interventions.

- The Aging and Adult Services Division, in collaboration with the Disability Services Division, conducts an annual survey whereby counties, tribes and health plans that provide waiver lead agency administrative responsibilities document administrative assurances in a Quality

Assurance Plan. The survey this year required an inventory of all home and community based providers under contract with the county to gain a more complete picture of the services available to individuals across the state.

## Evaluate Funding Methodologies

The Disability Services Division has allocated emergency waiver resources within parameters designed to provide a safety net for people counties are not otherwise be able to serve within their waiver program. These resources have been provided to counties to assist with discharges from METO.

A new state to county budget methodology for DD waiver funding will be implemented January 2009. Training will begin in September for counties. It is expected that the methodology and use of the management tools that were developed to support its implementation will provide more flexibility in the DD waiver program to serve people with developmental disabilities.

There are limits on funding available through the waiver programs. A number of people receiving services through METO are not eligible for ICF/MR level of care, and therefore not eligible for a DD waiver. They may be able to access CADI or TBI waiver programs, based on eligibility for nursing home level of care. Services available through the Mental Health System, health care and other sources are resources that must be appropriately utilized in order to effectively serve people. Staff from the Disability Services Division, Adult Mental Health, Children's Mental Health and other divisions are working to provide better information and support to counties about funding and services that may be available for their clients.

## Conclusion

METO is dedicated to upholding the highest standards of service attainable. Among the strategies METO employs to achieve this goal is soliciting and being receptive to input from independent evaluators, including the recommendations of the consultants and survey agencies discussed above. Where areas needing improvement have been properly identified, METO has and will continue to respond, including by implementing appropriate improvements.

Thank you for providing the opportunity to offer input regarding the July 2008 draft report.

Sincerely,

Mike Tessneer, CEO
State Operated Services

# Appendix A2

# DHS Licensing Response Letter

Minnesota Department of **Human Services**

August 8, 2008

Roberta C. Opheim
Office of the Ombudsman for
Mental Health and Developmental Disabilities
121 7th Place E., Suite 420
Metro Square Building
St. Paul, MN 55101-2117

Re: Your Correspondence Dated July 14, 2008, re: Ombudsman's July 2008 (Draft) Report Regarding the Use of Restraints in the Minnesota Extended Treatment Program

Dear Ms. Opheim,

This correspondence is in response to the referenced draft report compiled by your office. The report includes the Ombudsman's concerns regarding the use of restraints on disabled individuals at the Minnesota Department of Human Services' (DHS) Minnesota Extended Treatment Program (METO).

The description of the licensing oversight structure was not quite accurate in the report. The Minnesota Department of Health (MDH) issues a Supervised Licensing Facility (SLF) license to the entire 48 bed METO facility and also issues the Intermediate Care Facility for the Mentally Retarded (ICF/MR) federal certification for 12 of these beds. The SLF licensing standards contain the "Patient's Bill of Rights" that is enforced by MDH. The DHS Licensing Division issues a license under Minnesota Statutes, chapter 245A to the entire 48 bed METO facility, based on the licensing standards located in Minnesota Statutes, chapter 245B. The use of aversive and deprivation programs with clients is monitored by the DHS Licensing Division for compliance with the standards located in Minnesota Rules, parts 9525.2700 through 9535.2810, commonly referred to as "Rule 40." The report references "Minnesota Rules 9525, generally referred to as the 'Consolidated Rule for Persons with Developmental Disabilities.'" However, other than Rule 40, the only licensing standards in Minnesota Rules, chapter 9525, refer to day training and habilitation, and would not apply to METO.

The report refers to an interagency agreement between DHS and MDH. In an effort to reduce duplicative regulatory oversight, the Minnesota Legislature exempted SLF facilities that are certified by MDH as ICFs/MR from extensive sections of the otherwise applicable licensing standards under Minnesota Statutes, chapter 245B, enforced by DHS. DHS remains responsible for monitoring for compliance with those remaining licensing standards. (See Minnesota Statutes, section 245B.03, subdivision 2.) As it relates to investigation of maltreatment complaints under the Vulnerable Adult Act, the Minnesota Legislature assigned the investigative responsibility to the DHS Licensing Division under Minnesota Statutes, section 626.5572, subdivision 13. The Centers for Medicare and Medicaid (the

federal agency that oversees MDH certification of programs as ICF/MR) previously approved this arrangement for approximately 12 years, however, a recent change in their approval caused the need for an interagency agreement in late 2007 between MDH and DHS. Through this interagency joint powers agreement, MDH now has the duty to investigate alleged maltreatment in ICF/MR facilities.

While the Licensing Division conducted the investigation and issued the correction orders referenced in the report, the division also completed two additional investigations of the METO program involving issues related to the use of restraints also completed during the relevant time period. These investigations resulted in separate correction orders issued on September 10, 2007, and March 11, 2008.

The report recommends that the Licensing Division "consider revising its policy of limiting its investigation to only those specific items identified in a complaint." The Licensing Division does NOT have a policy of restricting its review of program compliance to only those specific issues identified in a complaint. In fact, the opening paragraph of the September 10, 2008, correction order letter states that the original complaint related to the use of mechanical restraints, and while no violations were determined related to that area, "during the course of the investigation, additional information revealed that the license holder was not in compliance" in other areas that resulted in citations and orders for correction that were not immediately related to the original complaint. This is common practice of the Licensing Division in its completion of approximately 1,600 investigations across various services per year.

To the extent that some inaccurate perceptions were established by the Ombudsman, the Licensing Division is committed to more clearly communicating the focus of its regulatory oversight.

Sincerely,

Jerry Kerber, Director
Licensing Division

# Appendix B

# Office of Health Facility Complaints

# Findings

Minnesota Department of **Human Services**

State Operated Forensic Services
Minnesota Extended Treatment Options
1425 State Street
Cambridge, MN 55008-9003

February 26, 2008

Kris Lohrke, RN, Supervisor
Office of Health Facility Complaints
Division of Compliance Monitoring
85 E. 7th Place, Suite #220
P.O. Box 64970
St. Paul, MN 55164-0970

Dear Ms. Lohrke:

Enclosed please find the revised Plan of Correction (POC) for the survey conducted at the Minnesota Extended Treatment Options (METO) program January 17, 2008. As requested, the POC has been entered onto your form. Some revisions were made after our telephone conversation with you on Monday, February 25. A copy of the document will also be sent to you by certified mail.

Please contact me at (763) 689-7160 if you need any additional information.

Sincerely,

Douglas Bratvold
METO Director

/jb

Enclosure

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24G502 | A. BUILDING _____ B. WING _____ | C 01/17/2008 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MN EXTENDED TREATMENT | 1425 STATE STREET CAMBRIDGE, MN 55008 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| W 000 | INITIAL COMMENTS<br><br>An unannounced visit was conducted on January 10 and 11, 2007, in connection with the investigation of complaint #HG502001 at Minnesota Extended Treatment Options (METO), related to the Condition of Client Behavior and Facility Practices (42 CFR 483.450), for Intermediate Care Facilities for the Mentally Retarded. The following deficiencies are issued: | W 000 | | |
| W 102 | 483.410 GOVERNING BODY AND MANAGEMENT<br><br>The facility must ensure that specific governing body and management requirements are met.<br><br>This CONDITION is not met as evidenced by: Based on the findings documented under the Condition of Participation, Client Protections, and the findings documented under the Condition of Participation, Client Behavior and Facility Practices, the Condition of Governing Body is Not Met. The findings include:<br><br>The Governing Body did not oversee the facility in a manner which would resolve systemic problems with the use of restraints for inappropriate client behaviors.<br><br>For related information: .<br><br>See W122 regarding client protection.<br><br>See W266 regarding client behavior and facility practices. | W 102 | The facility will forward a copy of final citations and the facility's accepted plan of correction to the State Operated Services Governing Board.<br>The facility will identify performance measures specific to the monitoring of the facility's use of psychotropic medications and restraint. The facility will enlist the assistance of State Operated Services Quality Management Office to identify quantitative and qualitative goals for reduction and use of psychotropic medications and restraint. Performance data will be collected, analyzed, prepared for report, and forwarded to the State Operated Services Governing Board for review on a quarterly basis.<br>Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D., L.P., METO Clinical Director | 2/26/08 |
| W 122 | 483.420 CLIENT PROTECTIONS | W 122 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Doug Bratvold | METO Director | 2/11/08 |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| W 122 | Continued From page 1<br>The facility must ensure that specific client protections requirements are met.<br><br>This CONDITION is not met as evidenced by:<br>Based on interview and documentation review the facility failed to ensure that clients were free from unnecessary chemical and physical restraints.<br><br>See documentation at tag #W128. | W 122 | With a policy change effective 11/23/07 the facility prohibited the emergency use of mechanical restraint of any client placed in the ICF/MR program. All assigned to the ICF/MR building will be trained to this change.<br>Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D., L.P., Clinical Director<br>(Continued on attached sheet) | 2/26/08 |
| W 128 | 483.420(a)(6) PROTECTION OF CLIENTS RIGHTS<br><br>The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints.<br><br>This STANDARD is not met as evidenced by:<br>Based on documentation review and interview, the facility failed to ensure that clients were free from unnecessary drugs and physical restraints for eight of nine clients (#2, #3, #4, #6, #7, #8, #9, and #10) in the sample. Findings include:<br><br>The following examples show a chronic use of restraints to control client behaviors that are prompted by staff behavior and/or are not threatening to the health of individuals. In addition, when the clients are restrained their arms are handcuffed behind their back with either metal handcuffs or soft Posey wrist restraints, and their legs are crossed and hobbled (a hobble is a nylon strap that is wrapped around a client's lower legs, tightened, and secured with Velcro) | W 128 | The facility's specially constituted committee will be oriented to changes in policy regarding both emergency and programmatic use of restraint, to ensure their review and approval process meets the revised policy's increased standard of severity of behavior for which use of restraint is indicated. Specifically, no use of restraint will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury.<br>Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D., L.P., Clinical Director<br><br>IPPs for all clients placed in the facility's ICF/MR program will be revised to ensure that each client's program plan includes a specific plan to increase the client's use of adaptive or appropriate alternatives to | 2/26/08<br><br>2/26/08 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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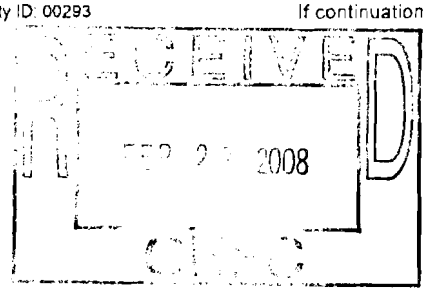
| W 128 | Continued From page 2<br>with a RIPP (brand name) restraint.<br><br>Client #2 has moderate mental retardation, autism, and deafness. A review of the facility's "Documentation For Implementation Of Approved Aversive And/Or Deprivation Procedures," revealed the following:<br>*On April 15, 2007 at 6:28 p.m., client #2 was eating and hit her elbows on a chair. She was cued to "stop," but client #2 "ignored" the request and hit the table with her elbows. The staff cued the client to "stop and go to her room." Then the client threw her plate and milk across the table and was restrained in leg hobbles and soft wrist cuffs for four minutes. The supervisory comments indicated that the use of the restraints was due to property destruction and was appropriate.<br>*On May 4, 2007 at 3:20 p.m., client #2 was in the rocking chair watching a movie and then hit her right forearm on the wall and also hit the wall with a closed fist, bit her "pointer finger," and kicked an end table with her right foot. Then she laid down on the floor and signed "finished". The client was put in leg hobbles and soft cuffs for four minutes. The form indicates that no other interventions were available. The supervisory comments indicated that use of the restraints was appropriate.<br>*On May 5, 2007 at 12:55 p.m., client #2 "awoke obsessing about shopping. Staff told her no shopping." At lunch client #2 requested more food and was told she would not get any more food. The staff explained that she would not be able to go shopping because of "behaviors" on May 4, 2007. Client #2 "cleared table and threw all dishes toward staff." The client was then restrained in accordance with her Rule 40 plan (the facility's specially constituted committees' pre-approved restrictive behavior management | W 128 | behaviors targeted for reduction.<br><br>All staff responsible for implementation of programs for clients placed in the facility's ICF/MR program will be trained to properly implement each client's program.<br>Persons Responsible: Scott TenNapel, Ph.D., L.P., METO Clinical Director; Beth Klute and Julie Patten, BA3s and QMRPs | |





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| W 128 | Continued From page 3 | W 128 | | |

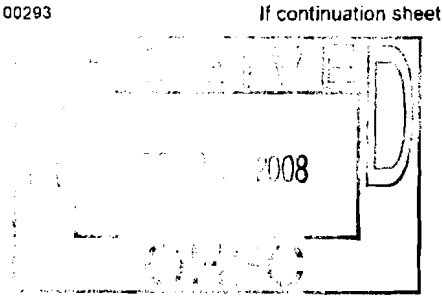
practice). Her legs were crossed, then hobbled, and her wrists were restrained behind her back in soft Posey cuffs for four minutes. The supervisory comments indicated that the use of the restraints was in accordance with her program and were appropriate.

*On May 17, 2007 at 5:28 p.m., client #2 "was rocking in her chair when she slapped the wall, hit her leg." Then the client laid down on the floor and kicked the nearest staff. She was cued to stop and calm down, "she refused" and was restrained in soft cuffs and hobbles for six minutes. Supervisor comments indicated that the use of the restraints was appropriate.

*On June 25, 2007 at 12:27 a.m., client #2 was "perseverating" on a home visit that was scheduled and wanted medication set up. Staff signed for client #2 to go to bed and that "work" would be finished the next day. Client #2 informed staff that she wanted to be tucked into bed. The "client went into her room [and] began hitting dresser and walls with hands with enough force to possibly hurt hands.(Also threw dresser into middle of room; but, stopped on own w/o redirect.)" Client #2 laid down on the floor per the staff's request and was put in restraints. Her wrists were put in soft cuffs and her legs were hobbled for four minutes. The supervisory comments indicated that the use of the restraints was appropriate.

*On July 10, 2007 at 4:13 p.m., client #2 was sitting at a table eating her snack when she "knocked" a glass of water and "shoved" a box of crafts off the table. Client #2 was told to "stop" and "lie down" and was restrained for ten minutes. During the time she was restrained she, "did minor SIB" (self injurious behavior), slapping her sides for six minutes. The client was released after being calm for four minutes. The supervisory





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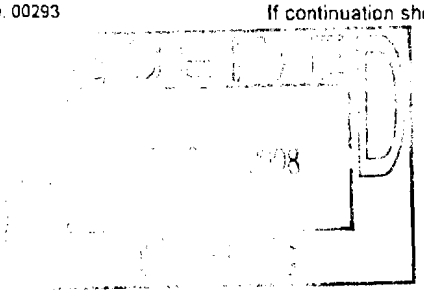
| W 128 | Continued From page 4 | W 128 | | |

comments indicated that the use of the restraints was appropriate.
*On July 25, 2007, at 2:34 p.m., client #2 was sitting at her work table hitting her hand on the corner of the table and banging her knee on the floor, biting her lips and hand "hard". Staff signed for her to stop. She was restrained for twelve minutes. No documentation of restraining device utilized other than hobble. The supervisor indicated the use of the restraint was appropriate.
Client #2 was again restrained at 2:49 p.m., for six minutes because she punched the floor and was "kicking at staff." Supervisory comments indicated that her behavior continued after release from restraints, the restraint procedure was again implemented and the use of the restraint was appropriate. At 2:58 p.m., after release from her Rule 40 restraints, staff attempted to escort her back to her household, when she started, "minor" self injurious behavior. Staff redirected her to stop. She began kicking staff and was restrained for six minutes. After being calm for two minutes she was given Imitrex for a headache and escorted back to the household. Supervisory comments indicated the use of restraints was appropriate.
*On July 29, 2007 at 4:11 p.m., client #2 was painting at the table and showed no signs of being upset. Then she "cleared everything off the table." She was put in Posey wrist restraint and hobbles for five minutes. No other interventions were implemented. Supervisory comments indicated the use of the restraint was appropriate and warranted given the target behaviors exhibited.
*On August 21, 2007 at 5:28 p.m., client #2, while at the table, shoved everything on the table, across the table. She was restrained for eight minutes with Posey wrist restraints and leg





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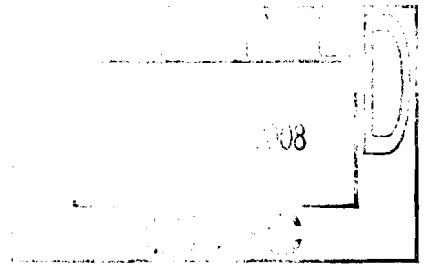
| W 128 | Continued From page 5 | W 128 | | |

hobbles, in accordance with her Rule 40 plan. During the time she was restrained, she kicked her feet and pinched her thighs for four minutes. After being calm for four minutes she was released. Supervisory comments indicated the use of the restraint per her Rule 40 was appropriate. No other interventions were implemented prior to the restraint.

Client #3 has mild mental retardation, osteoarthritis, limited range of motion in his left leg, a history of knee pain, and prefers to use a wheelchair. A review of the facility's "Documentation for Emergency Use of Controlled Procedure" revealed the following:
*On March 29, 2007 at 6:59 p.m., client #3 was watching the television. Staff asked that he watch an "age appropriate" program. Client #3 was not following directions and yelled at staff. The staff cued the client to stop and maintain boundaries and was escorted to his bedroom. Client #3 hit and shoved staff. An "arm bar takedown" (a manual method utilized by two staff, who apply pressure to the client's elbows, with the goal of lowering the client to the ground in a prone position-lying on their stomach) was performed on the client. Then he was manually and mechanically restrained for 21 minutes (the specific type of mechanical restraint was not identified).
*On May 10, 2007 at 4:14 p.m., client #3 was "yelling and screaming at staff, swearing, and attempting to hit staff." The client was asked "to go to his room and calm down, he refused. We then attempted to escort him. He hit staff." Client #3 was manually restrained and then mechanically restrained with leg hobbles and wrist cuffs for 12 minutes. Client #3's response section of the form indicated the client told staff,





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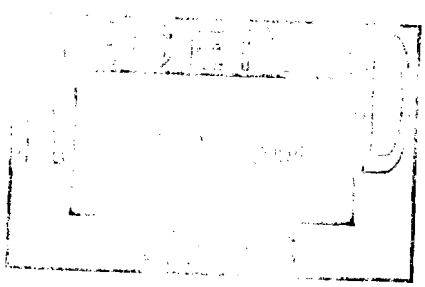
"Sorry, he deserved the implementation."
*On June 20, 2007 at 6:20 p.m. client #3 refused to stay away from a peer that was sitting on the floor. Client #3 "kicked at peer's feet." The client would not stop kicking at the peer, and it was "possible" that he "may have grazed peers feet." Client #3 was asked to stop and lie down on the floor. Client #3 was then manually restrained for two minutes.
*On June 23, 2007 at 5:43 p.m., client #3 was "swearing, refusing directions...invading peers/staffs space [with] wheelchair." The client then "slapped" a staff's forearm with an open hand. He was then restrained with leg hobbles and wrist cuffs for 22 minutes.
*On August 5, 2007 at 3:55 p.m., client #3 "was stopped in wheelchair in front of office, and would not redirect to move." The "other alternatives tried and/or considered:" included, cueing the client "several times to move" and "escort by pushing wheelchair." Client #3 was restrained in hand cuffs and leg hobbles for 23 minutes, after he "struck staff with fist." The documentation did not indicate when the client struck staff. However, the documentation did indicate that it was likely for the client's physical aggression to reoccur. At 6:00 p.m., "[client #3] was asked 3 times to move out of view of TV in dayroom. The 4th time he refused, he was being escorted to his room...As he was being escorted to room [client #3] hit staff." The client was manually restrained for two minutes then restrained with wrist cuffs and leg hobbles for 43 minutes.
*On September 6, 2007 at 5:48 p.m., client #3 was in the day room. He was asked to elevate his feet and he refused. Then he hit a peer in the stomach with the "outside of his wrist." He was told to stop. The staff did an "arm bar takedown" and manually restrained the client for one minute.





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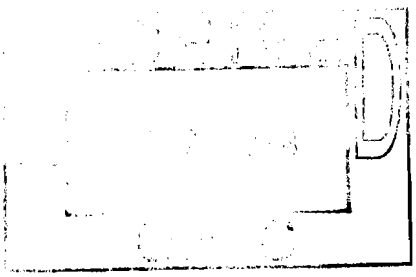
The client told the staff that the other client had previously kicked him. After the client was released from the manual restraints he was told to use personal boundaries, anger management skills and to talk to staff if he feels unsafe.
*On September 26, 2007 at 8:22 p.m., client #3 was watching the television and a staff person asked the client if he wanted to do one of his programs. Client #3 turned away from the staff and turned the television up. The staff person then attempted to turn the television off and client #3 "slapped" the staff person's hand and stated "F-ck You" and asked the staff person to leave him alone. The staff person then attempted to un-plug the television and put his/her hand behind the dresser to pull the plug and client #3 slammed the dresser against the wall. The client was manually restrained for two minutes then put in leg hobbles and his wrists were cuffed. The client was "agitated" for 18 minutes and released from restraints after 28 minutes. The documentation indicates that the behavior the restraints were utilized for, is "likely to reoccur." The client's response was the incident was "staffs fault."

Client #4 has mild mental retardation, asthma, epilepsy, and a history of poking others and throwing personal items at others' heads. A review of the facility's "Documentation for Emergency Use of Controlled Procedure" revealed the following:
*On May 24, 2007 at 8:43 p.m., client #4 was manually and mechanically restrained for 50 minutes. Prior to being restrained the client "appeared agitated and had been touching staff for over an hour." The client was cued to go to her room or take a shower or bath. The staff "attempted to talk w/ [client #4] about what was bothering her."





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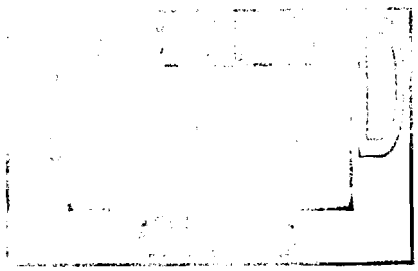
*On May 30, 2007 at 6:26 p.m., the client was in her room "hitting the door." Then she came out of the room and "tried to shove staff to get into the kitchen." An arm bar takedown was implemented to take the client to the floor. The client was manually then mechanically restrained for a total of 50 minutes (the specific mechanical restraints are not documented). The documentation indicates "Other Alternative tried and/or considered" included. the staff told the client to sit down and relax or to take a bath or shower.

Client #6 has severe mental retardation and a history of behavioral deterioration since November 2006. He was admitted to the facility in May 2007. A review of the facility's "Documentation for Emergency Use of Controlled Procedure" and "Documentation for Emergency Use or Emergency Initiation of Psychotropic Medication" revealed the following:
*Upon arrival to the facility on the day of admission, May 7, 2007, client #6 was attempting to bite and kick staff. An emergency mechanical restraint was implemented. The client "continued to struggle and attempt physical aggression." The client was in restraints for 30 minutes. In addition to the mechanical restraint, client #6 was given 10 milligrams of Haldol, 2 milligrams of Ativan and 50 milligrams of Benadryl, intramuscularly (IM), at 10:25 a.m. At 11:30 a.m. the client "was asleep." Documentation indicated that the client was "scared" and he did not know staff. At 6:20 p.m., client #6 was in the bathroom washing his hands. A staff person cued him to dry his hands with a washcloth. The client stuffed the washcloth in his mouth. The staff person pulled the washcloth out of the client's mouth. The client struck the staff person three times with an open hand. The staff implemented a "basic come along take down to





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prone position, handcuffs, and leg hobble." The client was in restraints for 50 minutes. At 8:50 p.m., client #6 attempted to enter the staff office. Documentation indicates he "was struggling during escort." The client kicked and punched staff. A double arm bar takedown was used and both emergency manual and mechanical restraint were implemented in response to physical aggression. The client was in restraints for 50 minutes.

*At 5:26 a.m., on May 8, 2007, client #6 "slapped staff open handedly on forearm, pinched staff" after being re-directed to his room and being asked to wash his hands. An arm bar take down was used and the client was put in mechanical restraints for 28 minutes. At 10:20 a.m., client #6 "came out of his room to go to the bathroom...attempting to hit staff and did kick a staff...Staff tried to verbal prompt [client #6] to stop." Client #6 was put in leg hobbles and handcuffs for 50 minutes. During restraint he yelled and was banging his head on the floor.

*At 12:55 p.m. on May 9, 2007, client #6 hit a staff person one time. The client was put in a manual hold by 4 staff and then in metal cuffs and leg hobbles. He was restrained for 50 minutes.

*At 3:15 a.m. on May 10, 2007, client #6 was trying to swing at staff person's face with a closed fist. The staff person used an arm bar take down to restrain the client. Documentation indicated that at 3:20 a.m. the hobble was removed. The client was agitated and kicking, and the hobble was re-applied. At 3:35 a.m. client #6 was struggling, trying to get cuffs off causing abrasions to his wrists. The cuffs were removed and the client was put in a manual hold. The client was restrained until 4:00 a.m. when he was released due to labored breathing.

*At 11:12 a.m., client #6 was "repeatedly touching

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staff, not following staff direction, and unresponsive." The client was put in a manual restraint for 15 minutes. At 2:02 p.m., client #6 was "pacing, grabbing at staff, walking in office and peers room". He was put in a manual restraint for 9 minutes. At 2:15 p.m., client #6 was given 10 milligrams of Zyprexa IM. At 5:45 p.m., client #6 "hit staff with handslaps." A double arm bar takedown was implemented and client #6 was put in handcuffs and hobbles for 30 minutes.
*At 11:17 p.m. and 11:28 p.m., on May 21, 2007, client #6 was hitting staff and the client was manually restrained each time for 2 minutes. At 12:30 p.m., client #6 tried to pinch and grab staff. He was put in a Posey restraint with leg hobbles for 45 minutes. At 1:20 p.m., client #6 was given 2 milligrams of Ativan IM.
*Documentation on June 2, 2007, indicated that client #6 was restrained at least seven times. At 2:40 p.m., client #6 was given 100 milligrams of Seroquel. Client #6 had "four Rule 40 implementations today for physical aggression (no specific behaviors identified) and PICA" (eating inedible objects). A note written as follow-up by a nurse indicated client #6's Rule 40 was re-implemented at 4:17 p.m. and the Seroquel was minimally effective. At 7:15 p.m., client #6 was given 2 milligrams of Ativan and 50 milligrams of Benadryl IM. The "precipitating behavior" indicated was "three more Rule 40's for agitation/aggression, each lasting nearly 50 minutes."
*Client #6 was put in mechanical restraints on June 5, 2007 at 10:09 for "physical aggression; grabbing, pinching, headbutting; PICA &SIB (fingers in mouth, biting), not calming, continues to aggress when releases attempted." The client received Ativan 2 milligrams at 10:45 a.m.
*Documentation for June 12, 2007 indicates that

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client #6 was "given the Ativan (2 milligrams at 2:45 p.m.) immediately after release of restraint while in his room." The precipitating behavior indicated was "aggression toward staff, refusal to redirect with verbal cues." (No specific behaviors were identified on the form.)
*Documentation regarding client #6 for June 18, 2007 indicates that "Rule 40 implemented 5x this afternoon for aggression/agitation-each one longer in length of time held." At 5:05 p.m. client #6 was given 2 milligrams of Ativan and 50 milligrams of Benadryl IM. A follow-up note written at 8:00 p.m. indicates that one Rule 40 was implemented "shortly after medication given."
*Documentation indicates that on January 8, 2008, at 1:08 p.m., client #6 "woke up from nap, took a shower, started aggression before getting dressed." Client #6 was asked to calm down and keep his hands to himself. He was escorted back to his room. Client #6 "attempted to kick/scratch/slap at staff multiple times." A mechanical restraint was implemented. The actual outcome indicates client #6, "did not meet release criteria, attempted release at 50 minutes, continued to aggress." At 1:58 p.m , on January 8, 2008, documentation indicated that client #6 was "in Rule 40 hold, reimplemented Rule 40 after 50 minutes." He was released at 2:48 p.m. Client #6 was mechanically restrained for a total of one hour and forty minutes.

Client #7 has mild mental retardation. A review of the facility's "Documentation for Emergency Use of Controlled Procedure" revealed the following:
*On December 12, 2007 at 7:00 p.m., client #7 "had been upset since supper, ignoring staff requests." Staff asked her to go to "home 3" so they could escort other clients. The client "refused shouting when staff stood beside her chair then

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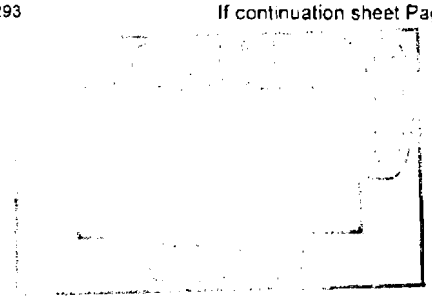
kicked tried to hit." The staff had tried to "negotiate" with the client for an hour, offered her quiet time in her room and time to talk. An arm bar takedown was implemented and the client was restrained manually for 20 minutes. The client's mood after the restraint was documented as "feeling depressed" and crying. A review by the QMRP (Qualified Mental Retardation Professional), indicated that a "Rule 40 program will be implemented, likely to reoccur."
*A review of the facility's "Documentation For Implementation Of Approved Aversive And/Or Deprivation Procedures, " revealed the following:
*On December 21, 2007 at 9:10 p.m., client #7 was "arguing w/ staff about her recovery[programing], when told she had to restart she started screaming at staff [and] kicked the wall very hard." The client was put in manual then mechanical restraints, leg hobbles and wrist cuffs, for 28 minutes due to property destruction, "kicking the wall." The client "screamed and cried" for 18 minutes before she was calm. The supervisory comments indicated that the implementation of the restraints was in accordance with client #7's program.
*On December 24, 2007 at 8:28 a.m., staff entered client #7's room to wake her for work. The client "screamed 'leave me alone' and swung [at and] kicked [at] staff." The client was cued to "stop" and then she was restrained in wrist cuffs and leg hobbles for 18 minutes. For the first eight minutes client #7 cried and struggled. The supervisory comments indicated that the use of the restraints was appropriate.

Client #8 has moderate mental retardation, autism, a brain stem tumor, and seizure disorder. A review of the facility's "Documentation For Implementation Of Approved Aversive And/Or





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Deprivation Procedures," revealed the following:
*On September 9, 2007 at 7:20 p.m., client #8, "ran to bathroom and threw his socks in the shower, then ran to his bedroom and slammed his door." Staff cued the client to "walk and not throw objects or slam doors because that is property destruction." As a result the client ran out of his bedroom and into another "unoccupied" bedroom and slammed that door. The client was handcuffed and his legs were hobbled for a total of 10 minutes. The supervisory comments indicated that the use of the Rule 40 restraints was appropriate because one of the target behaviors is slamming doors.
*On September 27, 2007 at 4:56 p.m., client #8 "ran through the house with pitcher of water. He refused to let staff have pitcher, and once he did, he ritually pounded on walls with both fist." Staff cued the client to "stop and put pitcher down and not to run... also cued not to hit walls." Client #8 "slapped at staff's hands when they asked for the pitcher. He ran into bathroom and slammed door." The client was restrained in hand cuffs and leg hobbles for 39 minutes. For the first 29 minutes the client "struggled, scratched, kicked, yelled, and tried to get up."
*On September 30, 2007 at 7:50 p.m., client #8 "ran up to the wall, pounded on it, banged his head on the floor and ran to his room and slammed the door." Staff re-directed the client. "stop [and] not pound or slam the door." The client's Rule 40 was implemented and he was hand cuffed and his legs were hobbled. He was restrained for 15 minutes and during his restraint he struggled, spit, tried to bite, kick, and scratch the staff for five minutes.
*On October 5, 2007 at 9:46 a.m., client #8 was in the shower for approximately 20 minutes and was refusing to get out. He slammed the door on staff



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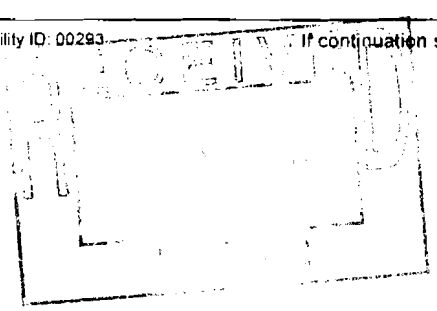
and was then put in leg hobbles and hand cuffs for 10 minutes for property destruction. The supervisory comments indicated that the use of the restraints was appropriate.
* On October 11, 2007 at 2.57 p.m., client #8 refused to attend his mental health review and was rocking in a chair when he "suddenly jumped up and ran towards" the bedroom and bathroom. The client "banged" on the door and the walls of the phone room, and linen closet, and slammed the bathroom door, and he"dropped" the phone against the wall of the phone room. The client, "was calm instantly when staff asked him to lay on the ground." He was then hand cuffed and leg hobbles were applied. He was restrained for 10 minutes. The supervisory comments indicated that the use of the restraints was appropriate.
*On October 14, 2007 at 8:24 a.m., client #8 was restrained in wrist cuffs and leg hobbles for 10 minutes for "property destruction and physical aggression." The documentation indicates that staff gave him a verbal prompt not to slam the door. The documentation does not indicate the specific behavior that required the implementation of restraints. However, the documentation does indicate that the client laid on the floor per staff request prior to the restraint implementation. The supervisory comments indicate that the use of the restraint was appropriate.

Client #9 has mild mental retardation, autism, and a brain lesion. A review of the facility's "Documentation For Implementation Of Approved Aversive And/Or Deprivation Procedures," revealed the following:
*On October 25, 2007 at 2:25 p.m. client #9 became "agitated" when he was returning to his "home 3." The client kicked a car and bit himself (specific location not identified). He was prompted





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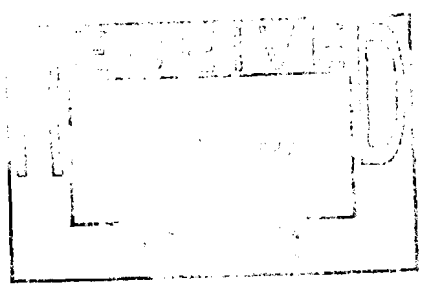
to "stop [and] calm" He hit staff and was restrained first manually then mechanically for a total of 46 minutes. The documentation does not indicate if he was restrained outside or back at home 3. The supervisory comments indicate that the use of the restraint was appropriate.
*On November 11, 2007 at 6:43 a.m client #9 was in taking a shower and "pounding" on the walls, toilet and his own head. Staff utilized negotiations to stop (the specific negotiations not documented). He was restrained with leg hobbles and hand cuffs for 10 minutes. The supervisory comments indicate that the use of the restraints was appropriate.
*On December 11, 2007 at 7:05 a.m., after client #9 took two bowls of cereal, he was cued to take only one bowl. The client slammed the table with his hands. Then he hit himself in the head three times. He was restrained with leg hobbles and hand cuffs for 37 minutes. The supervisory comments indicated that the use of the restraints was appropriate.
*On August 5, 2007 at 8:12 a.m., client #9, "was watching T.V. and laughing inappropriate." The client bit, slapped, and hit himself. "with strong force." Staff interventions included: "asked him what was wrong, why are you hitting yourself, [and] calm down." Staff cued client #9 to lie down. The client complied and was manually restrained, then put in leg hobbles and wrist cuffs for a total of 17 minutes. He was "agitated" for seven minutes. After ten minutes of being calm he was released from the restraints. The evaluation of the restraint implementation indicated that the use was appropriate and that "with great likelihood this behavior will reoccur." The client's response to the incident was, "I'm sorry - don't bite." In addition, client #9 only had red marks on his arms from the self inflicted biting. At 11:35 a.m. client





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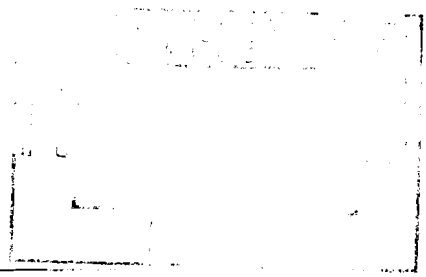
#9 was again laughing inappropriately while watching television. At some point, the client became self injurious (specifics not documented). Staff "attempted to negotiate" and the client "aggressed towards staff." The client was cued to calm down and to keep his boundaries. The staff "waited for extra staff before takedown." The client was manually restrained and placed in wrist cuffs and leg hobbles for a total of 50 minutes. The client was noted to be crying and trying to relax, but, "he was being held" in a prone position and the client "attempted to grab staff [and] get up." The leg hobbles and wrist cuffs were reapplied at 12:25 p.m. for an additional ten minutes. The documentation indicates that the plan was to, "encourage client to rest in room, listen to music, take deep breaths."

*On August 24, 2007 at 6:21 p.m., a peer removed the foot stool from under client #9's feet. Client #9 started to slap himself, clap, and bite his forearm. Staff interventions included: asking the client to lie down and not put his hand by his mouth and listening to music. The documentation does not indicate if the client followed the staff directives. A double arm bar takedown was used and then the resident was put in handcuffs and leg hobbles for 50 minutes. The documentation indicates that the client was restrained because of "self injurious behavior/physical aggression." An attempt was made to release the client from restraints and he "kicked [at] staff" and at 7:11 p.m. his restraints were continued for another 21 minutes. At 7:20 p.m. client #9 received 2 mg of Ativan IM.

*On September 28, 2007 at 12:55 p.m. client #9 received Ativan because he was "agitated [and] aggressive." At 2:36 p.m., client #9 was "pinching his cheeks and putting hands toward mouth." Staff attempted "verbal prompts," and the client





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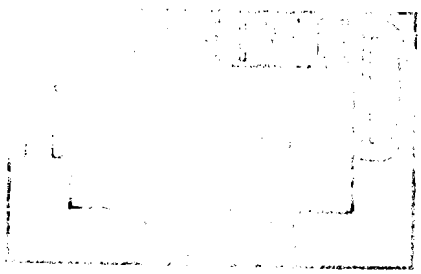
was "escorted to room by staff but [the client] kept grabbing at staff." The client was restrained for 12 minutes, manually then mechanically with handcuffs and leg hobbles because he was physically aggressive and hit staff.

Client #10 has moderate mental retardation and infantile autism, he has a history of biting people, making himself throw-up, and becoming increasingly agitated when others attempt to interact with him. Client #10 was discharged from the facility on November 7, 2007. A review of the facility's "Documentation For Implementation Of Approved Aversive And/Or Deprivation Procedures," revealed the following:
*On February 28, 2007 at 8:03 p.m., client #10 was restrained for ten minutes in handcuffs and hobbles because he bit his hand.
*On March 6, 2007 at 7:59 p.m., client #10, "was given a snack. He began spitting on kitchen table. Staff cued the client to stop spitting and to go to his room and calm down. While in his room he began vomiting on his floor and urinated. He was also laughing for no reason." He spit and vomited on staff and was restrained for 14 minutes in handcuffs and hobbles.
*On March 9, 2007 at 10:09 a.m., client #10 was restrained for six minutes in leg hobbles and handcuffs because he "bit self." At 12:38 p.m., client #10 was exhibiting "excessive laughing" and he spit water. He was "encouraged to calm [and] resume work x 3." He was restrained for 14 minutes in handcuffs and leg hobbles for "spitting/emesis directed at staff." At 6:25 p.m., client #10 spit in a staff person's face. He was cued to lay down and he complied and was restrained for six minutes.
*On March 13, 2007 at 1:17 p.m., client #10 was restrained in handcuffs and hobbles for ten





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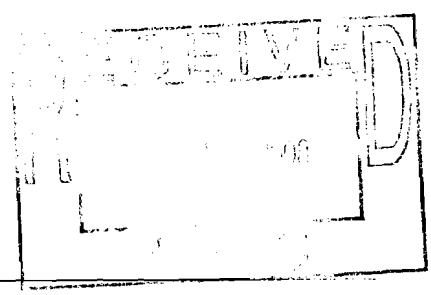
minutes because he bit the back of his left hand and made it bleed. The documentation indicates that other interventions were "NA" (not applicable).
*On March 17, 2007 at 4:41 p.m. client #10 was restrained in hand cuffs and hobbles for six minutes for biting his hand. The documentation indicates that there was "no time" for any other interventions.
*On March 18, 2007 at 1:58 p.m., client #10 was restrained for six minutes in leg hobbles and hand cuffs because he bit the back of his left hand after being directed to calm down. The documentation indicates that the client laid down on the floor on his own, and was restrained.
*On March 19, 2007 at 5:02 p.m. client #10 was in his room "self stimulating." Staff told the client to "relax and calm." The client bit his left hand through his shirt. He was told to lay down on the floor and he complied. He was "calm" but restrained for six minutes in handcuffs and leg hobbles.
*On March 20, 2007 at 12:00 p.m., client #10 was restrained after he had an emesis and spit it at staff and then was restrained for fourteen minutes in handcuffs and leg hobbles.
*On March 20, 2007 at 7:14 p.m., client #10 was restrained in leg hobbles and handcuffs for six minutes for biting his hand after staff told him not to bite himself.
*On March 20, 2007 at 9:14 p.m., client #10 bit a "pre-existing wound" on his hand and he was restrained for six minutes in leg hobbles and handcuffs. Documentation indicated that there were no other interventions available prior to the utilization of the restraints.
*On March 27, 2007 at 4:55 p.m., client #10 was asking repetitive questions and was asked to "relax" in his room. The client bit himself on the





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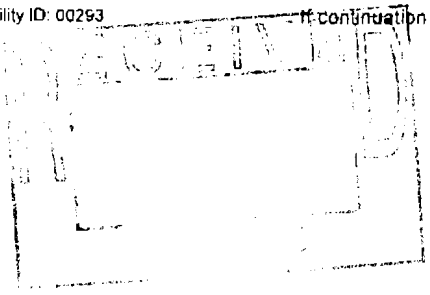
| W 128 | Continued From page 19 | W 128 | | |

hand and he was restrained for 12 minutes in handcuffs and leg hobbles.
*On April 3, 2007 at 9:28 p.m., client #10 was making "loud vocalization for 10 - 15 minutes." He was told to "quiet, take breaths, [and] go to sleep." The client bit the back of his hand and slapped his leg three times. The client was restrained for six minutes in leg hobbles and hand cuffs.
*On April 4, 2007 at 10:18 a.m., client #10 was at his day program and he was "wiggling hands in front of face making noises." The client was instructed to continue his work, "or to sit on his hands to calm." The client bit his hand through his shirt. He was mechanically restrained with handcuffs and leg hobbles for six minutes.
*On April 5, 2007 at 7:45 p.m., client #10 was "self stimulating in room, making loud noises, sounded like AHAHAH..." The client was cued to "quiet down," and "relax." The client bit an "old sore" on the back of his left hand. The client laid down on the floor after being cued by staff to do so. The client was manually restrained then mechanically restrained with leg hobbles and handcuffs for six minutes.
*On April 6, 2007 at 11:35 a.m., client #10, "was shredding [paper] and starting finger flaling by his mouth then put hand in shirt and bit his hand...Staff told [client #10] to stop and lie on the floor...He bit himself through his sweatshirt." The client was manually then mechanically restrained with leg hobbles and handcuffs for 7 minutes. The supervisory comments indicated that the use of the restraints was appropriate.
*On April 6, 2007 at 4:23 p.m., client #10, "was acting very manic. He was laughing about nothing and spitting all over his room." Staff cued him to "relax" and "take deep breaths." The client spit in the staff's face. The client was manually then





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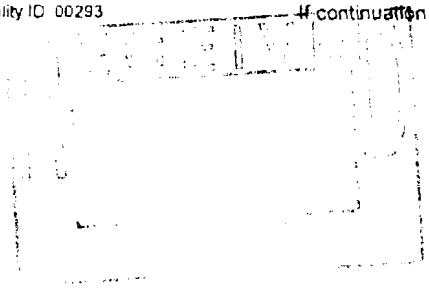
| W 128 | Continued From page 20 | W 128 | | |

mechanically restrained in leg hobbles and hand cuffs for 25 minutes. The supervisory comments indicated that the use of the restraints was per his program and appropriate.
*On April 8, 2007 at 3:48 p.m., client #10 bit his hand. Staff told the client to "stop." He bit his hand through a blanket that was covering his hand. At some point, the client hit himself twice (specific area of the body was not documented). The client was restrained in leg hobbles and handcuffs per his Rule 40 for 18 minutes. The supervisory comments indicated that the use of the restraints was appropriate.
*On April 11, 2007 at 8:42 p.m. client #10 "was jumping around his bedroom forcing himself to vomit [and] spit. He was also laughing hysterically." Staff told the client to "calm, encouraging deep breaths and relaxing in his bedroom." The client "forced himself to vomit and spit it at staff." The client was restrained for 20 minutes in leg hobbles and hand cuffs. The supervisory comments indicate that the use of the restraint was per his program and was appropriate.

Employee (A)/administrative staff was interviewed on January 10, 2008 at 9:30 a.m. and stated that all the clients at the facility are legally committed and exhibit either property destruction or physical aggression, and may have some degree of self injurious behavior. The average stay is based on how quickly the facility is able to stabilize a client's inappropriate behavior. Approximately one and a half to two years ago, the facility implemented the use of mechanical restraints for inappropriate behavior. In November 2007, the use of mechanical restraints for emergency situations was discontinued in the ICF/MR. However, the use of mechanical restraints continues to be





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| W 128 | Continued From page 21<br>utilized on the clients with Rule 40 (the facility's specially constituted committees' pre-approved restrictive behavior management practice) programs. In emergency situations, the staff use manual restraints only. Examples of the restraints utilized for the Rule 40 programs include: soft wrist cuffs, metal handcuffs and leg hobbles (usually used together), and in some cases a restraint board. The Rule 40 programs start with two minutes of manual restraining and if the client(s) continues to struggle, they are put in mechanical restraints.<br><br>Employee (E)/administrative staff was interviewed on January 31, 2008 at 9:30 a.m. and stated that the clients admitted at the facility should only be restrained to reduce target behaviors that are dangerous or likely to lead to dangerous behavior.<br><br>When two specific examples of client #3 being restrained, related to television viewing, were mentioned by the investigator, employee (E) stated that from the sounds of the examples reviewed, the risk analysis (risk of continuing the activity versus the risks of restraining) is "all out of whack."<br><br>The facility as a whole does not have a "no-touch" policy. There should be "household agreements," reviewed and open for negotiation, made by the people who live in a household. The "no-touch" policy is intended to be a therapeutic support for people who are aggressor's, the recipient of another's aggression, or there are other problems with interpersonal boundaries. If a client failed to observe the practice of "no-touch" and simply touched another client, that would not constitute a dangerous situation. | W 128 | | |
| W 239 | 483.440(c)(5)(vi) INDIVIDUAL PROGRAM PLAN | W 239 | | |

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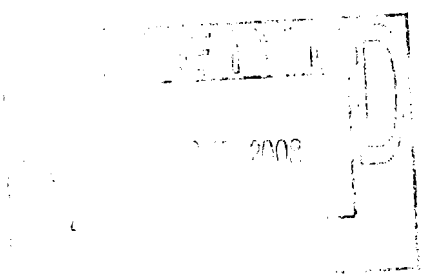
| W 239 | Continued From page 22<br><br>Each written training program designed to implement the objectives in the individual program plan must specify provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.<br><br>This STANDARD is not met as evidenced by:<br>Based on documentation review and interviews, the facility failed to develop functional replacement behaviors related to the target behaviors for three of nine clients (#6, #8, #9) in the sample. Findings include:<br><br>Client #6 has severe mental retardation and has a history of behavioral deterioration since November 2006. He was admitted to the facility in May 2007. His specific behaviors include biting, pinching, scratching, head-butting, hair pulling, and kicking. Client #6's Rule 40 (the facility's specially constituted committees' pre-approved restrictive behavior management practice) methodology states that if client #6 exhibits signs of agitation (reaching out or touching staff, not responding to verbal redirectives, pacing, perseverating, yelling, or screaming), the staff will provide the client a cue to stop the behavior. If the client does not "immediately" stop, staff will escort the client to his bedroom or a private place. If client #6 continues to engage in the behavior, staff will manually restrain his arms until they can secure Posey (brand name) soft cuffs to his wrists, which are attached to a RIPP (brand name) belt that is secured around his waist. A Rule 40 addendum indicates the restraints will be terminated when the client has zero incidents of | W 239 | IPPs for all clients placed in the facility's ICF/MR program will be revised to ensure that each client's program plan includes a specific plan to increase the client's use of adaptive or appropriate alternatives to behaviors targeted for reduction.<br><br>All staff responsible for implementation of programs for clients placed in the facility's ICF/MR program will be trained to properly implement each client's program.<br>Persons Responsible:<br>Scott TenNapel, Ph.D., L.P., METO Clinical Director; Beth Klute and Julie Patten, BA3s and QMRPs<br><br>  <br><br>2/26/08 | 2/26/08 |

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physical aggression, self injury, and PICA (eating inedible objects) over three consecutive months. Other than providing a cue to stop the behavior, there is no mention of interventions to modify or prevent the client's behaviors. There is no indication of the development of a list of antecedent behaviors to assist staff in knowing when the client might exhibit behaviors. From the day he arrived to present, client #6 continues to exhibit behaviors and he continues to be restrained for exhibiting these behaviors. The focus on the plan was to stop the "maladaptive behavior" with no indication of how staff would elicit or strengthen appropriate behaviors.

Client #8's medical record was reviewed and indicated that he has moderate mental retardation, autism, and a brain stem tumor. The client has a history of physical aggression, self-injurious behaviors, and property destruction. " Client #8's target behaviors include: "actual or attempted behavior that may cause pain or harm to other(s), including: lunging at others, biting, hitting, scratching, kicking, slapping, pushing others, throwing items at people, and spitting;" manipulating an object in a manner that causes significant damage to that object based upon its construction and or function, and/or poses risk to others if thrown or used as a weapon; including slamming doors and acts against self, regardless of intent, that may cause significant injury (i.e. slapping, hitting, scratching, biting self, pounding body parts on hard surfaces or head banging.)." The client's signs of agitation include: "running, checking doors, ignoring staff directions, and loud vocalizations." Client #8's behavior plan indicates that the client's alternative to agitation is to "take a break" with verbal cueing 80% of the time for two consecutive months. In addition, the client has a

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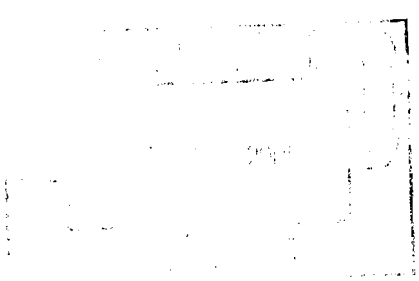
Rule 40 plan revised on August 22, 2007, with a duration of one year. The objective is to decrease the client's utilization of physical aggression, property destruction, and self-injurious behaviors to zero for three consecutive months. If the client exhibits any of the above target behaviors staff are to cue the client to stop the behavior and lie down on the floor. If the client does not lie down on the floor, the staff are to manually restrain the client in a prone position (on his stomach) and apply handcuffs to his wrists and hobbles around his legs. If the client lies down on the floor independently the handcuffs and leg hobbles will still be applied. Once the client is "safe" he will be turned onto his side. He needs to be calm for five minutes and then the leg hobbles will be released. After another five minutes of calm the handcuffs will be removed. The focus on the plan was to stop the "maladaptive behavior" with no indication of how staff would elicit or strengthen appropriate behaviors.

Client #9's medical record was reviewed and his diagnoses included mild mental retardation and autism. He has a history physical aggression, self injurious behaviors, and property destruction when he gets frustrated or angry, exhibiting "running, self injurious behaviors, ignoring staff directions, and loud vocalizations." His target behaviors include physical aggression-"Actual or attempts to hurt and/or cause pain or harm to other(s). Includes: hitting, biting, scratching, kicking, slapping, pushing others, throwing items at people, and spitting at others;" self-injurious behaviors - "acts against self that are intended to cause injury (i.e. slapping, hitting, scratching, biting self, pounding body parts on hard surfaces or head banging.)." Client #9's program plan indicates that when he exhibits symptoms of



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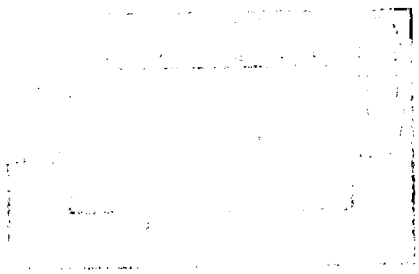
"agitation" his alternative to the agitation will be to take "a break." In addition, the client has a Rule 40 that was last updated on September 13, 2007 with a duration of one year. The objective was to decrease his "maladaptive behaviors" to zero for three consecutive months. The plan included cueing the client to "stop" and if the client stopped the behavior he then would be directed to go to a quiet setting and staff would offer calming techniques. The specific calming techniques were not delineated. If the client did not stop the behavior he again would be cued to "'stop' and lie down on the floor." If the client did not comply he would be manually restrained in a prone position and then mechanically restrained with handcuffs and leg hobbles, and turned to his side when he was "safe." After he was calm for five minutes his leg hobbles would be released and after another five minutes of being calm his handcuffs would be released. If the client followed directions when asked to lie down on the floor the procedure would continue with mechanically restraining him with the handcuffs and hobbles. The focus on the plan was to stop the "maladaptive behavior" with no indication of how staff would elicit or strengthen appropriate behaviors.

Employee (C)/human services support specialist (HSSS) was interviewed on January 10, 2008 at 12:30 p.m., and stated that she is able to visibly tell when client #9 is unable to control himself as he will start repetitive behaviors, and she thinks that the client acts out because he wants to be held, however this is a hands free (clients must not come within one arms length of each other and clients must not come within one arms length of staff) facility unless the clients need physical help.



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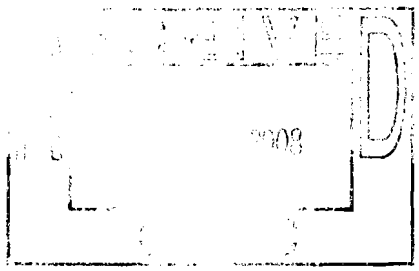
| W 239 | Continued From page 26<br>Employee (B)/behavior analyst I was interviewed on January 11, 2008 at 8:10 p m. and stated that when a client exhibits an inappropriate behavior that could lead to injury such as physical aggression or self injurious behaviors, or if a client is destructive to property, the staff are trained to utilize the following techniques: personal boundaries, negotiation and cueing, then escort, and then restrain. If the client has a Rule 40 restraint plan that is initiated as written. | W 239 | | |
| W 257 | 483.440(f)(1)(iii) PROGRAM MONITORING & CHANGE<br><br>The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made.<br><br>This STANDARD is not met as evidenced by:<br>Based on interview and record review, the qualified mental retardation professional (QMRP) failed to review and revise individual program plans as necessary, where the client was failing to progress toward identified objectives after reasonable effort had been made for three of nine clients (#2, #6, and #9) in the sample. Findings include:<br><br>Client #6 exhibited behaviors of biting, hitting, kicking, etc. on admission, May 7, 2007. He was restrained with handcuffs and leg hobbles for that behavior. According to a form titled, Documentation for Implementation of Approved Aversive And/Or Deprivation Procedures, dated January 8, 2008, client #6 exhibited similar behaviors of kicking, scratching, and headbutting. | W 257 | The facility will implement a quality management process to ensure that the QMRP makes changes to client IPPs such that adequate treatment velocity is maintained for all clients. Specifically, monthly data reflecting progress in treatment will be reviewed by the facility's Clinical Director, or designee, with the object of effecting appropriate revision to the client's IPP in order to reduce the need for restraint.<br><br>Persons Responsible: Scott TenNapel, Ph.D. L.P., METO Clinical Director | 2/26/08 |





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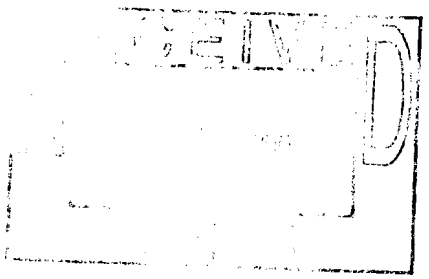
| W 257 | Continued From page 27 | W 257 | | |

etc. He was restrained with cuffs and a Rule 40 hold. The informed consent for psychotropic medications dated December 5, 2007 to December 4, 2008, indicates client #6 is on 700 milligrams of Seroquel daily, and two milligrams of Ativan twice a day with additional milligrams up to ten per day. Page two of the consent indicates that client #6's target behavior of physical aggression went from his "baseline" of 334 incidents to 1,325 incidents in the period of September 1, 2007 thru November 27, 2007. Physical and chemical restraints were used the day of admission and continue to be used even though some of client #6's behaviors have not changed since he was admitted.

Employee (B)/behavioral analyst, employee (C)/human services support specialist (HSSS), and employee (D)/HSSS, were interviewed while onsite on January 10-11, 2007, and stated that client #6's restraints are not effective, however the Rule 40 continues to be implemented as written.

Client #2 has moderate mental retardation, autism and deafness. She was admitted to the facility in August 2000. Her behaviors include clearing objects off tables, counters or desk; throwing, ripping, or slamming objects; biting or cutting herself; hitting the wall with her fist; or trying to injure others by hitting, biting, scratching, kicking, slapping, pushing, etc. A psychological evaluation, dated February 14, 2006, indicated that client #2 "continues to engage in self-injurious behavior at a high frequency," which fluctuates from month to month and ranges from six to eighty-five episodes. The majority of the episodes were considered "minor" in severity. The summary indicated that the client is overall





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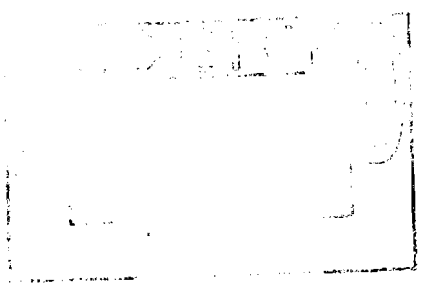
| W 257 | Continued From page 28 | W 257 | | |

functioning at her baseline. "There will most likely always be a high risk" that client #2 will aggress against others and cause considerable harm to herself. A comparison of informed consents for controlled procedures dated October 28, 2006 to January 27, 2007 and October 24, 2007 to January 25, 2008 indicates the reasons for the use of the restraints were basically the same. The later document indicates that restraints are necessary to control behavior. The controlled procedure will be terminated when the client has three consecutive months of "zero physical holdings." Client #2 continues to be put in restraints (see Tag 128).

Client #9 has mild mental retardation, autism, and a brain lesion. He was admitted to the facility in June 2007. Client #9 has a history of physical aggression, property destruction and self injury. According to his comprehensive functional assessment summary, dated July 10, 2007, client #9 does not understand his mental health condition and how it affects his life. According to a psychotropic medication addendum, dated October 2, 2007, the frequency of his target behaviors from July 1, 2007 to September 23, 2007 included 49 incidents of physical aggression. An informed consent for controlled procedures, dated December 10, 2007 to March 9, 2008 indicates that from September 16, 2007 to December 5, 2007, there was an increase to 72 incidents of physical aggression. Client #9 is currently on psychotropic medications and is mechanically restrained with handcuffs and leg hobbles in accordance with his Rule 40 program. The QMRP has not changed the client's programming to see if something other than restraints would reduce his behaviors.





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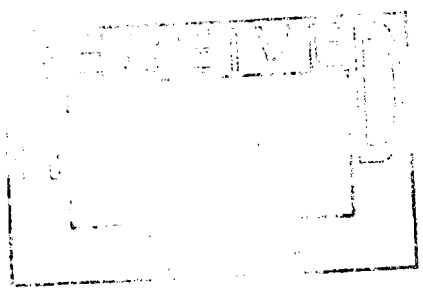
| W 257 | Continued From page 29<br>In summary, from the time of admission, these clients exhibited certain behaviors, were restrained for exhibiting those behaviors and they continue to be restrained for exhibiting those behaviors. The QMRP has not identified what behaviors would be considered acceptable for an individual, i.e. client #9 engaging in laughter or clients wanting to touch a staff person, etc. Also the QMRP has not provided the staff with identified antecedents to the client's behavior in order to help the staff identify when the clients will exhibit behaviors. The QMRP has not changed the client's programming to see if an intervention other than restraints (i.e., use of the time out room) would be effective. | W 257 | | |
| W 261 | 483.440(f)(3) PROGRAM MONITORING & CHANGE<br><br>The facility must designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility.<br><br>This STANDARD is not met as evidenced by:<br>Based on documentation review and interview, the facility failed to have the required members regular participation at the scheduled meetings of the Behavior Management Review Committee and at the Human and Legal Rights Committee. Findings include:<br><br>The committee members do not regularly participate in the function. | W 261 | The facility will revise its policy regarding the functioning of its specially constituted committees. Specifically, a single specially constituted committee (i.e., the Behavior Management Review Committee) will review the IPP, use of psychotropic medications, use of restraints, and proposals to restrict client rights for all clients placed in the facility's ICF/MR program. Additionally, policy will mandate that a quorum be present in order for a meeting of the committee to occur, | |





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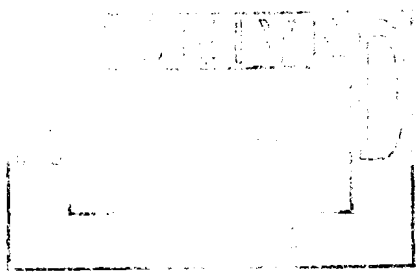
| W 261 | Continued From page 30<br>The facility's Behavioral Management Review Committee has five members, one of which is a community member. The minutes from the last year revealed that the committee met monthly to review Individual Program Plans related to behaviors. Of the meeting minutes reviewed between February 2007 to November 2007, the March 2007 meeting was the only meeting that all of the members attended.<br><br>There was no documentation to indicate that the members not in attendance participated via telephone or were contacted about the information reviewed at the meetings prior to approval.<br><br>The facility's Human and Legal Rights Committee minutes were reviewed between September 2007 and January 2008. This committee also met monthly. However, the only meeting which all of the members attended was the November 2007 meeting.<br><br>There was no documentation to indicate that the members not in attendance participated via telephone or were contacted about the information reviewed at the meetings prior to approval.<br><br>Employee (A)/administrative staff was interviewed on January 10, 2008 at 9:30 a.m. and stated both the Human and Legal Rights Committee and the Behavioral Management Review Committee meet monthly and review the client's Rule 40 plans (the facility's specially constituted committees' pre-approved restrictive behavior management practice). | W 261 | and a mechanism to ensure that any member not present was given opportunity to consider the information reviewed prior to the Committee's approval.<br><br>Persons Responsible: Doug Bratvold, METO Director | |
| W 266 | 483.450 CLIENT BEHAVIOR & FACILITY PRACTICES | W 266 | | |





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| W 266 | Continued From page 31<br><br>The facility must ensure that specific client behavior and facility practices requirements are met.<br><br>This CONDITION is not met as evidenced by:<br>Based on interviews and documentation review, the facility failed to provide clients with the least restrictive interventions related to inappropriate behaviors, failed to implement restraints without causing harm, failed to utilize Rule 40 (the facility's specially constituted committees' pre-approved restrictive behavior management practice) plans in accordance with active treatment plans, failed to change restraint interventions when they have failed to change behavior, failed to tailor the client interventions for inappropriate behavior to the client, failed to use less restrictive interventions instead of using emergency restraints, and failed to teach and encourage appropriate behavior to replace the maladaptive behavior. These failures render this Condition of Participation unmet.<br><br>See documentation at tags: W268, W278, W285, W288, W289, W295, W296, and W304. | W 266 | The facility will modify its program delivery practices to promote client growth, development and independence; ensure that less restrictive interventions are attempted prior to use of restraints; ensure that behavior management procedures are employed with sufficient safeguards and supervision to protect client rights; ensure restraint is never used as a substitute for active treatment; ensure systematic intervention to manage behaviors are incorporated into a client's IPP; ensure that use of restraint is part of an integral program leading to less restrictive means of behavior management; that<br>(Continued on attached sheet) | |
| W 268 | 483.450(a)(1)(i) CONDUCT TOWARD CLIENT<br><br>These policies and procedures must promote the growth, development and independence of the client.<br><br>This STANDARD is not met as evidenced by:<br>Based on interview and documentation review, the facility has failed to treat eight of nine clients (#2, #3, #4, #6, #7, #8, #9, and #10) in a dignified | W 268 | The facility will change its policy regarding client conduct to better promote the ability of clients to grow and develop with regard to physical/interpersonal boundaries and touch. Specifically, it will be clarified that there is no | 2/26/08 |

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| W 268 | Continued From page 32<br>manner related to the use of restraints and the facility has failed to promote the growth and development of clients related to touch. Findings include:<br><br>Client #2 has moderate mental retardation, autism, and deafness. A review of the client's record revealed that she was unnecessarily restrained on April 15, 2007, May 4, 2007, May 5, 2007, May 17, 2007, June 25, 2007, July 10, 2007, July 25, 2007, July 29, 2007, and August 21, 2007 in soft wrist cuffs behind her back and leg hobbles.<br><br>Client #3 has mild mental retardation, osteoarthritis, limited range of motion in his left leg, a history of knee pain, and prefers to use a wheelchair. A review of the client's record revealed that he was unnecessarily restrained on March 29, 2007, May 10, 2007, June 20, 2007, June 23, 2007, August 5, 2007, September 6, 2007, and September 26, 2007.<br><br>Client #4 has mild mental retardation, asthma, epilepsy, and a history of poking others and throwing personal items at others heads. A review of her record revealed that she had been inappropriately restrained on May 24, 2007, and May 30, 2007.<br><br>Client #6 has severe mental retardation and a history of behavioral deterioration since November 2006. A review of his medical record revealed that he was unnecessarily restrained in combination with psychotropic medications on May 7, 2007, May 10, 2007, May 21, 2007, June 2, 2007, June 5, 2007, June 12, 2007, and June 18, 2007. He was unnecessarily restrained with mechanical restraints on May 8, 2007, May 9, | W 268 | uniform facility policy that prohibits clients from touching staff or one another, and that specific boundaries regarding touch will be specified as group agreements, sensitive to the specific characteristics of the clients in the group, and open to negotiation. All staff will be trained to policy change.<br><br>Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D., L.P. METO Clinical Director<br><br>IPPs for all clients placed in the facility's ICF/MR program will be revised to ensure that, for any client having a behavior management program targeting the reduction of inappropriate touch, and/or where any use of restraint has been triggered by inappropriate touch, the IPP includes provisions for promoting the growth and development of appropriate touch. 2/26/08<br><br>Persons Responsible: Scott TenNapel, Ph.D. L.P., METO Clinical Director; Beth Klute, Julie Patten, BA3s and QMRPs | |



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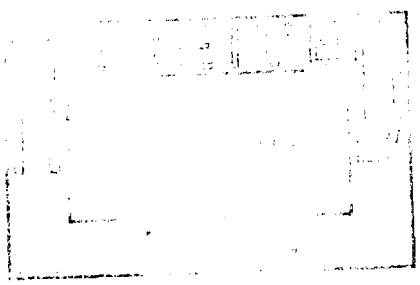
| W 268 | Continued From page 33<br>2007, and January 8, 2008.<br><br>Client #7 has mild mental retardation. A review of her record revealed that she was unnecessarily restrained on December 12, 2007, December 21, 2007, and December 24, 2007.<br><br>Client #8 has moderate mental retardation, autism, a brain stem tumor, and seizure disorder. A review of his medical record revealed that he was unnecessarily restrained on September 9, 2007, September 27, 2007, September 30, 2007, October 5, 2007, October 11, 2007, and October 14, 2007.<br><br>Client #9 has mild mental retardation, autism, and a brain lesion. A review his medical record revealed that he was unnecessarily restrained on August 5, 2007, August 24, 2007, September 28, 2007, October 25, 2007, November 11, 2007, and December 11, 2007.<br><br>Client #10 has moderate mental retardation and infantile autism, he has a history of biting people, making himself vomit, and becoming increasingly agitated when others attempt to interact with him. Client #10 was discharged from the facility on November 7, 2007. A review of client's record revealed that he was unnecessarily restrained on February 28, 2007, March 6, 2007, March 9, 2007, March 13, 2007, March 17, 2007, March 18, 2007, March 19, 2007, March 20, 2007, March 27, 2007, April 3, 2007, April 4, 2007, April 5, 2007, April 6, 2007, April 8, 2007, and April 11, 2007.<br><br>Interviews with employee (B), (C), and (D) on January 10 and 11, 2007, revealed that the facility has a no touch policy on the campus. This means | W 268 | The facility has contracted with a registered Occupational Therapist, with competency in delivering sensory integration therapies to individuals with developmental disabilities. Service delivery will begin effective 02-04-08 and be focused on clients placed in the facility's ICF/MR program, and will include: assessing clients to determine the degree to which problem behaviors may be reflective of sensory issues, assisting the treatment team to develop appropriate habilitation programming, and staff training to increase skill in meeting the sensory needs of clients.<br><br>Persons Responsible: Doug Bratvold, METO Director; Shirley Davis, R.N. METO Nursing Supervisor<br><br>Effective 01-08, the facility increased requirements for QMRP oversight of emergency use of restraint to include enhanced evaluation of factors that may have contributed to the use of restraint, effectiveness of less restrictive alternatives attempted, specific recommendations | 2/26/08<br><br>2/26/08 |





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| W 268 | Continued From page 34<br>that clients are not allowed to touch other clients, staff are not allowed to touch clients unless providing care, and clients are not allowed to touch staff. Employee (B) when interviewed stated this is because staff do not know if a client is going to hurt them. Employee (C) stated in an interview that the no touch policy is difficult in an ICF/MR facility because of the clients they serve, however, the facility is not their home it is a treatment center.<br><br>Employee (E)/administrative staff was interviewed on January 31, 2008 at 9:30 a.m. and stated that the clients admitted at the facility should only be restrained to reduce target behaviors that are dangerous or likely to lead to dangerous behavior.<br><br>When two specific examples of client #3 being restrained, related to television viewing, were mentioned by the investigator, employee (E) stated that from the sounds of the examples reviewed, the risk analysis (risk of continuing the activity versus the risks of restraining) is "all out of whack."<br><br>The facility as a whole does not have a "no-touch" policy. There should be "household agreements," reviewed and open for negotiation, made by the people who live in a household. The "no-touch" policy is intended to be a therapeutic support for people who are aggressor's, the recipient of another's aggression, or there are other problems with interpersonal boundaries. If a client failed to observe the practice of "no-touch" and simply touched another client, that would not constitute a dangerous situation. | W 268 | for changes to the client's IPP to reduce need for further restraint, and communication/ collaboration with members of the Expanded Interdisciplinary Team, including the legal representative and county case manager. QMRP documentation is recorded on a newly developed form and will be tracked as part of ongoing file audits.<br><br>Persons Responsible: Scott TenNapel, Ph.D., L.P., METO Clinical Director<br><br>The facility implemented a staff training initiative to increase staff skill in positive behavior management (alternatives to restraint) effective December 14, 2007. All staff currently assigned to the ICF/MR program will receive this training. This training has also been added to the new employee orientation<br>(Continued on attached sheet) | |
| W 278 | 483.450(b)(1)(iii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR | W 278 | | |

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| W 278 | Continued From page 35<br>Procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective.<br><br>This STANDARD is not met as evidenced by:<br>Based on interview and record review, the facility failed to clearly document in the medical record that less intrusive and more positive techniques had been tried systematically, prior to the implementation of more restrictive techniques, to manage inappropriate client behavior for eight of nine clients (#2, #3, #4, #6, #7, #8, #9 and #10) whose medical records were reviewed. Findings include:<br><br>A review of the facility's "Documentation For Implementation Of Approved Aversive And/Or Deprivation Procedures, Documentation for Emergency Use of Controlled Procedures, [and] Documentation for Emergency Use or Emergency Initiation of Psychotropic Medication" revealed that facility staff consistently implement chemical or mechanical restraint procedures without trying less intrusive and less restrictive techniques. Documentation of the use of the above procedures provided little or no evidence that staff tried 1) to anticipate the maladaptive behavior, 2) to determine what the individual was trying to accomplish or communicate by displaying his or her maladaptive behavior, 3) to use consistent positive reinforcement procedures, 4) to use a positive or less restrictive technique than a manual or mechanical restraint and 5) to consider if environmental alterations would | W 278 | The facility has modified its documentation format and administrative review process for any use of restraint, to assure that less intrusive techniques were tried and found to be ineffective or reasons why less intrusive interventions could not be used.<br><br>The facility has established a debriefing process to monitor and provide coaching regarding staff implementation of restraint.<br><br>IPPs for all clients placed in the facility's ICF/MR program will be revised to ensure that each client's program includes a specific system of positive (non-aversive) response to behaviors that are identified as precursors to more serious problem behaviors that may result in a need for restraint.<br><br>Persons Responsible: Scott TenNapel, Ph.D. L.P.,METO Clinical Director; Beth Klute and Julie Patten, BA3s and QMRPs<br><br>The facility will implement a quality management process to ensure that the QMRP makes changes to client IPPs such that adequate treatment velocity is maintained for all clients who | 2/26/08<br><br>2/26/08 |

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| | 24G502 | A. BUILDING _____ B. WING _____ | C 01/17/2008 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MN EXTENDED TREATMENT | 1425 STATE STREET CAMBRIDGE, MN 55008 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| W 278 | Continued From page 36<br>reduce or eliminate the maladaptive behavior. See tag W128 for examples of incidents where a maladaptive behavior was displayed by clients #2,#3, #4, #6, #7, #8, #9, and #10 and then was immediately followed by a restraint procedure. In these examples, documentation does not indicate that restraints were used "as a last resort."<br><br>Employee (A)/administrative staff was interviewed on January 10, 2008 at 9:30 a.m. and stated that all the clients at the facility are legally committed and exhibit either property destruction or physical aggression, and may have some degree of self injurious behavior. The average stay is based on how quickly the facility is able to stabilize a client's inappropriate behavior. Approximately one and a half to two years ago, the facility implemented the use of mechanical restraints for inappropriate behavior. In November 2007, the use of mechanical restraints for emergency situations was discontinued in the ICF/MR. However, the use of mechanical restraints continues to be utilized on the clients with Rule 40 programs. In emergency situations, the staff use manual restraints only. Examples of the restraints utilized for the Rule 40 programs include: soft wrist cuffs, metal handcuffs and leg hobbles (usually used together), and in some cases a restraint board. The Rule 40 programs start with two minutes of manual restraining and if the client(s) continues to struggle, they are put in mechanical restraints.<br><br>Employee (B)/behavioral analyst I was interviewed on January 11, 2008 at 8:10 a.m., and stated that emergency restraints are utilized until a plan is in place to address inappropriate behaviors. When a client exhibits a behavior that could lead to injury such as physical aggression or self injurious behaviors, or if a client is | W 278 | have experienced use of restraint. Specifically, monthly data reflecting the use of restraints and progress in treatment will be reviewed by the facility's Clinical Director, or other designee who is a mental health professional with competency in psycho-educational treatment of individuals with developmental disability, with the object of effecting appropriate revision to the client's IPP in order to reduce the need for restraint.<br><br>Persons Responsible: Scott TenNapel, Ph.D., L.P., METO Clinical Director<br><br>The facility increased requirements for Registered Nurse oversight of restraint use to include direct examination and documentation of the client's response to each implementation of restraint, effective 11-07.<br><br>Persons Responsible: Doug Bratvold, METO Director; Shirley Davis, R.N., METO Nursing Supervisor | 2/26/08 |

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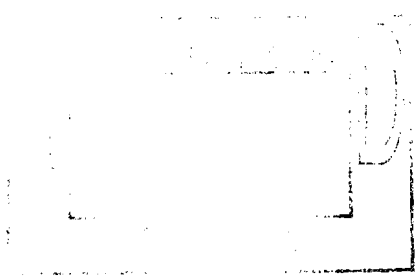
| W 278 | Continued From page 37<br>destructive to property, the staff utilize the following techniques: personal boundaries, negotiation and cueing, then escort, and then restrain. If the client has a Rule 40 restraint plan, that is initiated as written. The restraints used for the Rule 40 clients have been metal handcuffs or Posey soft handcuffs and leg hobbles (the cuffs and hobbles are used together), or Posey board. Of the five clients in the ICF/MR with rule 40's, all but one are put in handcuffs (metal or soft) and hobbles.<br><br>Employee (E)/administrative staff was interviewed on January 31, 2008 at 9:30 a.m. and stated that the clients admitted at the facility should only be restrained to reduce target behaviors that are dangerous or likely to lead to dangerous behavior.<br><br>When two specific examples of client #3 being restrained, related to television viewing, were mentioned by the investigator, employee (E) stated that from the sounds of the examples reviewed, the risk analysis (risk of continuing the activity versus the risks of restraining) is "all out of whack."<br><br>The facility as a whole does not have a "no-touch" policy. There should be "household agreements," reviewed and open for negotiation, made by the people who live in a household. The "no-touch" policy is intended to be a therapeutic support for people who are aggressor's, the recipient of another's aggression, or there are other problems with interpersonal boundaries. If a client failed to observe the practice of "no-touch" and simply touched another client, that would not constitute a dangerous situation. | W 278 | Effective 01-08, the facility increased requirements for QMRP oversight of emergency use of restraint to include enhanced evaluation of factors that may have contributed to the use of restraint, effectiveness of less restrictive alternatives attempted, specific recommendations for changes to the client's IPP to reduce need for further restraint, and communication/collaboration with members of the Expanded Interdisciplinary Team, including the legal representative and county case manager. QMRP documentation is recorded on a newly developed form and will be tracked as part of ongoing file audits.<br><br>Persons Responsible: Scott TenNapel, Ph.D., L.P., METO Clinical Director | 2/26/08 |
| W 285 | 483.450(b)(2) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR | W 285 | | |





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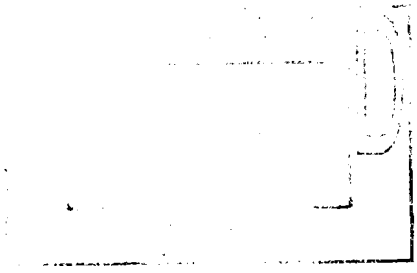
| W 285 | Continued From page 38<br><br>Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected.<br><br>This STANDARD is not met as evidenced by:<br>Based on interview and record review, the facility failed to implement interventions to ensure safety for three of nine clients (#6, #7, and #9) in the sample, and failed to protect the welfare and rights of eight of nine clients (#2, #3, #4, #6, #7, #8, #9 and #10) in the sample who were restrained without adequate justification and/or alternative interventions. Findings include:<br><br>According to progress notes in client #6's medical record, on August 11, 2007, at 8:11 a.m. the client "began to come at staff in an aggressive manner. Staff redirected client to room. [Client #6] went in room but came out again within several seconds. [Client #6] then began to grab at staff with force. Staff implemented Rule 40, by first putting [client #6] in an arm bar. [Client #6] resisted the arm bar and continued to claw and grab at staff. [Client #6] went to his knees but continued to fight. Staff then implemented an arm bar take down. As staff did this, [client #6] turned away from implementor to another staff, grabbing and clawing. At this moment implementor felt and heard upper left arm pop. Staff immediately stopped the arm bar take down and alerted the other staff. [Client #6] laid on the ground face down but still attempted to aggress by grabbing at staff, even though left arm had possible injury he aggressed with it. Staff attempted to keep [client #6] still, especially his left arm. Staff verbally | W 285 | With a policy change effective 11-23-07 the facility prohibited the emergency use of mechanical restraint of any client placed in the ICF/MR program. All staff assigned to the ICF/MR building have been trained to this change.<br><br>Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D., L.P., METO Clinical Director<br><br>The facility will change its policy regarding emergency use of manual restraint of clients placed in the ICF/MR program to effect an immediate reduction in use of restraint by increasing the standard of severity of behavior for which emergency use of manual restraint is indicated. Specifically, no use of restraint will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury.<br><br>The facility will change its policy on emergency use of psychotropic medications to | 2/26/08 |





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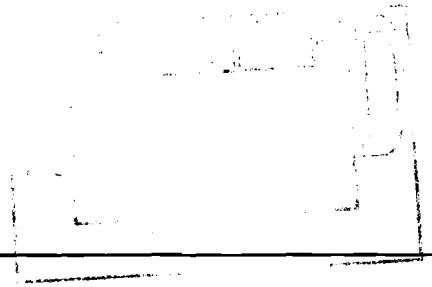
| W 285 | Continued From page 39<br>prompted [client #6] to calm down. [Client #6] calmed down a little but was still struggling. Staff called 9-1-1 and notified R.N." A splint was applied and the client was transported to the hospital by emergency medical technicians. Client #6 had a left distal humerus fracture and was admitted to the hospital for pain control after his arm was set and splinted. He returned to the facility on August 13, 2007. He returned to the hospital on August 28, 2007 for surgical repair of his fractured arm and returned to the facility on August 29, 2007.<br><br>According to documentation on incident reports, on October 12, 2007, at 8:30 a.m., client #7 sustained a "nickel sized swelling right outer orbit/brow of eye. Two bruised areas present. Client reportedly was banging head on floor. Staff attempted to move pillow under client's head during restraint however the client would not permit it to remain there." Description of the behavior for which client #7 was restrained, recorded on the "Documentation for Emergency Use of Controlled Procedure" form, dated October 12, 2007, at 8:35 a.m. indicated that client #7 was asked to take her bath and medication. The client began yelling and screaming at staff. When staff entered the bedroom, client #7 attempted to hit staff. The client was put in a manual restraint in prone position. After two minutes, mechanical restraints were applied. The procedure ended at 8:55 a.m. Documentation indicated that after the restraint procedure, client #7 was "very emotional and crying, stating she can't go to work today." The nurse assessment, at 9:05 a.m., indicated the client was anxious, and was rocking in the rocking chair. | W 285 | ensure that such use is exclosively for the reduction of symptoms of an identified psychiatric condition.<br><br>The facility will revise its policy on programmatic use of restraint (i.e., "Rule 40" programs) for clients placed in the ICF/MR program to reduce the use of programmatic restraint by increasing the standard of severity of behavior for which use of restraint is indicated. Specifically, no use of restraint will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury.<br><br>All staff assigned to the ICF/MR building will be trained to this change.<br><br>Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D., L.P., METO Clinical Director<br><br>Effective 01-08-08 the facility implemented a process of disclosure, for use at admission to the facility, involving clients, legal representatives, and members of clients' Expanded | 2/26/08<br><br>2/26/08 |





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| W 285 | Continued From page 40<br>On December 11, 2007, at 5:10 p.m. a staff person was getting water from client #7's refrigerator when the client, "came at staff yelling." The client "lunged at staff, threw a glass of water at staff, came at staff with fists raised." Staff executed an arm bar take down into a manual hold. The client struggled, scratched and yelled for twenty minutes. The nurse assessment indicated the color of the client's face and hands remained normal even though she yelled she couldn't breathe. At 5:30 p.m., client #7 was crying and went into her room. Documentation indicated the client said she was "sore." An incident report indicated that "during emergency restraint [client #7] was struggling, refusing to take her right arm out from under her chest, a small abrasion on her right elbow due to resisting on carpeted area."<br><br>An incident report, dated September 13, 2007, at 9:00 a.m., indicated that after being restrained, client #9 went into his bedroom and banged his head against the wall. He sustained a two centimeter abrasion mid-forehead and a two centimeter abrasion on his right temple. Description of the behavior for which client #9 was restrained, recorded on the Documentation for Emergency Use of Controlled Procedure form, dated September 13, 2007, at 8:10 a.m., indicated that while client #9 was doing his laundry, he "slammed his hamper. Walked to his room [and] threw hamper lid, talking to himself and pacing. He then said "shot" and went toward med cart. Staff asked if he was okay [and] opened his bedroom door." Client #9 was restrained due to "physical aggression-pulled staffs hair & grabbed, scratched staffs shoulder [and] neck area." During manual restraint, the client struggled for two minutes so mechanical | W 285 | Interdisciplinary Teams, describing the facility's policy regarding emergency use of restraints, including a written and photographic description of restraints used, soliciting concerns from clients and their teams regarding the facility's use of restraint, and offering consultation with clinical staff toward identification of alternatives to restraint.<br><br>Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D., L.P., METO Clinical Director; Kim Palmer and Connie O'Brien, METO Social Workers<br><br>The facility increased requirements for Registered Nurse oversight of restraint use to include direct examination and documentation of the client's response to each implementation of restraint, effective 11-07.<br><br>Persons Responsible: Doug Bratvold, METO Director; Shirley Davis, R.N. METO Nursing Supervisor | 2/26/08<br><br>2/26/08 |

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| W 285 | Continued From page 41<br>restraints were applied. The client continued to struggle for a total of twenty-nine minutes. The procedure ended at 8:44 a.m. At 2:32 p.m., "[client #9] went to his mental health review [and] did well, when he got out side he yelled, "pop, cookie" [and] began to flick his fingers infront of his face, walking rapidly [and] his body was shaking. He got into the household, grabbed staff by both their shoulders [and] shook her." Client #9 was restrained due to physical aggression --"grabbed staff by shoulders [and] began to shake her." The client struggled for thirteen minutes. At 2:40 p.m. client #9 received two milligrams of Ativan IM. The restraint procedure ended at 2:55 p.m., after 23 minutes.<br><br>The facility has not put interventions in place to manage inappropriate behavior in such a way that the welfare and civil and human rights of the clients in the sample (#2, #3, #4, #6, #7, #8, #9, and #10) have been adequately protected. The "culture" of the facility promotes the use of manual, mechanical, and or chemical restraints to manage maladaptive behaviors. Clients are put into restraints for behaviors without prior less restrictive interventions being implemented. Medical record documentation does not show that consistent positive reinforcement methods are offered to the clients. There is documentation that indicates some clients have suffered unfavorable effects from manual and mechanical restraints. There is documentation that indicates some of the client's behaviors have continued for long periods of time, despite the use of manual and mechanical restraints.<br><br>Employee (A)/administrative staff was interviewed on January 10, 2008 at 9:30 a.m. and stated that all the clients at the facility are legally committed | W 285 | Effective 01-08, the facility increased requirements for QMRP oversight of emergency use of restraint to include enhanced evaluation of factors that may have contributed to the use of restraint, effectiveness of less restrictive alternatives attempted, specific recommendations for changes to the client's IPP to reduce need for further restraint, and communication/collaboration with members of the Expanded Interdisciplinary Team, including the legal representative and county case manager. QMRP documentation is recorded on a newly developed form and will be tracked as part of ongoing file audits.<br><br>Persons Responsible: Scott TenNapel, Ph.D., L.P.,METO Clinical Director<br><br>IPPs for all clients placed in the facility's ICF/MR program will be revised to effect an immediate reduction in the use of restraints by increasing the standard of severity of behavior for which use of restraint is indicated. | 2/26/08<br><br>2/26/08 |

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| W 285 | Continued From page 42<br>and exhibit either property destruction or physical aggression, and may have some degree of self injurious behavior. The average stay is based on how quickly the facility is able to stabilize a client's inappropriate behavior. Approximately one and a half to two years ago, the facility implemented the use of mechanical restraints for inappropriate behavior. In November 2007, the mechanical restraints in emergency situations were stopped in the ICF/MR and only utilized on the clients with Rule 40 programs. In emergency situations, the staff use manual restraints only. Examples of the restraints utilized for the Rule 40 programs include: soft wrist cuffs, metal handcuffs and leg hobbles (usually used together), and in some cases a restraint board. The Rule 40 programs start with two minutes of manual restraining and if the client(s) continues to struggle, they are put in mechanical restraints.<br><br>Employee (A)/administrative staff was interviewed on January 10, 2008 at 10:15 a.m. and stated that the injuries related to restraint use have included redness from the handcuffs, and one broken arm (client #6). The majority of the bumps, bruises, and rug burns on the head, knees, and elbows are from the manual restraints. | W 285 | Specifically, no use of restraint will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury.<br><br>Persons Responsible: Scott TenNapel, Ph.D., L.P., METO Clinical Director; Beth Klute and Julie Patten, BA3s and QMRPs<br><br>The facility's specially constituted committee will be oriented to changes in policy regarding both emergency and programmatic use of restraint, to ensure their review and approval process meets the revised policy's increased standard of severity of behavior for which use of restraint is indicated. Specifically, no use of<br>(Continued on attached sheet) | 2/26/08 |
| W 288 | 483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR<br><br>Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program.<br><br>This STANDARD is not met as evidenced by:<br>Based on documentation review, the facility used restraints for inappropriate behaviors in the absence of active treatment to teach, improve, or | W 288 | | |



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| W 288 | Continued From page 43<br>substitute appropriate behavior for three of nine clients (#6, #8, and #9) in the sample. Findings include:<br><br>Client #6 has severe mental retardation and has a history of behavioral deterioration since November 2006. He was admitted to the facility in May 2007. His specific behaviors include biting, pinching, scratching, head-butting, hair pulling, and kicking. Client #6's Rule 40 (the facility's specially constituted committees' pre-approved restrictive behavior management practice) methodology states that if client #6 exhibits signs of agitation (reaching out or touching staff, not responding to verbal redirectives, pacing, perseverating, yelling, or screaming), the staff will provide the client a cue to stop the behavior. If the client does not "immediately" stop, staff will escort the client to his bedroom or a private place. If client #6 continues to engage in the behavior, staff will manually restrain his arms and apply a RIPP belt to the client's waist, and staff will apply Posey cuff's to the client's wrists. A Rule 40 addendum indicates the restraints will be terminated when the client has zero incidents of physical aggression, self injury, and PICA (eating inedible objects) over three consecutive months. Other than providing a cue to stop the behavior, there is no mention of interventions to modify or prevent the client's behaviors. There is no indication of the development of a list of antecedent behaviors to assist staff in knowing when the client might exhibit behaviors. From the day he arrived to present, client #6 continues to exhibit behaviors and he continues to be restrained for exhibiting these behaviors. The focus on the plan was to stop the "maladaptive behavior" with no indication of how staff would elicit or strengthen appropriate behaviors. | W 288 | IPPs for all clients placed in the facility's ICF/MR program will be revised to ensure that each client's program includes a specific system of positive (non-aversive) response to behaviors that are identified as precursors to more serious problem behaviors that may result in a need for restraint.<br><br>Persons Responsible: Scott TenNapel, Ph.D. L.P., METO Clinical Director; Beth Klute and Julie Patten, BA3s and QMRPs<br><br>The facility will implement a quality management process to ensure that the QMRP makes changes to client IPPs such that adequate treatment velocity is maintained for all clients who have experienced use of restraint. Specifically, monthly data reflecting the use of restraints and progress in treatment will be reviewed by the facility's Clinical Director, or other designee who is a mental health professional with competency in psycho-educational treatment of individuals with | 2/26/08<br><br>2/26/08 |

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| W 288 | Continued From page 44<br><br>Client #8's medical record was reviewed and indicated that he has moderate mental retardation, autism, and a brain stem tumor. The client has a history of physical aggression, self-injurious behaviors, and property destruction. Client #8's target behaviors include: "actual or attempted behavior that may cause pain or harm to other(s), including: lunging at others, biting, hitting, scratching, kicking, slapping, pushing others, throwing items at people, and spitting;" manipulating an object in a manner that causes significant damage to that object based upon its construction and or function, and/or poses risk to others if thrown or used as a weapon; including slamming doors and acts against self, regardless of intent, that may cause significant injury (i.e. slapping, hitting, scratching, biting self, pounding body parts on hard surfaces or head banging.)." The client's signs of agitation include: "running, checking doors, ignoring staff directions, and loud vocalizations." Client #8's behavior plan indicates that the client's alternative to agitation is to "take a break" with verbal cueing 80% of the time for two consecutive months. In addition, the client has a Rule 40 plan revised on August 22, 2007, with a duration of one year. The objective is to decrease the client's utilization of physical aggression, property destruction, and self-injurious behaviors to zero for three consecutive months. If the client exhibits any of the above target behaviors staff are to cue the client to stop the behavior and lie down on the floor. If the client does not lie down on the floor the staff are to manually restrain the client in a prone position and then apply handcuffs to his wrist and leg hobbles. If the client lies down on the floor independently the handcuffs and leg hobbles will still be applied. Once the client is "safe" he will be turned onto his | W 288 | developmental disability, with the object of effecting appropriate revision to the client's IPP in order to reduce the need for restraint.<br><br>Persons Responsible: Scott TenNapel, Ph.D. L.P., METO Clinical Director<br><br>Effective 01-08, the facility increased requirements for QMRP oversight of emergency use of restraint to include enhanced evaluation of factors that may have contributed to the use of restraint, effectiveness of less restrictive alternatives attempted, specific recommendations for changes to the client's IPP to reduce need for further restraint, and communication/collaboration with members of the Expanded Interdisciplinary Team, including the legal representative and county case manager. QMRP documentation is recorded on a newly developed form and will be tracked as part of ongoing file audits.<br><br>Persons Responsible: Scott TenNapel, Ph.D., L.P., METO Clinical Director | 2/26/08 |

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| MN EXTENDED TREATMENT | 1425 STATE STREET CAMBRIDGE, MN 55008 |

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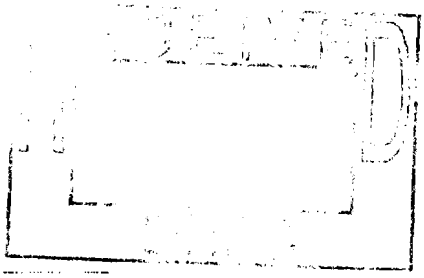
| W 288 | Continued From page 45<br>side. He needs to be calm for five minutes and then the leg hobbles will be released. After another five minutes of calm the handcuffs will be removed. The focus on the plan was to stop the "maladaptive behavior" with no indication of how staff would teach, elicit, improve, or strengthen appropriate behaviors.<br><br>Client #9's medical record was reviewed and his diagnoses included mild mental retardation and autism. He has a history physical aggression, self injurious behaviors, and property destruction when he gets frustrated or angry, exhibiting "running, self injurious behaviors, ignoring staff directions, and loud vocalizations." His target behaviors include physical aggression-"Actual or attempts to hurt and/or cause pain or harm to other(s). Includes: hitting, biting, scratching, kicking, slapping, pushing others, throwing items at people, and spitting at others;" self-injurious behaviors - "acts against self that are intended to cause injury (i.e. slapping, hitting, scratching, biting self, pounding body parts on hard surfaces or head banging.)." Client #9's program plan indicates that when he exhibits symptoms of "agitation" his alternative to the agitation will be to take "a break." In addition, the client has a Rule 40 plan that was last updated on September 13, 2007 with a duration of one year. The objective was to decrease his "maladaptive behaviors" to zero for three consecutive months. The plan included cueing the client to "stop" and if the client stopped the behavior he would be directed to go to a quiet setting and staff would offer calming techniques. The specific calming techniques were not delineated. If the client did not stop the behavior he again would be cued to "'stop' and lie down on the floor." If the client did not comply he would be manually restrained in a | W 288 | IPPs for all clients placed in the facility's ICF/MR program will be revised to effect an immediate reduction in the use of restraints by increasing the standard of severity of behavior for which use of restraint is indicated. Specifically, no use of restraint will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury.<br><br>Persons Responsible: Scott TenNapel, Ph.D., L.P., METO Clinical Director; Beth Klute and Julie Patten, BA3s and QMRPs | |





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| W 288 | Continued From page 46 | W 288 | | |

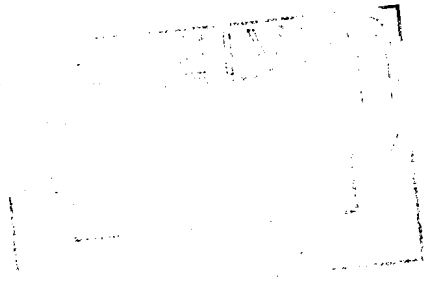
prone position and then mechanically restrained with handcuffs and leg hobbles, and turned to his side when he was "safe." After he was calm for five minutes his leg hobbles would be released and after another five minutes of being calm his handcuffs would be released. If the client followed directions when asked to lie down on the floor the procedure would continue with mechanically restraining him with the handcuffs and hobbles. The focus on the plan was to stop the "maladaptive behavior" with no indication of how staff would teach, elicit, improve or strengthen appropriate behaviors.

Employee (E)/administrative staff was interviewed on January 31, 2008 at 9:30 a.m. and stated that the clients admitted at the facility should only be restrained to reduce target behaviors that are dangerous or likely to lead to dangerous behavior.

When two specific examples of client #3 being restrained, related to television viewing, were mentioned by the investigator, employee (E) stated that from the sounds of the examples reviewed, the risk analysis (risk of continuing the activity versus the risks of restraining) is "all out of whack."

The facility as a whole does not have a "no-touch" policy. There should be "household agreements," reviewed and open for negotiation, made by the people who live in a household. The "no-touch" policy is intended to be a therapeutic support for people who are aggressor's, the recipient of another's aggression, or there are other problems with interpersonal boundaries. If a client failed to observe the practice of "no-touch" and simply touched another client, that would not constitute a dangerous situation.





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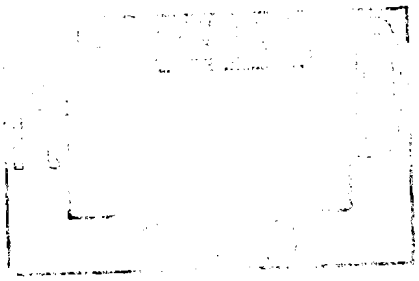
| W 289 | 483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR<br><br>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.<br><br>This STANDARD is not met as evidenced by:<br>Based on interview and documentation review, the facility has failed to incorporate alternative interventions, in place of restraints, into the client's individual program plan for two of nine clients (#8, #9) in the sample. In addition, the facility has failed to change client programs as behavior indicates for two of nine clients (#2, #6) in the sample. Findings include:<br><br>Client #9's medical record was reviewed and his diagnoses includes mild mental retardation and autism. He has a history of physical aggression, self injurious behaviors, and property destruction when he gets frustrated or angry, exhibiting "running, self injurious behaviors, ignoring staff directions, and loud vocalizations." His target behaviors include physical aggression-"Actual or attempts to hurt and/or cause pain or harm to other(s). Includes: hitting, biting, scratching, kicking, slapping, pushing others, throwing items at people, and spitting at others;" self-injurious behaviors - "acts against self that are intended to cause injury (i.e. slapping, hitting, scratching, biting self, pounding body parts on hard surfaces or head banging.)." Client #9's program plan indicates that when he exhibits symptoms of "agitation" his alternative to the agitation will be to take "a break." In addition, the client has a Rule | W 289 | IPPs for all clients placed in the facility's ICF/MR program will be revised to ensure that each client's program includes a specific system of positive (non-aversive) response to behaviors that are identified as precursors to more serious problem behaviors that may result in a need for restraint.<br><br>Persons Responsible: Scott TenNapel, Ph.D. L.P., METO Clinical Director; Beth Klute and Julie Patten, BA3s and QMRPs<br><br>The facility will implement a quality management process to ensure that the QMRP makes changes to client IPPs such that adequate treatment velocity is maintained for all clients who have experienced use of restraint. Specifically, monthly data reflecting the use of restraints and progress in treatment will be reviewed by the facility's Clinical Director, or other designee who is a mental health professional with competency in psycho-educational treatment of individuals with developmental disability, with the | 2/26/08<br><br>2/26/08 |





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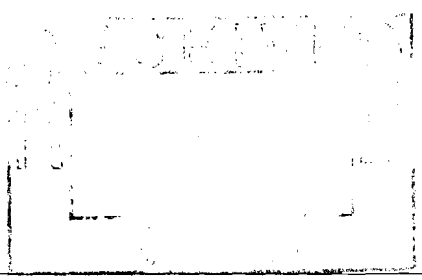
| W 289 | Continued From page 48<br>40 (the facility's specially constituted committees' pre-approved restrictive behavior management practice) plan that was last updated on September 13, 2007 with a duration of one year. The objective was to decrease his "maladaptive behaviors" to zero for three consecutive months. The plan included cueing the client to "stop" and if the client stopped the behavior he would be directed to go to a quiet setting and staff would offer calming techniques. The specific calming techniques were not delineated. If the client did not stop the behavior he again would be cued to "'stop' and lie down on the floor." If the client did not comply he would be manually restrained in a prone position and then mechanically restrained with handcuffs and leg hobbles, and turned to his side when he was "safe." After he was calm for five minutes his leg hobbles would be released and after another five minutes of being calm his handcuffs would be released. If the client followed directions when asked to lie down on the floor the procedure would continue with mechanically restraining him with the handcuffs and hobbles. The use of the Rule 40 was not incorporated into the clients plan for alternatives to his maladaptive behavior plan.<br><br>Client #8's medical record was reviewed and indicated that he has moderate mental retardation, autism, and a brain stem tumor. The client has a history of physical aggression, self-injurious behaviors, and property destruction. " Client #8's target behaviors include: "actual or attempted behavior that may cause pain or harm to other(s), including: lunging at others, biting, hitting, scratching, kicking, slapping, pushing others, throwing items at people, and spitting;" manipulating an object in a manner that causes significant damage to that object based upon its | W 289 | object of effecting appropriate revision to the client's IPP in order to reduce the need for restraint.<br><br>Persons Responsible: Scott TenNapel, Ph.D. L.P., METO Clinical Director<br><br>The facility will change its policy regarding emergency use of manual restraint of clients placed in the ICF/MR program to effect an immediate reduction in use of restraint by increasing the standard of severity of behavior for which emergency use of manual restraint is indicated. Specifically, no use of restraint will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury.<br><br>The facility will change its policy on emergency use of psychotropic medications to ensure that such use is exclusively for the reduction of symptoms of an identified psychiatric condition. | 2/26/08 |





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| W 289 | Continued From page 49<br>construction and or function, and/or poses risk to others if thrown or used as a weapon; including slamming doors and acts against self, regardless of intent, that may cause significant injury (i.e. slapping, hitting, scratching, biting self, pounding body parts on hard surfaces or head banging.)." The client's signs of agitation include: "running, checking doors, ignoring staff directions, and loud vocalizations." Client #8's behavior plan indicates that the client's alternative to agitation is to "take a break" with verbal cueing 80% of the time for two consecutive months. In addition, the client has a Rule 40 plan revised on August 22, 2007, with a duration of one year. The objective is to decrease the client's utilization of physical aggression, property destruction, and self-injurious behaviors to zero for three consecutive months. If the client exhibits any of the above target behaviors staff are to cue the client to stop the behavior and lie down on the floor. If the client does not lie down on the floor, the staff are to manually restrain the client in a prone position and then apply handcuffs to his wrist and hobbles to his legs. If the client lies down on the floor independently the handcuffs and leg hobbles will still be applied. Once the client is "safe" he will be turned onto his side. He needs to be calm for five minutes and then the leg hobbles will be released. After another five minutes of calm the handcuffs will be removed. The use of the Rule 40 was not incorporated into the clients plan for alternatives to his maladaptive behavior plan.<br><br>Client #2 has moderate mental retardation, autism and deafness. She was admitted to the facility in August 2000. Her behaviors include clearing objects off tables, counters or desk; throwing, ripping, or slamming objects; biting or cutting herself; hitting the wall with her fist; or | W 289 | The facility will revise its policy on programmatic use of restraint (i.e., "Rule 40" programs) for clients placed in the ICF/MR program to reduce the use of programmatic restraint by increasing the standard of severity of behavior for which use of restraint is indicated. Specifically, no use of restraint will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury.<br><br>All staff assigned to the ICF/MR building will be trained to this change.<br><br>Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D., L.P., METO Clinical Director<br><br>Effective 01-08, the facility increased requirements for QMRP oversight of emergency use of restraint to include enhanced evaluation of factors that may have contributed to the use of restraint, effectiveness of less restrictive alternatives attempted, specific recommendations for changes | 2/26/08<br><br>2/26/08 |

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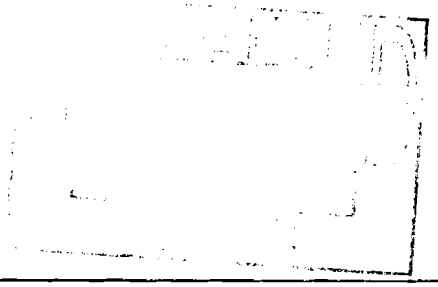
| W 289 | Continued From page 50<br>trying to injure others by hitting, biting, scratching, kicking, slapping, pushing, etc. A psychological evaluation, dated February 14, 2006, indicated that client #2 "continues to engage in self-injurious behavior at a high frequency," which fluctuates from month to month and ranges from six to eighty-five episodes. The majority of the episodes were considered "minor" in severity. The summary indicated that the client is overall functioning at her baseline. "There will most likely always be a high risk" that client #2 will aggress against others and cause considerable harm to herself. A comparison of informed consents for controlled procedures dated October 28, 2006 to January 27, 2007 and October 24, 2007 to January 25, 2008 indicates the reasons for the use of the restraints were basically the same. The later document indicates that restraints are necessary to control behavior. The controlled procedure will be terminated when the client has three consecutive months of "zero physical holdings." Client #2 continues to be put in restraints (see Tag 128).<br><br>Client #6 has severe mental retardation and has a history of behavioral deterioration since November 2006. He was admitted to the facility in May 2007. His specific behaviors include biting, pinching, scratching, head-butting, hair pulling, and kicking. Client #6's Rule 40 methodology states that if client #6 exhibits signs of agitation (reaching out or touching staff, not responding to verbal redirectives, pacing, perseverating, yelling, or screaming), the staff will provide the client a cue to stop the behavior. If the client does not "immediately" stop, staff will escort the client to his bedroom or a private place. If client #6 continues to engage in the behavior, staff will manually restrain his arms and apply a RIPP belt | W 289 | to the client's IPP to reduce need for further restraint, and communication/collaboration with members of the Expanded Interdisciplinary Team, including the legal representative and County case manager. QMRP documentation is recorded on a newly developed form and will be tracked as part of ongoing file audits.<br><br>Persons Responsible: Scott TenNapel, Ph.D., L.P., METO Clinical Director<br><br>IPPs for all clients placed in the facility's ICF/MR program will be revised to effect an immediate reduction in the use of restraints by increasing the standard of severity of behavior for which use of restraint is indicated. Specifically, no use of restraint will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury.<br><br>Persons Responsible: Scott TenNapel, Ph.D., L.P., METO Clinical Director; Beth Klute and Julie Patten, BA3s and QMRPs | 2/26/08 |





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| W 289 | Continued From page 51 | W 289 | | |

to the client's waist, and staff will apply Posey cuff's to the client's wrists. A Rule 40 addendum indicates the restraints will be terminated when the client has zero incidents of physical aggression, self injury, and PICA (eating inedible objects) over three consecutive months. Other than providing a cue to stop the behavior, there is no mention of interventions to modify or prevent the client's behaviors. There is no indication of the development of a list of antecedent behaviors to assist staff in knowing when the client might exhibit behaviors. From the day he arrived to present, client #6 continues to exhibit behaviors and he continues to be restrained for exhibiting these behaviors. The focus on the plan was to stop the "maladaptive behavior" with no indication of how staff would elicit or strengthen appropriate behaviors.

Employee (B)/behavioral analyst I, employee (C)/human services support specialist (HSSS), and employee (D)/HSSS, were interviewed while onsite on January 10-11, 2007, and stated that client #6's restraints are not effective, however the Rule 40 continues to be implemented as written.

Employee (E)/administrative staff was interviewed on January 31, 2008 at 9:30 a.m. and stated that the clients admitted at the facility should only be restrained to reduce target behaviors that are dangerous or likely to lead to dangerous behavior.

When two specific examples of client #3 being restrained, related to television viewing, were mentioned by the investigator, employee (E) stated that from the sounds of the examples reviewed, the risk analysis (risk of continuing the activity versus the risks of restraining) is "all out of

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| W 289 | Continued From page 52<br>whack."<br><br>The facility as a whole does not have a "no-touch" policy. There should be "household agreements," reviewed and open for negotiation, made by the people who live in a household. The "no-touch" policy is intended to be a therapeutic support for people who are aggressor's, the recipient of another's aggression, or there are other problems with interpersonal boundaries. If a client failed to observe the practice of "no-touch" and simply touched another client, that would not constitute a dangerous situation. | W 289 | | |
| W 295 | 483.450(d)(1)(i) PHYSICAL RESTRAINTS<br><br>The facility may employ physical restraint only as an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied.<br><br>This STANDARD is not met as evidenced by:<br>Based on interview and record review, the facility has failed to utilize restraints in a manner that will reduce the restraint or eliminate the behavior for four of nine clients (#2, #6, #8, and #9) in the sample. Findings include:<br><br>Client #2 has moderate mental retardation, autism and deafness. She was admitted to the facility in August 2000. Her behaviors include clearing objects off tables, counters or desk; throwing, ripping, or slamming objects; biting or cutting herself; hitting the wall with her fist; or trying to injure others by hitting, biting, scratching, kicking, slapping, pushing, etc. A psychological evaluation, dated February 14, 2006, indicated that client #2 "continues to engage in | W 295 | IPPs for all clients placed in the facility's ICF/MR program will be revised to ensure that each client's program includes a specific system of positive (non-aversive) response to behaviors that are identified as precursors to more serious problem behaviors that may result in a need for restraint.<br><br>Persons Responsible: Scott TenNapel, Ph.D. L.P., METO Clinical Director; Beth Klute and Julie Patten, BA3s and QMRPs<br><br>The facility will implement a quality management process to ensure that the QMRP makes changes to client IPPs such that adequate treatment velocity | 2/26/08<br><br>2/26/08 |

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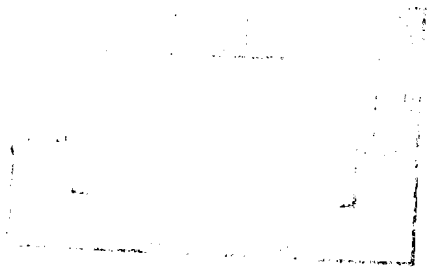
| W 295 | Continued From page 53<br>self-injurious behavior at a high frequency," which fluctuates from month to month and ranges from six to eighty-five episodes. The majority of the episodes were considered "minor" in severity. The summary indicated that the client is overall functioning at her baseline. "There will most likely always be a high risk" that client #2 will aggress against others and cause considerable harm to herself. A comparison of informed consents for controlled procedures dated October 28, 2006 to January 27, 2007 and October 24, 2007 to January 25, 2008 indicates the reasons for the use of the restraints were basically the same. The later document indicates that restraints are necessary to control behavior. The controlled procedure will be terminated when the client has three consecutive months of "zero physical holdings." Client #2 continues to be put in restraints (see Tag 128).<br><br>Client #6 has severe mental retardation and has a history of behavioral deterioration since November 2006. He was admitted to the facility in May 2007. His specific behaviors include biting, pinching, scratching, head-butting, hair pulling, and kicking. Client #6's Rule 40 methodology states that if client #6 exhibits signs of agitation (reaching out or touching staff, not responding to verbal redirectives, pacing, perseverating, yelling, or screaming), the staff will provide the client a cue to stop the behavior. If the client does not "immediately" stop, staff will escort the client to his bedroom or a private place. If client #6 continues to engage in the behavior, staff will manually restrain his arms and apply a RIPP belt to the client's waist, and staff will apply Posey cuff's to the client's wrists. A Rule 40 (the facility's specially constituted committees' pre-approved restrictive behavior management practice) | W 295 | is maintained for all clients who have experienced use of restraint. Specifically, monthly data reflecting the use of restraints and progress in treatment will be reviewed by the facility's Clinical Director, or other designee who is a mental health professional with competency in psycho-educational treatment of individuals with developmental disability, with the object of effecting appropriate revision to the client's IPP in order to reduce the need for restraint.<br><br>Persons Responsible: Scott TenNapel, Ph.D. L.P., METO Clinical Director<br><br>With a policy change effective 11-23-07 the facility prohibited the emergency use of mechanical restraint of any client placed in the ICF/MR program. All staff assigned to the ICF/MR building have been trained to this change. 2/26/08<br><br>Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D., L.P., METO Clinical Director | |





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| W 295 | Continued From page 54<br>addendum indicates the restraints will be terminated when the client has zero incidents of physical aggression, self injury, and PICA (eating inedible objects) over three consecutive months. Other than providing a cue to stop the behavior, there is no mention of interventions to modify or prevent the client's behaviors. There is no indication of the development of a list of antecedent behaviors to assist staff in knowing when the client might exhibit behaviors. From the day he arrived to present, client #6 continues to exhibit behaviors and he continues to be restrained for exhibiting these behaviors. The focus on the plan was to stop the "maladaptive behavior" with no indication of how staff would elicit or strengthen appropriate behaviors.<br><br>Client #9's medical record was reviewed and his diagnoses included mild mental retardation and autism. He has a history physical aggression, self injurious behaviors, and property destruction when he gets frustrated or angry, exhibiting "running, self injurious behaviors, ignoring staff directions, and loud vocalizations." His target behaviors include physical aggression-"Actual or attempts to hurt and/or cause pain or harm to other(s). Includes: hitting, biting, scratching, kicking, slapping, pushing others, throwing items at people, and spitting at others;" self-injurious behaviors - "acts against self that are intended to cause injury (i.e. slapping, hitting, scratching, biting self, pounding body parts on hard surfaces or head banging.)." Client #9's program plan indicates that when he exhibits symptoms of "agitation" his alternative to the agitation will be to take "a break." In addition, the client has a Rule 40 plan that was last updated on September 13, 2007 with a duration of one year. The objective was to decrease his "maladaptive behaviors" to | W 295 | The facility will change its policy regarding emergency use of manual restraint of clients placed in the ICF/MR program to effect an immediate reduction in use of restraint by increasing the standard of severity of behavior for which emergency use of manual restraint is indicated. Specifically, no use of restraint will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury.<br><br>The facility will change its policy on emergency use of psychotropic medications to ensure that such use is exclusively for the reduction of symptoms of an identified psychiatric condition.<br><br>The facility will revise its policy on programmatic use of restraint (i.e., "Rule 40" programs) for clients placed in the ICF/MR program to reduce the use of programmatic restraint by increasing the standard of severity of behavior for which use of restraint is indicated. Specifically, no use of restraint | 2/26/08 |

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| W 295 | Continued From page 55<br>zero for three consecutive months. The plan included cueing the client to "stop" and if the client stopped the behavior he would be directed to go to a quiet setting and staff would offer calming techniques. The specific calming techniques were not delineated. If the client did not stop the behavior he again would be cued to "'stop' and lie down on the floor." If the client did not comply he would be manually restrained in a prone position and then mechanically restrained with handcuffs and leg hobbles, and turned to his side when he was "safe." After he was calm for five minutes his leg hobbles would be released and after another five minutes of being calm his handcuffs would be released. If the client followed directions when asked to lie down on the floor, the procedure would continue with mechanically restraining him with the handcuffs and leg hobbles. The use of the Rule 40 was not incorporated into the clients plan for alternatives to his maladaptive behavior plan.<br><br>Client #8's medical record was reviewed and indicated that he has moderate mental retardation, autism, and a brain stem tumor. The client has a history of physical aggression, self-injurious behaviors, and property destruction. " Client #8's target behaviors include: "actual or attempted behavior that may cause pain or harm to other(s), including: lunging at others, biting, hitting, scratching, kicking, slapping, pushing others, throwing items at people, and spitting;" manipulating an object in a manner that causes significant damage to that object based upon its construction and or function, and/or poses risk to others if thrown or used as a weapon; including slamming doors and acts against self, regardless of intent, that may cause significant injury (i.e. slapping, hitting, scratching, biting self, pounding | W 295 | will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury.<br><br>All staff assigned to the ICF/MR building will be trained to this change.<br><br>Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D., L.P., METO Clinical Director<br><br>Effective 01-08, the facility increased requirements for QMRP oversight of emergency use of restraint to include enhanced evaluation of factors that may have contributed to the use of restraint, effectiveness of less restrictive alternatives attempted, specific recommendations for changes to the client's IPP to reduce need for further restraint, and communication/collaboration with members of the Expanded Interdisciplinary Team, including the legal representative and county case manager. QMRP documentation is recorded on a newly developed form and will be tracked as part of ongoing file audits. | 2/26/08 |

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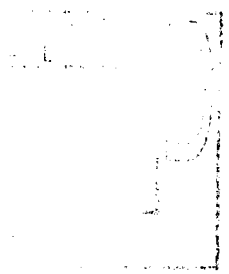
| W 295 | Continued From page 56<br>body parts on hard surfaces or head banging.)." The client's signs of agitation include: "running, checking doors, ignoring staff directions, and loud vocalizations. Client #8's behavior plan indicates that the client's alternative to agitation is to "take a break" with verbal cueing 80% of the time for two consecutive months. In addition, the client has a Rule 40 plan revised on August 22, 2007, with a duration of one year. The objective is to decrease the client's utilization of physical aggression, property destruction, and self-injurious behaviors to zero for three consecutive months. If the client exhibits any of the above target behaviors staff are to cue the client to stop the behavior and lie down on the floor. If the client does not lie down on the floor the staff are to manually restrain the client in a prone position. Then apply handcuffs to his wrist and leg hobbles. If the client lies down on the floor independently the handcuffs and leg hobbles will still be applied. Once the client is "safe" he will be turned onto his side. He needs to be calm for five minutes and then the leg hobbles will be released. After another five minutes of calm the handcuffs will be removed. The focus on the plan was to stop the "maladaptive behavior" with no indication of how staff would elicit or strengthen appropriate behavior.<br><br>Employee (B)/behavior analyst one was interviewed on January 11, 2008 at 8:10 p.m. and stated that when a client exhibits a behavior that could lead to injury such as physical aggression or self injurious behaviors, or if a client is destructive to property, The staff utilize the following techniques: personal boundaries, negotiation and cueing, then escort, and then restraint and if the client has a Rule 40 restraint plan that is initiated as written. In addition, the type of restraint is individualized. However, the | W 295 | Persons Responsible: Scott TenNapel, Ph.D., L.P. METO Clinical Director<br><br>IPPs for all clients placed in the facility's ICF/MR program will be revised to effect an immediate reduction in the use of restraints by increasing the standard of severity of behavior for which use of restraint is indicated. Specifically, no use of restraint will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury. 2/26/08<br><br>Persons Responsible: Scott TenNapel, Ph.D., L.P., METO Clinical Director; Beth Klute and Julie Patten, BA3s and QMRPs | |





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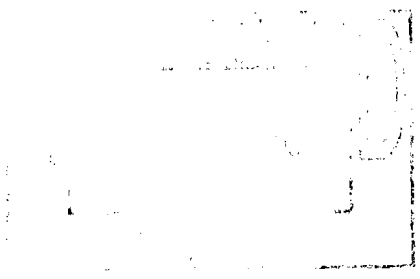
| W 295 | Continued From page 57<br>restraints used for the Rule 40 clients have been metal handcuffs or Posey soft handcuffs and leg hobbles (the cuffs an hobbles are used together), or Posey board, and of the five clients in the ICF/MR with Rule 40's all but one are put in handcuffs (metal or Posey) and leg hobbles.<br><br>Employee (E)/administrative staff was interviewed on January 31, 2008 at 9:30 a.m. and stated that the clients admitted at the facility should only be restrained to reduce target behaviors that are dangerous or likely to lead to dangerous behavior.<br><br>When two specific examples of client #3 being restrained, related to television viewing, were mentioned by the investigator, employee (E) stated that from the sounds of the examples reviewed, the risk analysis (risk of continuing the activity versus the risks of restraining) is "all out of whack."<br><br>The facility as a whole does not have a "no-touch" policy. There should be "household agreements," reviewed and open for negotiation, made by the people who live in a household. The "no-touch" policy is intended to be a therapeutic support for people who are aggressor's, the recipient of another's aggression, or there are other problems with interpersonal boundaries. If a client failed to observe the practice of "no-touch" and simply touched another client, that would not constitute a dangerous situation. | W 295 | | |
| W 296 | 483.450(d)(1)(ii) PHYSICAL RESTRAINTS<br><br>The facility may employ physical restraint as an emergency measure, but only if absolutely necessary to protect client or others from injury. | W 296 | The facility has modified its documentation format and administrative review process for any use of restraint, to assure that less intrusive techniques were | 2/26/08 |





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| W 296 | Continued From page 58<br>This STANDARD is not met as evidenced by:<br>Based on interview and record review, the facility failed to anticipate known client behavior thus emergency restraints were unnecessarily utilized in place of alternative interventions for three of nine clients (#3, #4, and #9), in the sample. Findings include:<br><br>Client #3's medical record was reviewed and revealed that he has mild mental retardation, degenerative arthritis, osteoarthritis, limited range of motion in his left leg, a history of knee pain, and prefers to use a wheelchair. A review of his individual program plan (IPP) revealed that when client #3 is frustrated, he displays verbal and physical aggression and after he has asked for help he, "becomes increasingly agitated when others encourage him to complete tasks independently." A review of the facility's "Documentation for Emergency Use of Controlled Procedure" revealed emergency restraints were utilized on client #3 on March 29, 2007, May 10, 2007, June 20, 2007, June 23, 2007, multiple times on August 5, 2007, September 6, 2007, and on September 26, 2007, for behavior that the documentation indicates is likely to re-occur, therefore, the behavior should have been anticipated by staff and interventions implemented to de-escalate the situation instead of escalating the situation. In addition, given the client's diagnoses of degenerative arthritis, osteoarthritis, and knee pain the use of handcuffs and leg hobbles was severe. In addition, on March 29, 2007, May 10, 2007, and two incidents on August 5, 2007, as a result of being physically escorted by staff, client #3 hit or shoved the staff that were escorting him.<br><br>Client #4's medical record was reviewed and | W 296 | tried and found to be ineffective or reasons why less intrusive interventions could not be used.<br><br>The facility has established a debriefing process to monitor and provide coaching regarding staff implementation of restraint.<br><br>IPPs for all clients placed in the facility's ICF/MR program will be revised to ensure that each client's program includes a specific system of positive non-aversive) response to behaviors that are identified as precursors to more serious problem behaviors that may result in a need for restraint.<br><br>Persons Responsible: Scott TenNapel, Ph.D. L.P.,METO Clinical Director; Beth Klute and Julie Patten, BA3s and QMRPs<br><br>The facility will implement a quality management process to ensure that the QMRP makes changes to client IPPs such that adequate treatment velocity is maintained for all clients who have experienced use of restraint. Specifically, monthly data reflecting the use of | 2/26/08<br><br>2/26/08 |

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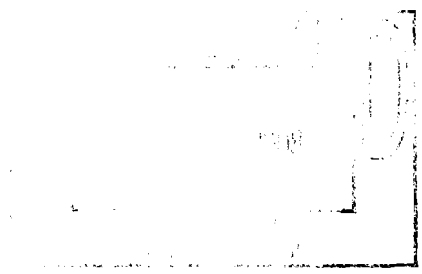
| W 296 | Continued From page 59<br>indicated that she has mild mental retardation, asthma, epilepsy, and a history of poking others and throwing personal items at others heads. The client's history indicates that when she gets agitated or angry she may display maladaptive behaviors. A review of the facility's "Documentation for Emergency Use of Controlled Procedure" revealed emergency restraints were utilized for 50 minutes on client #4 on May 24, 2007 for touching staff and on May 30, 2007, for trying to shove staff. In both instances the client was first manually restrained then mechanically restrained.<br><br>Client #9's medical record was reviewed and his diagnoses included mild mental retardation and autism. According to the client's IPP, he has a history of physical aggression, self injurious behaviors, and property destruction. When he gets frustrated or angry, he exhibits "running, self injurious behaviors, ignoring staff directions, and loud vocalizations." A review of the facility's "Documentation for Emergency Use of Controlled Procedure" revealed emergency restraints were utilized on client #9 multiple times on August 5, 2007, on August 24, 2007, and on September 28, 2007, for inappropriate laughter, hitting himself, and biting himself. The behaviors were known and therefore should have been anticipated and interventions implemented to de-escalate the situation instead of escalating the situation. In addition, the use of handcuffs and leg hobbles was severe given the nature of the behavior.<br><br>Employee (B)/behavioral analyst I was interviewed on January 11, 2008 at 8:10 a.m., and stated that emergency restraints are utilized until a plan is in place to address inappropriate behaviors. | W 296 | restraints and progress in treatment will be reviewed by the facility's Clinical Director, or other designee who is a mental health professional with competency in psycho-educational treatment of individuals with developmental disability, with the object of effecting appropriate revision to the client's IPP in order to reduce the need for restraint.<br><br>Persons Responsible: Scott TenNapel, Ph.D. L.P., METO Clinical Director<br><br>With a policy change effective 11-23-07 the facility prohibited the emergency use of mechanical restraint of any client placed in the ICF/MR program. All staff assigned to the ICF/MR building have been trained to this change.<br><br>Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D., L.P., METO Clinical Director | 2/26/08 |





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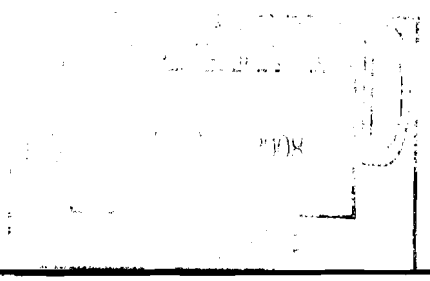
| W 296 | Continued From page 60<br><br>Employee (E)/administrative staff was interviewed on January 31, 2008 at 9:30 a.m. and stated that the clients admitted at the facility should only be restrained to reduce target behaviors that are dangerous or likely to lead to dangerous behavior.<br><br>When two specific examples of client #3 being restrained, related to television viewing, were mentioned by the investigator, employee (E) stated that from the sounds of the examples reviewed, the risk analysis (risk of continuing the activity versus the risks of restraining) is "all out of whack."<br><br>The facility as a whole does not have a "no-touch" policy. There should be "household agreements," reviewed and open for negotiation, made by the people who live in a household. The "no-touch" policy is intended to be a therapeutic support for people who are aggressor's, the recipient of another's aggression, or there are other problems with interpersonal boundaries. If a client failed to observe the practice of "no-touch" and simply touched another client, that would not constitute a dangerous situation. | W 296 | The facility will change its policy regarding emergency use of manual restraint of clients placed in the ICF/MR program to effect an immediate reduction in use of restraint by increasing the standard of severity of behavior for which emergency use of manual restraint is indicated. Specifically, no use of restraint will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury.<br>(Continued on attached sheet) | 2/26/08 |
| W 304 | 483.450(d)(5) PHYSICAL RESTRAINTS<br><br>Restraints must be designed and used so as not to cause physical injury to the client.<br><br>This STANDARD is not met as evidenced by:<br>Based on interview and record review, the facility failed to protect clients from physical injury during a restraint procedure for three of nine clients (#6, #7, #9) in the sample who had behaviors.<br>Findings include: | W 304 | The facility will change its policy regarding use of manual restraint, both emergency and programmatic, to ensure that staff response to a situation indicating use of manual restraint follows a sequential application of physical techniques, beginning with the least intrusive technique likely to effect significant change in | 2/26/08 |





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| W 304 | Continued From page 61<br>According to progress notes in client #6's medical record, on August 11, 2007, at 8:11 a.m. the client "began to come at staff in an aggressive manner. Staff redirected client to room. [Client #6] went in room but came out again within several seconds. [Client #6] then began to grab at staff with force. Staff implemented Rule 40 (the facility's specially constituted committees' pre-approved restrictive behavior management practice), by first putting [client #6] in an arm bar. [Client #6] resisted the arm bar and continued to claw and grab at staff. [Client #6] went to his knees but continued to fight. Staff then implemented an arm bar take down. As staff did this, [client #6] turned away from implementor to another staff, grabbing and clawing. At this moment implementor felt and heard upper left arm pop. Staff immediately stopped the arm bar take down and alerted the other staff. [Client #6] laid on the ground face down but still attempted to aggress by grabbing at staff, even though left arm had possible injury he aggressed with it. Staff attempted to keep [client #6] still, especially his left arm. Staff verbally prompted [client #6] to calm down. [Client #6] calmed down a little but was still struggling. Staff called 9-1-1 and notified R.N." A splint was applied and the client was transported to the hospital by emergency medical technicians. Client #6 had a left distal humerus fracture and was admitted to the hospital for pain control after his arm was set and splinted. He returned to the facility on August 13, 2007. He returned to the hospital on August 28, 2007 for surgical repair of his fractured arm and returned to the facility on August 29, 2007.<br><br>According to documentation on incident reports, on October 12, 2007, at 8:30 a.m., client #7 sustained a "nickel sized swelling right outer | W 304 | client behavior, progressing to more intrusive techniques only if less intrusive techniques have been tried and are unsuccessful, or if the risk of attempting less intrusive techniques is unacceptably high. Specifically, the physical technique associated with the injury to Client #6 would not be the least intrusive technique and therefore would not be the first to be applied, barring an unacceptable risk if it were not used first. All staff will be trained to this policy change.<br><br>Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D., L.P., METO Clinical Director<br><br>The facility will implement a program of staff debriefing, for the purpose of determining whether each use of emergency restraint was clinically appropriate, i.e., was balanced in risk of negative impact against the risk of allowing the continuation of the behavioral situation that triggered the use of restraint, and fully adherent to facility policy. Debriefing will be | 2/26/08 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| W 304 | Continued From page 62<br>orbit/brow of eye. Two bruised areas present. Client reportedly was banging head on floor. Staff attempted to move pillow under client's head during restraint however the client would not permit it to remain there." Description of the behavior for which client #7 was restrained, recorded on the "Documentation for Emergency Use of Controlled Procedure" form, dated October 12, 2007, at 8:35 a.m. indicated that client #7 was asked to take her bath and medication. The client began yelling and screaming at staff. When staff entered the bedroom, client #7 attempted to hit staff. The client was put in a manual restraint in prone position. After two minutes, mechanical restraints were applied. The procedure ended at 8:55 a.m. Documentation indicated that after the restraint procedure, client #7 was "very emotional and crying, stating she can't go to work today." The nurse assessment, at 9:05 a.m., indicated the client was anxious, and was rocking in the rocking chair.<br><br>On December 11, 2007, at 5:10 p.m. a staff person was getting water from client #7's refrigerator when the client, "came at staff yelling." The client "lunged at staff, threw a glass of water at staff, came at staff with fists raised." Staff executed an arm bar take down into a manual hold. The client struggled, scratched and yelled for twenty minutes. The nurse assessment indicated the color of the client's face and hands remained normal even though she yelled she couldn't breathe. At 5:30 p.m., client #7 was crying and went into her room. Documentation indicated the client said she was "sore." An incident report indicated that "during emergency restraint [client #7] was struggling, refusing to take her right arm out from under her chest, a | W 304 | conducted by a supervisor or Administrative Officer of the Day within 60 minutes following each use of emergency restraint. Data regarding this debriefing will be incorporated into the facility performance improvement monitoring plan.<br><br>Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D.,L.P., METO Clinical Director<br><br>The facility will implement a program of debriefing and aftercare for clients, following each use fo emergency or programmatic restraint, that is appropriate to the developmental level of the client, for the purpose of minimizing emotional anguish, through assisting the client to understand the circumstances giving rise to the need for restraint or emergency medication, and identifying strategies or modifications to the client's IPP or program environment that might reduce the need for future use of restraint or emergency medication. | 2/26/08 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 24G502 | A. BUILDING _____ B. WING _____ | C 01/17/2008 |

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| W 304 | Continued From page 63<br>small abrasion on her right elbow due to resisting on carpeted area."<br><br>An incident report, dated September 13, 2007, at 9:00 a.m., indicated that after being restrained, client #9 went into his bedroom and banged his head against the wall. He sustained a two centimeter abrasion mid-forehead and a two centimeter abrasion on his right temple. Description of the behavior for which client #9 was restrained, recorded on the Documentation for Emergency Use of Controlled Procedure form, dated September 13, 2007, at 8:10 a.m., indicated that while client #9 was doing his laundry, he "slammed his hamper. Walked to his room [and] threw hamper lid, talking to himself and pacing. He then said "shot" and went toward med cart. Staff asked if he was okay [and] opened his bedroom door." Client #9 was restrained due to "physical aggression-pulled staffs hair & grabbed, scratched staffs shoulder [and] neck area." During manual restraint, the client struggled for two minutes so mechanical restraints were applied. The client continued to struggle for a total of twenty-nine minutes. The procedure ended at 8:44 a.m. At 2:32 p.m., "[client #9] went to his mental health review [and] did well, when he got out side he yelled, "pop, cookie" [and] began to flick his fingers infront of his face, walking rapidly [and] his body was shaking. He got into the household, grabbed staff by both their shoulders [and] shook her." Client #9 was restrained due to physical aggression --"grabbed staff by shoulders [and] began to shake her." The client struggled for thirteen minutes. At 2:40 p.m. client #9 received two milligrams of Ativan IM. The restraint procedure ended at 2:55 p.m , after 23 minutes. | W 304 | Debriefing will be conducted by staff assigned to each client's living unit, and will be guided by a written plan developed by the client's treatment team and monitored for appropriateness by the QMRP.<br><br>Persons Responsible: Scott TenNapel, Ph.D., L.P., METO Clinical Director; Beth Klute and Julie Patten, BA3s and QMRPs<br><br>With a policy change effective 11-23-07 the facility prohibited the emergency use of mechanical restraint of any client placed in the ICF/MR program. All staff assigned to the ICF/MR building have been trained to this change.<br><br>Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D., L.P., METO Clinical Director<br><br>The facility will change its policy regarding emergency use of manual restraint of clients placed in the ICF/MR program to effect an immediate reduction in use of restraint by increasing the standard of severity of behavior | 2/26/08<br><br>2/26/08<br><br>2/26/08 |

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| W 304 | Continued From page 64<br>Employee (A)/administrative staff was interviewed on January 10, 2008 at 10:15 a.m. and stated that the injuries related to restraint use have included redness from the handcuffs, and one broken arm (client #6). The majority of the bumps, bruises, and rug burns on the head, knees, and elbows are from the manual restraints. | W 304 | for which emergency use of manual restraint is indicated. Specifically, no use of restraint will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury.<br><br>The facility will change its policy on emergency use of psychotropic medications to ensure that such use is exclusively for the reduction of symptoms of an identified psychiatric condition.<br><br>The facility will revise its policy on programmatic use of restraint (i.e., "Rule 40" programs) for clients placed in the ICF/MR program to reduce the use of programmatic restraint by increasing the standard of severity of behavior for which use of restraint is indicated. Specifically, no use of restraint will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury.<br><br>(Continued on attached sheet) | 2/26/08<br><br>2/26/08 |

| ID Prefix Tag | Action Taken as Part of Plan of Correction | Expected Date of Completion |
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| **W122 (Cont.)** | The facility will change its policy regarding emergency use of manual restraint of clients placed in the ICF/MR program to effect an immediate reduction in use of restraint by increasing the standard of severity of behavior for which emergency use of manual restraint is indicated. Specifically, no use of restraint will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury.<br><br>The facility will change its policy on emergency use of psychotropic medications to ensure that such use is exclusively for the reduction of symptoms of an identified psychiatric condition.<br><br>The facility will revise its policy on programmatic use of restraint (i.e., "Rule 40" programs) for clients placed in the ICF/MR program to reduce the use of programmatic restraint by increasing the standard of severity of behavior for which use of restraint is indicated. Specifically, no use of restraint will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury.<br><br>All staff assigned to the ICF/MR building will be trained to this change.<br><br>Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D., L.P. METO Clinical Director | 2/26/08 |
| | Effective 01-08-08 the facility implemented a process of disclosure, for use at admission to the facility, involving clients, legal representatives, and members of clients' Expanded Interdisciplinary Teams, describing the facility's policy regarding emergency use of restraints, including a written and photographic description of restraints used, soliciting concerns from clients and their teams regarding the facility's use of restraint, and offering consultation with clinical staff toward identification of alternatives to restraint.<br><br>Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D., L.P. METO Clinical Director; Kim Palmer and Connie O'Brien, METO Social Workers | 2/26/08 |
| | The facility increased requirements for Registered Nurse oversight of restraint use to include direct examination and documentation of the client's response to each implementation of restraint, effective 11-07.<br><br>Persons Responsible: Doug Bratvold, METO Director; Shirley Davis, R.N. METO Nursing Supervisor | 2/26/08 |
| | Effective 01-08, the facility increased requirements for QMRP oversight of emergency use of restraint to include enhanced evaluation of factors that may have contributed to the use of restraint, effectiveness of less restrictive alternatives attempted, specific recommendations for changes to the client's IPP to reduce need for further restraint, and communication / collaboration with members of the Expanded Interdisciplinary Team, including the legal representative and County case manager. QMRP documentation is recorded on a newly developed form and will be tracked as part of ongoing file audits.<br><br>Persons Responsible: Scott TenNapel, Ph.D., L.P. METO Clinical Director | 2/26/08 |

| ID Prefix Tag | Action Taken as Part of Plan of Correction | Expected Date of Completion |
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| **W122 (Cont.)** | IPPs for all clients placed in the facility's ICF/MR program will be revised to effect an immediate reduction in the use of restraints by increasing the standard of severity of behavior for which use of restraint is indicated. Specifically, no use of restraint will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury.<br><br>Persons Responsible: Scott TenNapel, Ph.D., L.P. METO Clinical Director; Beth Klute and Julie Patten, BA3s and QMRPs | 2/26/08 |
| | The facility implemented a staff training initiative to increase staff skill in positive behavior management (alternatives to restraint) effective December 14, 2007. All staff currently assigned to the ICF/MR program will receive this training. This training has also been added to the new employee orientation curriculum, and to the annual staff refresher training curriculum.<br><br>The facility implemented a staff training initiative to increase staff awareness of the adverse impact of restraint use effective December 20, 2007. All staff currently assigned to the ICF/MR program will receive this training. This training has also been added to the new employee orientation curriculum, and to the annual staff refresher training curriculum.<br><br>Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D., L.P. METO Clinical Director; Pam Zimmerman, Staff Development Coordinator | 2/26/08 |
| **W266 (Cont.)** | restraint is used in emergencies only as absolutely necessary to protect the safety of clients or others; and ensure that restraints are designed and used so as not to cause injury to the client. The facility will ensure compliance with this standard through actions specified in responses to tags W268, W278, W285, W288, W289, W295, W296 and W304.<br><br>Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D., L.P., METO Clinical Director | 2/26/08 |
| **W268 (Cont.)** | curriculum, and to the annual staff refresher training curriculum.<br><br>The facility implemented a staff training initiative to increase staff awareness of the adverse impact of restraint use effectivfe December 20, 2007. All staff currently assigned to the ICF/MR program will receive this training. This training has also been added to the new employee orientation curriculum, and to the annual staff refresher training curriculum.<br><br>Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D., L.P. METO Clinical Director; Pam Zimmerman, Staff Development Coordinator | 2/26/08 |
| **W285 (Cont.)** | restraint will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury.<br><br>Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D., L.P. METO Clinical Director | 2/26/08 |
| | The facility's specially constituted committee will be oriented to changes in policy regarding both emergency and programmatic use of restraint, to ensure their review and approval process meets the revised policy's increased standard of severity of behavior for which use of restraint is indicated. Specifically, no use of restraint will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury.<br><br>Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D., L.P. METO Clinical Director | 2/26/08 |

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| **W296 (Cont.)** | The facility will change its policy on emergency use of psychotropic medications to ensure that such use is exclusively for the reduction of symptoms of an identified psychiatric condition.<br><br>The facility will revise its policy on programmatic use of restraint (i.e., "Rule 40" programs) for clients placed in the ICF/MR program to reduce the use of programmatic restraint by increasing the standard of severity of behavior for which use of restraint is indicated. Specifically, no use of restraint will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury.<br><br>All staff assigned to the ICF/MR building will be trained to this change.<br><br>Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D., L.P. METO Clinical Director | 2/26/08 |
| | Effective 01-08, the facility increased requirements for QMRP oversight of emergency use of restraint to include enhanced evaluation of factors that may have contributed to the use of restraint, effectiveness of less restrictive alternatives attempted, specific recommendations for changes to the client's IPP to reduce need for further restraint, and communication / collaboration with members of the Expanded Interdisciplinary Team, including the legal representative and County case manager. QMRP documentation is recorded on a newly developed form and will be tracked as part of ongoing file audits.<br><br>Persons Responsible: Scott TenNapel, Ph.D., L.P. METO Clinical Director | 2/26/08 |
| | IPPs for all clients placed in the facility's ICF/MR program will be revised to effect an immediate reduction in the use of restraints by increasing the standard of severity of behavior for which use of restraint is indicated. Specifically, no use of restraint will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury.<br><br>Persons Responsible: Scott TenNapel, Ph.D., L.P. METO Clinical Director; Beth Klute and Julie Patten, BA3s and QMRPs | 2/26/08 |
| **W304 (Cont.)** | All staff assigned to the ICF/MR building will be trained to this change.<br><br>Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D., L.P. METO Clinical Director | 2/26/08 |

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| **W304 (Cont.)** | The facility will change its policy regarding emergency use of manual restraint of clients placed in the ICF/MR program to effect an immediate reduction in use of restraint by increasing the standard of severity of behavior for which emergency use of manual restraint is indicated. Specifically, no use of restraint will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury.<br><br>The facility will change its policy on emergency use of psychotropic medications to ensure that such use is exclusively for the reduction of symptoms of an identified psychiatric condition.<br><br>The facility will revise its policy on programmatic use of restraint (i.e., "Rule 40" programs) for clients placed in the ICF/MR program to reduce the use of programmatic restraint by increasing the standard of severity of behavior for which use of restraint is indicated. Specifically, no use of restraint will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury.<br><br>All staff assigned to the ICF/MR building will be trained to this change.<br><br>Persons Responsible: Doug Bratvold, METO Director; Scott TenNapel, Ph.D., L.P. METO Clinical Director | 2/26/08 |
| | The facility increased requirements for Registered Nurse oversight of restraint use to include direct examination and documentation of the client's response to each implementation of restraint, effective 11-07.<br><br>Persons Responsible: Doug Bratvold, METO Director; Shirley Davis, R.N. METO Nursing Supervisor | 2/26/08 |
| | Effective 01-08, the facility increased requirements for QMRP oversight of emergency use of restraint to include enhanced evaluation of factors that may have contributed to the use of restraint, effectiveness of less restrictive alternatives attempted, specific recommendations for changes to the client's IPP to reduce need for further restraint, and communication / collaboration with members of the Expanded Interdisciplinary Team, including the legal representative and County case manager. QMRP documentation is recorded on a newly developed form and will be tracked as part of ongoing file audits.<br><br>Persons Responsible: Scott TenNapel, Ph.D., L.P. METO Clinical Director | 2/26/08 |
| | IPPs for all clients placed in the facility's ICF/MR program will be revised to effect an immediate reduction in the use of restraints by increasing the standard of severity of behavior for which use of restraint is indicated. Specifically, no use of restraint will be prescribed for use in response to any behavior which does not pose a risk of immediate, serious injury.<br><br>Persons Responsible: Scott TenNapel, Ph.D., L.P. METO Clinical Director; Beth Klute and Julie Patten, BA3s and QMRPs | 2/26/08 |

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| 5 000 | Initial Comments<br><br>In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number or MN Statute indicated below. When a rule or statute contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.<br><br>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.<br>On January 17, 2008, investigators with the Office of Health Facility Complaints competed a complaint investigation, which began on January 10, 2008, at Minnesota Extended Treatment Options. The following correction order is issued. When corrections are completed, please sign and date, make a copy of the form for your records and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Office of Health Facility Complaints; 85 East Seventh Place, Suite 220; P.O. Box | 5 000 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Supervised Living Facilities.<br><br>The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule | |

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| 5 000 | Continued From page 1<br>64970, St. Paul, Minnesota 55164-0970. | 5 000 | out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by."<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | |
| 5 700 | MN Statute 144.651 Subd. 14. RES. RIGHTS Freedom from maltreatment.<br><br>Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and nontherapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from nontherapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. | 5 700 | | |

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| 5 700 | Continued From page 2<br><br>This MN Requirement is not met as evidenced by:<br>Based on documentation review and interview, the facility failed to ensure that clients were free from unnecessary drugs and physical restraints for ten of eleven clients (#1, #2, #3, #4, #6, #7, #8, #9, #10, and #11) in the sample. Findings include:<br><br>The following examples show a chronic use of restraints to control client behaviors that are prompted by staff behavior and/or are not threatening to the health of individuals. In addition, when the clients are restrained their arms are handcuffed behind their back with either metal handcuffs or soft Posey wrist restraints, and their legs are crossed and hobbled (a hobble is a nylon strap that is wrapped around a client's lower legs, tightened, and secured with Velcro) with a RIPP (brand name) restraint.<br><br>Client #1 was admitted to the facility in August 2003. His diagnoses included schizoaffective disorder, conduct disorder, pervasive developmental disorder, and mild mental retardation. He has a history of severe aggression and severe self-injury with multiple head injuries. According to his "Informed Consent for Controlled Procedures" form, dated January 23, 2007 to April 23, 2007, the facility utilized manual restraints, physical escort, and the following mechanical restraints: a RIPP restraint board (a client is put on their back and restrained on a board), RIPP straps (straps utilized for restraining a client's extremities), and RIPP cuffs (wrist restraints). The Informed Consent for Controlled Procedures form, dated September 30 to December 29, 2007, indicated that client # 1's target behaviors included eye poking, touching above the shoulder without permission, striking, | 5 700 | | |

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| 5 700 | Continued From page 3<br><br>hitting, punching, kicking, scratching, biting, or pulling hair. His self injurious behavior included repeated and forceful hand-to-head hitting/punching; head-to-surface hitting; scratching/picking sores and eye gouging. The informed consent indicated that if the client engaged in physical aggression or touching without permission, staff would immediately implement the use of controlled procedures using a RIPP Restraint Board until the client was calm and ceased resisting. If the client engaged in self-injurious behavior, staff would prompt the client to go to a quiet area. If he refused the first prompt, staff would escort him to the area and verbally prompt him to lie down and relax. If he refused to relax on his own and continued to exhibit self-injurious behaviors, client #1 would be restrained using a RIPP Restraint Board. Staff could implement the use of RIPP cuffs or straps to assist them in securing the client's hands and arms. In addition to physical restraints, the "Informed Consent for Psychotropic Medications", dated December 15, 2007 to December 14, 2008, indicated that client #1 received the following: Depakote 3000 (up to 4000) milligrams a day, Clozaril 600 (up to 900) milligrams a day, Geodon 200 milligrams a day, Haldol 1 (up to 10) milligram a day and Zoloft 100 (up to 200) milligrams a day.<br><br>A temporary interruption program (a less restrictive procedure) was added to client #1's program on July 31, 2007. If the client touched others or spit directly on others, up to two times in an hour, staff would direct the client a safe distance away from others, but where he could still observe others. Staff would inform the client that touching others without permission/spitting on others was inappropriate and that his "program" was implemented. Staff would direct | 5 700 | | |

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| 5 700 | Continued From page 4<br><br>the client to sit on the floor and inform him of the 3 minute criteria of calm. If the client touched/spit directly on others 3 times in an hour, staff would implement the RIPP mechanical wrist restraints and inform the client of the 5 minute "calm criteria." If the client engaged in aggression or serious self-injurious behavior while in the wrist restraints, staff would then implement the restraint board. Staff would also implement the RIPP wrist restraints procedure if the client exhibited aggression towards others. For this client, touching others above the shoulder was considered aggression.<br><br>The Informed Consent for Controlled Procedures form indicated that client #1 had eleven incidents of aggression from January 22, 2001 to February 4, 2001, "his baseline period." He had six incidents of physical aggression from November 1, 2007 to November 15, 2007. The form indicates that the client had thirteen incidents of touching others from January 22, 2001 thru February 4, 2001, "his baseline period." Data from November 1, 2007 to November 25, 2007 indicated that the client had thirty-one incidents of touching others.<br><br>The "Informed Consent for Controlled Procedures" form, dated December 15, 2007 to March 14, 2008, indicated that the facility continues to use the RIPP restraint board, straps and cuffs for client #1's target behaviors.<br><br>"Documentation for Implementation of Approved Aversive and/or Deprivation Procedures" forms indicated client #1 was restrained on the following dates, for his target behaviors:<br><br>*On February 9, 2007, client #1 walked into the resident phone room and "touched peer." Client | 5 700 | | |

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| 5 700 | Continued From page 5<br>#1 was mechanically restrained (no specifics noted) from 3:09 p.m. to 3:24 p.m. When the client was "completely released" he touched a staff person. He was re-restrained mechanically, (again no specifics noted) from 3:29 p.m. to 4:14 p.m., for a total of 50 minutes. During the time the client was restrained it was noted that he was "screaming, crying and swearing " at staff. At 4:24 p.m. client #1 was restrained per his " Rule 40 on board " again for " yelling, crying, screaming and swearing at staff." He was restrained until 5:04 p.m., another 40 minutes. Client #1 was restrained one more time on February 9, 2007. At 5:10 p.m., client #1 was restrained "Rule 40 on board" for "yelling, screaming and swearing." He was released at 5:23 p.m., after 18 minutes. Client #1 also received Benadryl, 25 milligrams and Ativan, 2 milligrams IM at 5:00 p.m.<br>*On February 12, 2007, client #1 was mechanically restrained, from 8:30 a.m. to 8:55 a.m., for 25 minutes. The target behavior was touching staff with a sock. At 10:14 a.m., client #1 was restrained for touching staff. He was restrained until 10:56 a.m., a total of 42 minutes. At 2:14 p.m., client #1 was restrained because he "came up to the table to touch peers belongings, pounded his head unto [sic] table with force." He was released at 2:34 p.m., a total of 20 minutes restrained. At 4:35 p.m., client #1 was restrained for a fourth time, for "pushing staff " twice. The client was talking with staff at the "office door." He was released from the restraint at 4:45 p.m.<br>*On February 15, 2007, client #1 was mechanically restrained for 50 minutes, from 8:00 a.m. to 8:50 a.m., for walking up to a peer and touching him twice. During the restraint procedure, client #1 was crying, screaming, and swearing. Client #1 received Haldol, 5 milligrams and Ativan, 1 milligram at 8:40 a.m. The client | 5 700 | | |

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| 5 700 | Continued From page 6<br>was restrained for another 50 minutes, from 8:55 a.m. to 9:40 a.m. Again, he was yelling and crying. At 9:45 a.m., he was re-restrained for another 50 minutes, until 10:35 a.m. He received Ativan, 1 milligram at 10:10 a.m. The client was crying and swearing at staff. At 10:40 a.m. (after three prior implementations of his Rule 40 program), client #1 was restrained. He was released at 11:00 a.m., after 20 minutes.<br>*On February 17, 2007, client #1 was mechanically restrained for 50 minutes, from 8:50 a.m. to 9:40 a.m. for touching staff with a sock. During the restraint procedure, client #1 was crying and swearing. As a result, the Rule 40 was continued and client #1 was restrained from 9:40 a.m. to 10:30 a.m. The client had 25 milligrams of Benadryl at 10:22 a.m. The client continued in restraints from 10:30 a.m. to 11:20 a.m. The client was crying, screaming, and yelling during this time. A second dose of Benadryl was given at 10:58 a.m. for not "calming." The restraint procedure continued. The client was restrained from 11:20 a.m. to 12:10 p.m., 50 minutes.<br>*On March 23, 2007, client #1 was mechanically restrained from 9:54 a.m. to 10:40 a.m. for touching staff. He was crying and calling people names. The restraint continued, from 10:40 a.m. to 11:30 a.m. At 11:30 a.m. Benadryl was given. The client continued to cry and scream. The restraint continued from 11:30 a.m. to 12:08 a.m. At 12:25 p.m. the client was restrained for touching "staff's walkie." The client was restrained until 1:15 p.m. At 1:28 p.m. the client was restrained for touching staff while staff was holding the "walkie". The restraint was on until 1:51 p.m. (22 minutes.) At 6:35 p.m. the client was restrained for touching a peer's finger. He was restrained until 6: 47 p.m., 12 minutes.<br>*On May 29, 2007, client #1 was mechanically restrained for 65 minutes, from 9:00 a.m., to | 5 700 | | |

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| 5 700 | Continued From page 7<br><br>10:05 a.m. No target behavior was noted. The antecedent noted was, "[client #1] sat down then immediately reached for staff as staff came up to talk." Client #1 was restrained from 11:10 a.m. to 11:56 a.m. for touching a "staff's walkie" while the staff was holding it. The client was restrained from 12:19 p.m. to 12:33 p.m. as, "[client #1] walked into a staff office and deliberately touched the staff."<br>*On November 20, 2007, client #1 was mechanically restrained from 10:15 a.m. to 10:30 a.m., for throwing a rag in a peer's face. The client was restrained from 11:56 a.m. to 12:11 p.m. for touching a staff's face. The client was restrained from 12:33 p.m. to 12:52 p.m. for touching a peer on his back, above his shoulders. And the client was restrained from 6:58 p.m. to 7:13 p.m. for touching staff "for the 3rd time in an hour period."<br><br>In summary, between January 1, 2007 and December 26, 2007, client #1 was restrained 143 times for touching a peer or staff person (including 12 times, which he did not calm down during a restraint procedure, consequently, he was re-restrained). Depending on his response, he was restrained from 5 to 65 minutes each time. He was restrained many other times for behaviors other than touching. However, as noted above, the periods of restraint were often one right after the other and there were examples of the client receiving medication along with the physical restraints.<br><br>Client #1 was observed at his day program on January 11, 2008. When he walked to and from the sensory room, with a staff person, the client touched doors, light switches, electrical outlets, and walls. The staff person asked the client to stop touching the items, and client #1's response | 5 700 | | |

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| 5 700 | Continued From page 8<br>was to touch the wall one more time.<br><br>Client #2 has moderate mental retardation, autism, and deafness. A review of the facility's "Documentation For Implementation Of Approved Aversive And/Or Deprivation Procedures, " revealed the following:<br>*On April 15, 2007 at 6:28 p.m., client #2 was eating and hit her elbows on a chair. She was cued to "stop," but client #2 "ignored" the request and hit the table with her elbows. The staff cued the client to "stop and go to her room." Then the client threw her plate and milk across the table and was restrained in leg hobbles and soft wrist cuffs for four minutes. The supervisory comments indicated that the use of the restraints was due to property destruction and was appropriate.<br>*On May 4, 2007 at 3:20 p.m., client #2 was in the rocking chair watching a movie and then hit her right forearm on the wall and also hit the wall with a closed fist, bit her "pointer finger," and kicked an end table with her right foot. Then she laid down on the floor and signed "finished". The client was put in leg hobbles and soft cuffs for four minutes. The form indicates that no other interventions were available. The supervisory comments indicated that use of the restraints was appropriate.<br>*On May 5, 2007 at 12:55 p.m., client #2 "awoke obsessing about shopping. Staff told her no shopping." At lunch client #2 requested more food and was told she would not get any more food. The staff explained that she would not be able to go shopping because of "behaviors" on May 4, 2007. Client #2 "cleared table and threw all dishes toward staff." The client was then restrained in accordance with her Rule 40 plan (the facility's specially constituted committees' pre-approved restrictive behavior management practice). Her legs were crossed, then hobbled, | 5 700 | | |

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| 5 700 | Continued From page 9<br>and her wrists were restrained behind her back in soft Posey cuffs for four minutes. The supervisory comments indicated that the use of the restraints was in accordance with her program and were appropriate.<br>*On May 17, 2007 at 5:28 p.m., client #2 "was rocking in her chair when she slapped the wall, hit her leg." Then the client laid down on the floor and kicked the nearest staff. She was cued to stop and calm down, "she refused" and was restrained in soft cuffs and hobbles for six minutes. Supervisor comments indicated that the use of the restraints was appropriate.<br>*On June 25, 2007 at 12:27 a.m., client #2 was "perseverating" on a home visit that was scheduled and wanted medication set up. Staff signed for client #2 to go to bed and that "work" would be finished the next day. Client #2 informed staff that she wanted to be tucked into bed. The "client went into her room [and] began hitting dresser and walls with hands with enough force to possibly hurt hands.(Also threw dresser into middle of room; but, stopped on own w/o redirect.)" Client #2 laid down on the floor per the staff's request and was put in restraints. Her wrists were put in soft cuffs and her legs were hobbled for four minutes. The supervisory comments indicated that the use of the restraints was appropriate.<br>*On July 10, 2007 at 4:13 p.m., client #2 was sitting at a table eating her snack when she "knocked" a glass of water and "shoved" a box of crafts off the table. Client #2 was told to "stop" and "lie down" and was restrained for ten minutes. During the time she was restrained she, "did minor SIB" (self injurious behavior), slapping her sides for six minutes. The client was released after being calm for four minutes. The supervisory comments indicated that the use of the restraints was appropriate. | 5 700 | | |

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| 5 700 | Continued From page 10<br>*On July 25, 2007, at 2:34 p.m., client #2 was sitting at her work table hitting her hand on the corner of the table and banging her knee on the floor, biting her lips and hand "hard". Staff signed for her to stop. She was restrained for twelve minutes. No documentation of restraining device utilized other than hobble. The supervisor indicated the use of the restraint was appropriate. Client #2 was again restrained at 2:49 p.m., for six minutes because she punched the floor and was "kicking at staff." Supervisory comments indicated that her behavior continued after release from restraints, the restraint procedure was again implemented and the use of the restraint was appropriate. At 2:58 p.m., after release from her Rule 40 restraints, staff attempted to escort her back to her household, when she started, "minor" self injurious behavior. Staff redirected her to stop. She began kicking staff and was restrained for six minutes. After being calm for two minutes she was given Imitrex for a headache and escorted back to the household. Supervisory comments indicated the use of restraints was appropriate.<br>*On July 29, 2007 at 4:11 p.m., client #2 was painting at the table and showed no signs of being upset. Then she "cleared everything off the table." She was put in Posey wrist restraint and hobbles for five minutes. No other interventions were implemented. Supervisory comments indicated the use of the restraint was appropriate and warranted given the target behaviors exhibited.<br>*On August 21, 2007 at 5:28 p.m., client #2, while at the table, shoved everything on the table, across the table. She was restrained for eight minutes with Posey wrist restraints and leg hobbles, in accordance with her Rule 40 plan. During the time she was restrained, she kicked her feet and pinched her thighs for four minutes. | 5 700 | | |

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| 5 700 | Continued From page 11<br><br>After being calm for four minutes she was released. Supervisory comments indicated the use of the restraint per her Rule 40 was appropriate. No other interventions were implemented prior to the restraint.<br><br>Client #3 has mild mental retardation, osteoarthritis, limited range of motion in his left leg, a history of knee pain, and prefers to use a wheelchair. A review of the facility's "Documentation for Emergency Use of Controlled Procedure" revealed the following:<br>*On March 29, 2007 at 6:59 p.m., client #3 was watching the television. Staff asked that he watch an "age appropriate" program. Client #3 was not following directions and yelled at staff. The staff cued the client to stop and maintain boundaries and was escorted to his bedroom. Client #3 hit and shoved staff. An "arm bar takedown" (a manual method utilized by two staff, who apply pressure to the client's elbows, with the goal of lowering the client to the ground in a prone position-lying on their stomach) was performed on the client. Then he was manually and mechanically restrained for 21 minutes (the specific type of mechanical restraint was not identified).<br>*On May 10, 2007 at 4:14 p.m., client #3 was "yelling and screaming at staff, swearing, and attempting to hit staff." The client was asked "to go to his room and calm down, he refused. We then attempted to escort him. He hit staff." Client #3 was manually restrained and then mechanically restrained with leg hobbles and wrist cuffs for 12 minutes. Client #3's response section of the form indicated the client told staff, "Sorry, he deserved the implementation."<br>*On June 20, 2007 at 6:20 p.m. client #3 refused to stay away from a peer that was sitting on the floor. Client #3 "kicked at peer's feet." The client | 5 700 | | |

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| 5 700 | Continued From page 12<br>would not stop kicking at the peer, and it was "possible" that he "may have grazed peers feet." Client #3 was asked to stop and lie down on the floor. Client #3 was then manually restrained for two minutes.<br>*On June 23, 2007 at 5:43 p.m., client #3 was "swearing, refusing directions...invading peers/staffs space [with] wheelchair." The client then "slapped" a staff's forearm with an open hand. He was then restrained with leg hobbles and wrist cuffs for 22 minutes.<br>*On August 5, 2007 at 3:55 p.m., client #3 "was stopped in wheelchair in front of office, and would not redirect to move." The "other alternatives tried and/or considered:" included, cueing the client "several times to move" and "escort by pushing wheelchair." Client #3 was restrained in hand cuffs and leg hobbles for 23 minutes, after he "struck staff with fist." The documentation did not indicate when the client struck staff. However, the documentation did indicate that it was likely for the client's physical aggression to reoccur. At 6:00 p.m., "[client #3] was asked 3 times to move out of view of TV in dayroom. The fourth time he refused, he was being escorted to his room...As he was being escorted to room [client #3] hit staff." The client was manually restrained for two minutes then restrained with wrist cuffs and leg hobbles for 43 minutes.<br>*On September 6, 2007 at 5:48 p.m., client #3 was in the day room. He was asked to elevate his feet and he refused. Then he hit a peer in the stomach with the "outside of his wrist." He was told to stop. The staff did an "arm bar takedown" and manually restrained the client for one minute. The client told the staff that the other client had previously kicked him. After the client was released from the manual restraints he was told to use personal boundaries, anger management skills and to talk to staff if he feels unsafe. | 5 700 | | |

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| 5 700 | Continued From page 13<br><br>*On September 26, 2007 at 8:22 p.m., client #3 was watching the television and a staff person asked the client if he wanted to do one of his programs. Client #3 turned away from the staff and turned the television up. The staff person then attempted to turn the television off and client #3 "slapped" the staff person's hand and stated "F-ck You" and asked the staff person to leave him alone. The staff person then attempted to un-plug the television and put his/her hand behind the dresser to pull the plug and client #3 slammed the dresser against the wall. The client was manually restrained for two minutes then put in leg hobbles and his wrists were cuffed. The client was "agitated" for 18 minutes and released from restraints after 28 minutes. The documentation indicates that the behavior the restraints were utilized for, is "likely to reoccur." The client's response was the incident was "staffs fault."<br><br>Client #4 has mild mental retardation, asthma, epilepsy, and a history of poking others and throwing personal items at others' heads. A review of the facility's "Documentation for Emergency Use of Controlled Procedure" revealed the following:<br>*On May 24, 2007 at 8:43 p.m., client #4 was manually and mechanically restrained for 50 minutes. Prior to being restrained the client "appeared agitated and had been touching staff for over an hour." The client was cued to go to her room or take a shower or bath. The staff "attempted to talk w/ [client #4] about what was bothering her."<br>*On May 30, 2007 at 6:26 p.m., the client was in her room "hitting the door." Then she came out of the room and "tried to shove staff to get into the kitchen." An arm bar takedown was implemented to take the client to the floor. The client was | 5 700 | | |

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| 5 700 | Continued From page 14<br><br>manually then mechanically restrained for a total of 50 minutes (the specific mechanical restraints are not documented). The documentation indicates "Other Alternative tried and/or considered" included: the staff told the client to sit down and relax or to take a bath or shower.<br><br>Client #6 has severe mental retardation and a history of behavioral deterioration since November 2006. He was admitted to the facility in May 2007. A review of the facility's "Documentation for Emergency Use of Controlled Procedure" and "Documentation for Emergency Use or Emergency Initiation of Psychotropic Medication" revealed the following:<br>*Upon arrival to the facility on the day of admission, May 7, 2007, client #6 was attempting to bite and kick staff. An emergency mechanical restraint was implemented. The client "continued to struggle and attempt physical aggression." The client was in restraints for 30 minutes. In addition to the mechanical restraint, client #6 was given 10 milligrams of Haldol, 2 milligrams of Ativan and 50 milligrams of Benadryl, intramuscularly (IM), at 10:25 a.m. At 11:30 a.m. the client "was asleep." Documentation indicated that the client was "scared" and he did not know staff. At 6:20 p.m., client #6 was in the bathroom washing his hands. A staff person cued him to dry his hands with a washcloth. The client stuffed the washcloth in his mouth. The staff person pulled the washcloth out of the client's mouth. The client struck the staff person three times with an open hand. The staff implemented a "basic come along take down to prone position, handcuffs, and leg hobble." The client was in restraints for 50 minutes. At 8:50 p.m., client #6 attempted to enter the staff office. Documentation indicates he "was struggling during escort." The client kicked and punched staff. A double arm bar takedown | 5 700 | | |

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| 5 700 | Continued From page 15<br>was used and both emergency manual and mechanical restraint were implemented in response to physical aggression. The client was in restraints for 50 minutes.<br>*At 5:26 a.m., on May 8, 2007, client #6 "slapped staff open handedly on forearm, pinched staff" after being re-directed to his room and being asked to wash his hands. An arm bar take down was used and the client was put in mechanical restraints for 28 minutes. At 10:20 a.m., client #6 "came out of his room to go to the bathroom...attempting to hit staff and did kick a staff...Staff tried to verbal prompt [client #6] to stop." Client #6 was put in leg hobbles and handcuffs for 50 minutes. During restraint he yelled and was banging his head on the floor.<br>*At 12:55 p.m. on May 9, 2007, client #6 hit a staff person one time. The client was put in a manual hold by 4 staff and then in metal cuffs and leg hobbles. He was restrained for 50 minutes.<br>*At 3:15 a.m. on May 10, 2007, client #6 was trying to swing at staff person's face with a closed fist. The staff person used an arm bar take down to restrain the client. Documentation indicated that at 3:20 a.m. the hobble was removed. The client was agitated and kicking, and the hobble was re-applied. At 3:35 a.m. client #6 was struggling, trying to get cuffs off causing abrasions to his wrists. The cuffs were removed and the client was put in a manual hold. The client was restrained until 4:00 a.m. when he was released due to labored breathing.<br>*At 11:12 a.m., client #6 was "repeatedly touching staff, not following staff direction, and unresponsive." The client was put in a manual restraint for 15 minutes. At 2:02 p.m., client #6 was "pacing, grabbing at staff, walking in office and peers room". He was put in a manual restraint for 9 minutes. At 2:15 p.m., client #6 was | 5 700 | | |

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| 5 700 | Continued From page 16<br>given 10 milligrams of Zyprexa IM. At 5:45 p.m., client #6 "hit staff with handslaps." A double arm bar takedown was implemented and client #6 was put in handcuffs and hobbles for 30 minutes.<br>*At 11:17 p.m. and 11:28 p.m., on May 21, 2007, client #6 was hitting staff and the client was manually restrained each time for 2 minutes. At 12:30 p.m., client #6 tried to pinch and grab staff. He was put in a Posey restraint with leg hobbles for 45 minutes. At 1:20 p.m., client #6 was given 2 milligrams of Ativan IM.<br>*Documentation on June 2, 2007, indicated that client #6 was restrained at least seven times. At 2:40 p.m., client #6 was given 100 milligrams of Seroquel. Client #6 had "four Rule 40 implementations today for physical aggression (no specific behaviors identified) and PICA" (eating inedible objects). A note written as follow-up by a nurse indicated client #6's Rule 40 was re-implemented at 4:17 p.m. and the Seroquel was minimally effective. At 7:15 p.m., client #6 was given 2 milligrams of Ativan and 50 milligrams of Benadryl IM. The "precipitating behavior" indicated was "three more Rule 40's for agitation/aggression, each lasting nearly 50 minutes."<br>*Client #6 was put in mechanical restraints on June 5, 2007 at 10:09 for "physical aggression; grabbing, pinching, headbutting; PICA &SIB (fingers in mouth, biting), not calming, continues to aggress when releases attempted." The client received Ativan 2 milligrams at 10:45 a.m.<br>*Documentation for June 12, 2007 indicates that client #6 was "given the Ativan (2 milligrams at 2:45 p.m.) immediately after release of restraint while in his room." The precipitating behavior indicated was "aggression toward staff, refusal to redirect with verbal cues." (No specific behaviors were identified on the form.)<br>*Documentation regarding client #6 for June 18, | 5 700 | | |

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| 5 700 | Continued From page 17<br><br>2007 indicates that "Rule 40 implemented [five times] this afternoon for aggression/agitation-each one longer in length of time held." At 5:05 p.m. client #6 was given 2 milligrams of Ativan and 50 milligrams of Benadryl IM. A follow-up note written at 8:00 p.m. indicates that one Rule 40 was implemented "shortly after medication given."<br>*Documentation indicates that on January 8, 2008, at 1:08 p.m., client #6 "woke up from nap, took a shower, started aggression before getting dressed." Client #6 was asked to calm down and keep his hands to himself. He was escorted back to his room. Client #6 "attempted to kick/scratch/slap at staff multiple times." A mechanical restraint was implemented. The actual outcome indicates client #6, "did not meet release criteria, attempted release at 50 minutes, continued to aggress." At 1:58 p.m., on January 8, 2008, documentation indicated that client #6 was "in Rule 40 hold, reimplemented Rule 40 after 50 minutes." He was released at 2:48 p.m. Client #6 was mechanically restrained for a total of one hour and forty minutes.<br><br>Client #7 has mild mental retardation. A review of the facility's "Documentation for Emergency Use of Controlled Procedure" revealed the following: *On December 12, 2007 at 7:00 p.m., client #7 "had been upset since supper, ignoring staff requests." Staff asked her to go to "home 3" so they could escort other clients. The client "refused shouting when staff stood beside her chair then kicked tried to hit." The staff had tried to "negotiate" with the client for an hour, offered her quiet time in her room and time to talk. An arm bar takedown was implemented and the client was restrained manually for 20 minutes. The client's mood after the restraint was documented as "feeling depressed" and crying. A | 5 700 | | |

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| 5 700 | Continued From page 18<br>review by the QMRP (Qualified Mental Retardation Professional), indicated that a "Rule 40 program will be implemented, likely to reoccur."<br>*A review of the facility's "Documentation For Implementation Of Approved Aversive And/Or Deprivation Procedures, " revealed the following:<br>*On December 21, 2007 at 9:10 p.m., client #7 was "arguing w/ staff about her recovery[programing], when told she had to restart she started screaming at staff [and] kicked the wall very hard." The client was put in manual then mechanical restraints, leg hobbles and wrist cuffs, for 28 minutes due to property destruction, "kicking the wall." The client "screamed and cried" for 18 minutes before she was calm. The supervisory comments indicated that the implementation of the restraints was in accordance with client #7's program.<br>*On December 24, 2007 at 8:28 a.m., staff entered client #7's room to wake her for work. The client "screamed 'leave me alone' and swung [at and] kicked [at] staff." The client was cued to "stop" and then she was restrained in wrist cuffs and leg hobbles for 18 minutes. For the first eight minutes client #7 cried and struggled. The supervisory comments indicated that the use of the restraints was appropriate.<br><br>Client #8 has moderate mental retardation, autism, a brain stem tumor, and seizure disorder. A review of the facility's "Documentation For Implementation Of Approved Aversive And/Or Deprivation Procedures," revealed the following:<br>*On September 9, 2007 at 7:20 p.m., client #8, "ran to bathroom and threw his socks in the shower, then ran to his bedroom and slammed his door." Staff cued the client to "walk and not throw objects or slam doors because that is property destruction." As a result the client ran | 5 700 | | |

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| 5 700 | Continued From page 19<br>out of his bedroom and into another "unoccupied" bedroom and slammed that door. The client was handcuffed and his legs were hobbled for a total of 10 minutes. The supervisory comments indicated that the use of the Rule 40 restraints was appropriate because one of the target behaviors is slamming doors.<br>*On September 27, 2007 at 4:56 p.m., client #8 "ran through the house with pitcher of water. He refused to let staff have pitcher, and once he did, he ritually pounded on walls with both fist." Staff cued the client to "stop and put pitcher down and not to run... also cued not to hit walls." Client #8 "slapped at staff's hands when they asked for the pitcher. He ran into bathroom and slammed door." The client was restrained in hand cuffs and leg hobbles for 39 minutes. For the first 29 minutes the client "struggled, scratched, kicked, yelled, and tried to get up."<br>*On September 30, 2007 at 7:50 p.m., client #8 "ran up to the wall, pounded on it, banged his head on the floor and ran to his room and slammed the door." Staff re-directed the client, "stop [and] not pound or slam the door." The client's Rule 40 was implemented and he was hand cuffed and his legs were hobbled. He was restrained for 15 minutes and during his restraint he struggled, spit, tried to bite, kick, and scratch the staff for five minutes.<br>*On October 5, 2007 at 9:46 a.m., client #8 was in the shower for approximately 20 minutes and was refusing to get out. He slammed the door on staff and was then put in leg hobbles and hand cuffs for 10 minutes for property destruction. The supervisory comments indicated that the use of the restraints was appropriate.<br>* On October 11, 2007 at 2:57 p.m., client #8 refused to attend his mental health review and was rocking in a chair when he "suddenly jumped up and ran towards" the bedroom and bathroom. | 5 700 | | |

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| 5 700 | Continued From page 20<br>The client "banged" on the door and the walls of the phone room, and linen closet, and slammed the bathroom door, and he"dropped" the phone against the wall of the phone room. The client, "was calm instantly when staff asked him to lay on the ground." He was then hand cuffed and leg hobbles were applied. He was restrained for 10 minutes. The supervisory comments indicated that the use of the restraints was appropriate.<br>*On October 14, 2007 at 8:24 a.m., client #8 was restrained in wrist cuffs and leg hobbles for 10 minutes for "property destruction and physical aggression." The documentation indicates that staff gave him a verbal prompt not to slam the door. The documentation does not indicate the specific behavior that required the implementation of restraints. However, the documentation does indicate that the client laid on the floor per staff request prior to the restraint implementation. The supervisory comments indicate that the use of the restraint was appropriate.<br><br>Client #9 has mild mental retardation, autism, and a brain lesion. A review of the facility's "Documentation For Implementation Of Approved Aversive And/Or Deprivation Procedures," revealed the following:<br>*On October 25, 2007 at 2:25 p.m. client #9 became "agitated" when he was returning to his "home 3." The client kicked a car and bit himself (specific location not identified). He was prompted to "stop [and] calm" He hit staff and was restrained first manually then mechanically for a total of 46 minutes. The documentation does not indicate if he was restrained outside or back at home 3. The supervisory comments indicate that the use of the restraint was appropriate.<br>*On November 11, 2007 at 6:43 a.m. client #9 | 5 700 | | |

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| 5 700 | Continued From page 21<br>was in taking a shower and "pounding" on the walls, toilet and his own head. Staff utilized negotiations to stop (the specific negotiations not documented). He was restrained with leg hobbles and hand cuffs for 10 minutes. The supervisory comments indicate that the use of the restraints was appropriate.<br>*On December 11, 2007 at 7:05 a.m., after client #9 took two bowls of cereal, he was cued to take only one bowl. The client slammed the table with his hands. Then he hit himself in the head three times. He was restrained with leg hobbles and hand cuffs for 37 minutes. The supervisory comments indicated that the use of the restraints was appropriate.<br>*On August 5, 2007 at 8:12 a.m., client #9, "was watching T.V. and laughing inappropriate." The client bit, slapped, and hit himself, "with strong force." Staff interventions included: "asked him what was wrong, why are you hitting yourself, [and] calm down." Staff cued client #9 to lie down. The client complied and was manually restrained, then put in leg hobbles and wrist cuffs for a total of 17 minutes. He was "agitated" for seven minutes. After ten minutes of being calm he was released from the restraints. The evaluation of the restraint implementation indicated that the use was appropriate and that "with great likelihood this behavior will reoccur." The client's response to the incident was, "I'm sorry - don't bite." In addition, client #9 only had red marks on his arms from the self inflicted biting. At 11:35 a.m. client #9 was again laughing inappropriately while watching television. At some point, the client became self injurious (specifics not documented). Staff "attempted to negotiate" and the client "aggressed towards staff." The client was cued to calm down and to keep his boundaries. The staff "waited for extra staff before takedown." The client was manually | 5 700 | | |

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| 5 700 | Continued From page 22<br><br>restrained and placed in wrist cuffs and leg hobbles for a total of 50 minutes. The client was noted to be crying and trying to relax, but, "he was being held" in a prone position and the client "attempted to grab staff [and] get up." The leg hobbles and wrist cuffs were reapplied at 12:25 p.m. for an additional ten minutes. The documentation indicates that the plan was to, "encourage client to rest in room, listen to music, take deep breaths."<br>*On August 24, 2007 at 6:21 p.m., a peer removed the foot stool from under client #9's feet. Client #9 started to slap himself, clap, and bite his forearm. Staff interventions included: asking the client to lie down and not put his hand by his mouth and listening to music. The documentation does not indicate if the client followed the staff directives. A double arm bar takedown was used and then the resident was put in handcuffs and leg hobbles for 50 minutes. The documentation indicates that the client was restrained because of "self injurious behavior/physical aggression." An attempt was made to release the client from restraints and he "kicked [at] staff" and at 7:11 p.m. his restraints were continued for another 21 minutes. At 7:20 p.m. client #9 received 2 mg of Ativan IM.<br>*On September 28, 2007 at 12:55 p.m. client #9 received Ativan because he was "agitated [and] aggressive." At 2:36 p.m., client #9 was "pinching his cheeks and putting hands toward mouth." Staff attempted "verbal prompts," and the client was "escorted to room by staff but [the client] kept grabbing at staff." The client was restrained for 12 minutes, manually then mechanically with handcuffs and leg hobbles because he was physically aggressive and hit staff.<br><br>Client #10 has moderate mental retardation and infantile autism, he has a history of biting people, | 5 700 | | |

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| 5 700 | Continued From page 23<br>making himself throw-up, and becoming increasingly agitated when others attempt to interact with him. Client #10 was discharged from the facility on November 7, 2007. A review of the facility's "Documentation For Implementation Of Approved Aversive And/Or Deprivation Procedures," revealed the following:<br>*On February 28, 2007 at 8:03 p.m., client #10 was restrained for ten minutes in handcuffs and hobbles because he bit his hand.<br>*On March 6, 2007 at 7:59 p.m., client #10, "was given a snack. He began spitting on kitchen table. Staff cued the client to stop spitting and to go to his room and calm down. While in his room he began vomiting on his floor and urinated. He was also laughing for no reason." He spit and vomited on staff and was restrained for 14 minutes in handcuffs and hobbles.<br>*On March 9, 2007 at 10:09 a.m., client #10 was restrained for six minutes in leg hobbles and handcuffs because he "bit self." At 12:38 p.m., client #10 was exhibiting "excessive laughing" and he spit water. He was "encouraged to calm [and] resume work x 3." He was restrained for 14 minutes in handcuffs and leg hobbles for "spitting/emesis directed at staff." At 6:25 p.m., client #10 spit in a staff person's face. He was cued to lay down and he complied and was restrained for six minutes.<br>*On March 13, 2007 at 1:17 p.m., client #10 was restrained in handcuffs and hobbles for ten minutes because he bit the back of his left hand and made it bleed. The documentation indicates that other interventions were "NA" (not applicable).<br>*On March 17, 2007 at 4:41 p.m. client #10 was restrained in hand cuffs and hobbles for six minutes for biting his hand. The documentation indicates that there was "no time" for any other interventions. | 5 700 | | |

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| 5 700 | Continued From page 24<br>*On March 18, 2007 at 1:58 p.m., client #10 was restrained for six minutes in leg hobbles and hand cuffs because he bit the back of his left hand after being directed to calm down. The documentation indicates that the client laid down on the floor on his own, and was restrained.<br>*On March 19, 2007 at 5:02 p.m. client #10 was in his room "self stimulating." Staff told the client to "relax and calm." The client bit his left hand through his shirt. He was told to lay down on the floor and he complied. He was "calm" but `restrained for six minutes in handcuffs and leg hobbles.<br>*On March 20, 2007 at 12:00 p.m., client #10 was restrained after he had an emesis and spit it at staff and then was restrained for fourteen minutes in handcuffs and leg hobbles.<br>*On March 20, 2007 at 7:14 p.m., client #10 was restrained in leg hobbles and handcuffs for six minutes for biting his hand after staff told him not to bite himself.<br>*On March 20, 2007 at 9:14 p.m., client #10 bit a "pre-existing wound" on his hand and he was restrained for six minutes in leg hobbles and handcuffs. Documentation indicated that there were no other interventions available prior to the utilization of the restraints.<br>*On March 27, 2007 at 4:55 p.m., client #10 was asking repetitive questions and was asked to "relax" in his room. The client bit himself on the hand and he was restrained for 12 minutes in handcuffs and leg hobbles.<br>*On April 3, 2007 at 9:28 p.m., client #10 was making "loud vocalization for 10 - 15 minutes." He was told to "quiet, take breaths, [and] go to sleep." The client bit the back of his hand and slapped his leg three times. The client was restrained for six minutes in leg hobbles and hand cuffs.<br>*On April 4, 2007 at 10:18 a.m., client #10 was at | 5 700 | | |

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| 5 700 | Continued From page 25<br>his day program and he was "wiggling hands in front of face making noises." The client was instructed to continue his work, "or to sit on his hands to calm." The client bit his hand through his shirt. He was mechanically restrained with handcuffs and leg hobbles for six minutes.<br>*On April 5, 2007 at 7:45 p.m., client #10 was "self stimulating in room, making loud noises, sounded like AHAHAH..." The client was cued to "quiet down," and "relax." The client bit an "old sore" on the back of his left hand. The client laid down on the floor after being cued by staff to do so. The client was manually restrained then mechanically restrained with leg hobbles and handcuffs for six minutes.<br>*On April 6, 2007 at 11:35 a.m., client #10, "was shredding [paper] and starting finger flailing by his mouth then put hand in shirt and bit his hand...Staff told [client #10] to stop and lie on the floor...He bit himself through his sweatshirt." The client was manually then mechanically restrained with leg hobbles and handcuffs for 7 minutes. The supervisory comments indicated that the use of the restraints was appropriate.<br>*On April 6, 2007 at 4:23 p.m., client #10, "was acting very manic. He was laughing about nothing and spitting all over his room." Staff cued him to "relax" and "take deep breaths." The client spit in the staff's face. The client was manually then mechanically restrained in leg hobbles and hand cuffs for 25 minutes. The supervisory comments indicated that the use of the restraints was per his program and appropriate.<br>*On April 8, 2007 at 3:48 p.m., client #10 bit his hand. Staff told the client to "stop." He bit his hand through a blanket that was covering his hand. At some point, the client hit himself twice (specific area of the body was not documented). The client was restrained in leg hobbles and handcuffs per his Rule 40 for 18 minutes. The | 5 700 | | |

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| MN EXTENDED TREATMENT | 1425 STATE STREET CAMBRIDGE, MN 55008 |

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|---|---|---|---|---|
| 5 700 | Continued From page 26<br><br>supervisory comments indicated that the use of the restraints was appropriate.<br>*On April 11, 2007 at 8:42 p.m. client #10 "was jumping around his bedroom forcing himself to vomit [and] spit. He was also laughing hysterically." Staff told the client to "calm, encouraging deep breaths and relaxing in his bedroom." The client "forced himself to vomit and spit it at staff." The client was restrained for 20 minutes in leg hobbles and hand cuffs. The supervisory comments indicate that the use of the restraint was per his program and was appropriate.<br><br>Client #11 was committed to the supervised living portion of the facility in August 2007, and her diagnoses include fetal alcohol syndrome and mild mental retardation. Between the client's admission and November 2, 2007, the facility manually and mechanically restrained client #11 in handcuffs and leg hobbles 19 times, for self-injurious behavior, attempted or actual physical aggression, or for property destruction. A Rule 40 plan was then implemented in November 2007. The client's Rule 40 plan included the implementation of a "time out," and was to be implemented if the client exhibits self-injurious behavior, attempted or actual physical aggression, property destruction, or trying to leave "AWOL." Client #11's Rule 40 plan indicated that if the client exhibited the above target behaviors she would be asked to go to her room or sit in a chair. If the client did not go to the designated area independently, she would be manually escorted, then left alone, but supervised, for five minutes. However, since the first implementation of her Rule 40 plan, in November 2007, facility staff have continued to manually restrain the resident, five times between December 3, 2007 and January 1, 2008, for up to | 5 700 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00293 | A. BUILDING _____ B. WING _____ | C 01/17/2008 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MN EXTENDED TREATMENT | 1425 STATE STREET CAMBRIDGE, MN 55008 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 5 700 | Continued From page 27<br>fourteen minutes, for the target behaviors identified in her rule 40 plan.<br><br>Employee (A)/administrative staff was interviewed on January 10, 2008 at 9:30 a.m. and stated that all the clients at the facility are legally committed and exhibit either property destruction or physical aggression, and may have some degree of self injurious behavior. The average stay is based on how quickly the facility is able to stabilize a client's inappropriate behavior. Approximately one and a half to two years ago, the facility implemented the use of mechanical restraints for inappropriate behavior. In November 2007, the use of mechanical restraints for emergency situations was discontinued in the ICF/MR. However, the use of mechanical restraints continues to be utilized on the clients with Rule 40 (the facility's specially constituted committees' pre-approved restrictive behavior management practice) programs. In emergency situations, the staff use manual restraints only. Examples of the restraints utilized for the Rule 40 programs include: soft wrist cuffs, metal handcuffs and leg hobbles (usually used together), and in some cases a restraint board. The Rule 40 programs start with two minutes of manual restraining and if the client(s) continues to struggle, they are put in mechanical restraints.<br><br>Employee (E)/administrative staff was interviewed on January 31, 2008 at 9:30 a.m. and stated that the clients admitted at the facility should only be restrained to reduce target behaviors that are dangerous or likely to lead to dangerous behavior. When two specific examples of client #3 being restrained, related to television viewing, were mentioned by the investigator, employee (E) stated that from the sounds of the examples reviewed, the risk analysis (risk of continuing the | 5 700 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00293 | A. BUILDING _____ B. WING _____ | C 01/17/2008 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| 5 700 | Continued From page 28<br>activity versus the risks of restraining) is "all out of whack." The facility as a whole does not have a "no-touch" policy. There should be "household agreements," reviewed and open for negotiation, made by the people who live in a household. The "no-touch" policy is intended to be a therapeutic support for people who are aggressor's, the recipient of another's aggression, or there are other problems with interpersonal boundaries. If a client failed to observe the practice of "no-touch" and simply touched another client, that would not constitute a dangerous situation.<br><br>SUGGESTED METHOD OF CORRECTION: The director and/or designee could review the facility's policies and procedures related to the use of restraints and revise as necessary. Then the director and/or designee could in-service staff on the use of restraint procedures.<br><br>TIME PERIOD FOR CORRECTION: Fourty (40) days. | 5 700 | | |

# Appendix C

# DHS Licensing Citations

**INVESTIGATION MEMORANDUM**
**Department of Human Services Division of Licensing'**
**Public Information**

**Report Number:** 20074279 **Date Issued:** April 4, 2008

**License Number:** 804294 (245B-RS)


**Name and Address of Program Investigated:**
Minnesota Extended Treatment Options (METO)
1235 Hwy 293
Cambridge, MN 55008

**Investigator(s):**
Amy Petersen with Pat Afwerke, Deb Amman, Dawn Bramel, Rita Maguire, Mary Truax
Human Service Licensors
Division of Licensing
Minnesota Department of Human Services
PO Box 64242
St. Paul, MN 55164-0242
(651) 215-1588

**Suspected Licensing Violations Reported:**

Allegation number 1: METO uses coercion to obtain informed consent for the use of controlled procedures by telling legal representatives that unless they consent to the use of the controlled procedure METO will not serve the consumer.

Allegation number 2: METO's Individual Program Plans (IPPs) developed for the use of controlled procedures do not meet the required standards for assessment, content, and review, including the failure to obtain a report from the physician on whether there are existing medical conditions that could result in the demonstration of behavior for which a controlled procedure may be proposed or should be considered in the development of an IPP for controlled procedure use.

Allegation number 3: METO staff use controlled procedures for staff convenience and not based on the standards and conditions for use of the procedures to increase adaptive skills and decrease target behaviors, e.g., consumers are told that if they do not stop engaging in a behavior that a controlled procedure will be used and that no efforts to teach an alternative behavior are used.

Allegation number 4: METO staff implement controlled procedures on an emergency basis for staff convenience without the consumers' behavior meeting the criteria for use, i.e., immediate intervention is needed to protect the person or others from physical injury or to prevent severe property damage that is an immediate threat to the physical safety of the person or others, and METO fails to complete the required review and reporting when a controlled procedure is used on an emergency basis.

It was alleged that for one consumer (C1), METO used controlled procedures (manual and mechanical restraints) on C1 on an emergency basis on 17 occasions since March 26, 2007, without consulting C1's primary care physician on whether the restraints would be medically contraindicated and without consideration of C1's diagnosed seizure condition. A formal IPP for the use of the controlled procedures was still not developed after the first 15 uses.

It was alleged that for one consumer (C2), METO used controlled procedures (manual and mechanical restraints) on C2 without consulting with the primary care physician on whether the restraints would be medically contraindicated due to C2's diagnosed sensory hearing loss and did not assess whether C2's sensory hearing loss was related to C2's behavior or how staff needed to accommodate the hearing loss when implementing a controlled procedure.

It was alleged that for one consumer (C3), METO staff used controlled procedures (manual and mechanical restraints) on C3 without consulting with the primary care physician on whether the restraints would be medically contraindicated due to C3's diagnosis of asthma.

It was alleged that for one consumer (C4), METO staff used controlled procedures (manual and mechanical restraints) on C4 without consulting with the primary care physician on whether the use of the restraints were medically contraindicated due to C4's diagnosed seizure disorder and "brain stem dermoid tumor." METO staff threatened C4 that a controlled procedure would be used if C4 did not stop pounding on a wall or slamming the door, without their first trying another less restrictive method to redirect or prevent the target behavior.

It was alleged that for one consumer (C5), METO staff used controlled procedures on an emergency basis 15 times prior to developing an IPP for its use. The legal representative signed an informed consent form for the use of the controlled procedure conditional on METO implementing the procedures according to the modifications to the plan that the legal representative wrote on the consent form. METO implemented the procedure as written, not as modified and consented to by the legal representative. METO did not attempt to otherwise have the IPP modified with review and approval by the interdisciplinary team.

**Investigation Procedure:**

Onsite visit: November 26, 2007

Documents reviewed:

Consumer records for C1:
- *Individual Service Plan (ISP)* dated March 2005
- *Risk Management Plan (RMP)* dated July 13, 2007
- *Physical exam (PE) reports* dated July 6, 2005, May 17, 2006, and July 2, 2007
- *Individual Program Plans (IPP)* dated July 13, 2007
- *Emergency Use of Controlled Procedure (EUCP) reports* - 26 reports dated August 11, 2005 to August 27, 2007

Consumer records for C2:
- *ISP* dated September 19, 2007
- *RMP* dated September 19, 2007
- *PE reports* Admission and Annual - 7 reports dated August 30, 2000 - August 13, 2007
- *Medical Information in Behavior Management Program Using Controlled Procedures* dated June 25, 2007
- *IPP* dated September 19, 2007
- *IPP Rule 40 Addendum* dated February 23, 2007, revised September 17, 2007
- *IPP/CP Informed Consents*- 6 quarterly consents dated October 28, 2006-October 27, 2007
- *IPP/CP use reports* - 18 reports dated April 15, 2007 - October 28, 2007
- *IPP/CP quarterly reports* - 6 reports dated April 2006 - September 2007

- *IPP staff in-service records* dated January 2006 - November 2007
- *EUCP reports* - 5 reports dated April 14, 2004- October 6, 2006

Consumer records for C3:
- *ISP* dated August 30, 2007
- *RMP* dated August 30, 2007
- *Physical Exam reports* dated August 10, 2005, July 19, 2006, August 17, 2007
- *IPP* dated August 30, 2007
- *IPP Rule 40 Addendums* dated August 29, 2005, September 1, 2005, August 3, 2007
- *IPP/Controlled Procedure (CP) Informed Consents* - 12 quarterly consents dated August 19, 2005- October 13, 2007
- *IPP/CP use reports* - 22 reports, dated June 7, 2007 - November 18, 2007
- *IPP/CP quarterly reports* dated May-July 2007, Aug-Oct 2007
- *IPP staff in-service records* dated September 2005 - October 2007
- *Education/Treatment Objectives* dated August 30, 2007

Consumer records for C4:
- *RMP* dated November 27, 2006
- *PE reports* dated November 8, 2006 and October 29, 2007
- *Medical Information in Behavior Management Program Using Controlled Procedures* dated June 25, 2007
- *IPP* dated November 27, 2006
- *IPP Rule 40 Addendum* dated November 22, 2006, revised May 7, 2007, revised August 22, 2007
- *IPP/CP Informed Consents* - 4 quarterly consents dated February 10, 2007 - September 16, 2007
- *IPP/CP use reports* - 19 reports dated September 4, 2007 - October 14, 2007
- *IPP/CP quarterly reports* - 4 reports dated November 2006 - July 2007
- *IPP staff in-service records* dated November 2006 - October 2007
- *EUCP reports* dated November 8, 2006 - December 2, 2006
- *Psychotropic Medication Addendum* dated October 22, 2007
- Emergency Use of Psychotropic Medication report - 4 reports dated November 19, 2006 - November 21, 2006
- *Education/Treatment Objectives* dated November 29, 2006
- *Annual Plan Summary* dated November 27, 2006

Consumer records for C5:
- *45-Day meeting notes* dated September 24, 2007
- *PE report* dated August 10, 2007
- *IPP* dated September 24, 2007
- *IPP Rule 40 Addendum* dated September 24, 2007
- *IPP informed consent* dated October 11, 2007
- *Education/Treatment Objectives* dated September 24, 2007
- *IPP use report* dated November 14, 2007
- *EUCP reports* - 15 reports dated August 10, 2007 - September 13, 2007
- *EUCP reports completed after IPP/CP consent* -5 reports October 22, 2007 - December 3, 2007
- *IPP staff in-service records* dated November 2007
- *E-mail correspondence between C5's Legal Representative and METO* (provided by FM5) dated



The program's policies and procedures:

- *Use of Emergency Controlled Procedures at Minnesota Extended Treatment Options*, including *Pictures of Mechanical Restraints used on Emergency Basis at METO* (Interdisciplinary Team Guide, no date or policy number)
- *Emergency Use of Controlled Procedures (Manual and Mechanical Restraint)* (Policy Number 3503, effective November 26, 2007)
- *Emergency Use of Controlled Procedures (Manual and Mechanical Restraint)* (Policy Number 3503, effective February 7, 2008)
- *Use of Controlled Procedures in Behavior Management* (Policy Number 3504, effective December 19, 2006).
- *Therapeutic Intervention/ Personal Safety Techniques* (Policy Number 3505, effective March 28, 2007)
- *METO Therapeutic Intervention and Physical Safety Techniques Protocol* (Procedure 3505 Appendix A, not dated)
- *Therapeutic Intervention Instructor Guidelines for Role, Distribution, Selection, Training, and Position Description* (Procedure 3505 Appendix B, not dated)

The program's forms:

- *Documentation for Implementation of Approved Aversive and/or Deprivation Procedures* including *Directions for Documentation* (Form 31032, dated November 2007)
- *Documentation for Emergency Use of Controlled Procedure* (Form 31025, dated November 2007)
- *Documentation for Emergency Use of Controlled Procedure* (Form 31025, dated January 2008)

Interviews (conducted between November 20, 2007, and March 24, 2008):

- Two facility administration staff (FA1 and FA2)
- DHS-DSD Rule 40 Coordinator (P2)
- C2's case manager (CM2) via telephone
- C2's family member and legal representative (FM2) via telephone
- C3's case manager (CM3) via telephone
- C4's case manager (CM4) via telephone
- C4's family member and legal representative (FM4) via telephone
- C5's case manager (CM5) via telephone
- C5's family member and legal representative (FM5) via telephone

**Pertinent Information/Summary of Findings:**

Minnesota Extended Treatment Options (METO) is located at what had been the Cambridge Regional Treatment Center campus. It consists of 8 program units or "homes" in four buildings. Each building is licensed by the Minnesota Department of Health as a Supervised Living Facility. Homes 3 and 4 are in one building and are ICF/MR certified. This building is also licensed by DHS as a Residential Services program. The other buildings are not ICF/MR certified but are subject to DHS licensing standards as Residential Services, not ICF/MR certified.

Minnesota Rules, parts 9525.2700 to 9525.2810 govern the use of controlled procedures in programs serving people with developmental disabilities that are licensed by the Department of Human Services (DHS).

Rule part 9525.2750, subpart 1, which governs the standards for controlled procedures, states that:

> The controlled procedure is proposed and implemented only as part of a total methodology specified in the person's individual program plan. The individual program plan has as its primary focus the development of adaptive behaviors. The controlled procedure approved represents the lowest level of intrusiveness required to influence the target behavior and is not excessively intrusive in relation to the behavior being addressed.

Rule part 9525.2770, subpart 2, which governs requirements for the emergency use of controlled procedures states that:

> Emergency use of controlled procedures must meet the conditions in items A to C.
>
> A. Immediate intervention is needed to protect the person or others from physical injury or to prevent severe property damage that is an immediate threat to the physical safety of the person or others.
>
> B. The individual program plan of the person demonstrating the behavior does not include provisions for the use of the controlled procedure.
>
> C. The procedure used is the least intrusive intervention possible to react effectively to the emergency situation.

Rule part 9525.2780, subpart 1, which governs requirements for obtaining informed consent states that:

> Except in situations governed by part 9525.2730, subpart 3 or 9525.2770, the case manager must obtain or reobtain written informed consent before implementing the following:
>
> A. a controlled procedure for which consent has never been given;
>
> B. a controlled procedure for which informed consent has expired. Informed consent must be obtained every 90 days in order to continue use of the controlled procedure; or
>
> C. a substantial change in the individual program plan.
>
> If the case manager is unable to obtain written informed consent, the procedure must not be implemented. "

In addition, rule part 9525.2780, subpart 4, requires information identified in items A-K to be provided by the case manager to the legal representative as a condition of obtaining informed consent, and states in part that:

- Consent obtained without providing the information is not considered to be informed consent.
- The case manager must document that the information was provided orally and in writing and that consent was given voluntarily.
- The information must be provided in a nontechnical manner and in whatever form is necessary to communicate the information effectively and in a manner that does not suggest coercion.

FA1 and FA2 provided the following information during an interview:

FA1 and FA2 denied that legal representatives were coerced into providing consent for the use of controlled procedures. FA1 and FA2 stated that it would not be possible for them to not serve a consumer admitted to METO as they were under commitment to the METO program and would be served regardless of consent. FA2 stated that there were difficulties in obtaining consent for the use of a controlled procedure with a former consumer and with a current consumer, C5.

METO's Therapeutic Intervention/Personal Safety Techniques Procedure (Procedure Number 3505; Effective Date March 28, 2007) provides the following information:

- The definition of "Therapeutic Intervention" states in part that therapeutic intervention is, "A form of intervention which consists of early identification of potential crises; prevention through verbal, non-verbal, and *non-physical* methods [Emphasis added]."

- The definition of "Personal Safety Techniques" states in part that a personal safety technique is, "Application of external physical control by employees to clients who become aggressive despite the preventive strategies attempted."

**For C1:**

C1 was admitted into METO on June 30, 2005, under civil commitment and assigned to Home 4, the ICF/MR building. C1 does not have an Individual Program Plan (IPP) for the use of controlled procedures. However, controlled procedures were used on an emergency basis a total of 26 times between August 11, 2005 and August 27, 2007, 15 of which occurred between May 7, 2007 and August 27, 2007. These occurrences included manual restraints using "arm bar takedowns" and prone holds, and mechanical restraints using "cuffs" and "hobbles."

The purpose statement of METO's Emergency Use of Controlled Procedures (Manual and Mechanical Restraint) Procedure Number 3503, dated November 26, 2007, states in part that, "Exception: The only controlled procedure as defined in Minnesota Rules 9525.2740 that can be used in an emergency with a client assigned to the ICF-MR building shall be manual restraint. Staff may use emergency manual, and if necessary, mechanical restraint, with clients assigned to Non ICF-MR buildings." However, in both the EUCPs implemented for C1 mechanical restraints were used on eight separate occurrences between June 15, 2006 and June 26, 2007.

C1's Risk Management Plan (RMP) dated May 22, 2007, states C1 engages in maladaptive behaviors that "may frustrate others and promote physical abuse." C1 "pokes others," throws personal items (pillows, stuffed animals, art supplies) "at people and at their head," and C1 "refuses to leave areas when directed." C1 engages in "self-abusive behaviors of scratching (breaking the skin), kicking or banging his/her head on the cement floor or wall for hours." The plan to reduce the risk as stated in the RMP is for C1 to participate in a maladaptive behavior reduction program that combines learning alternatives to expressing anger, anxiety, and fear with adaptive coping strategies. The RMP does not address the previous use emergency use of controlled procedures.

A physical examination and health assessment completed for C1 on July 6, 2005, by METO's registered nurse (RN) / Certified Nurse Practitioner (CNP), identifies "seizure disorder" under past medical history and includes the statement, "No contraindications to emergency manual restraint. May use prone hold and switch to side lying after control gained." A handwritten note was added to that form dated December 14, 2005, stating, "No contraindications to mechanical or manual intervention measures. Should be side lying after initial control is obtained."

C1's physical examination and health assessment completed on May 17, 2006, by the RN/CNP also identifies "seizure disorder" and includes the statement, "No contraindications to mechanical or manual intervention measures. Should be side lying after initial control is obtained." C1's physical examination and health assessment completed on July 2, 2007, by METO's attending physician, identifies "seizure disorder, controlled," "seasonal allergies, controlled," and includes the statement, "No contraindication to therapeutic intervention procedures."

C1's ISP dated March 2005 identified C1 as having asthma. C1's RMP dated May 22, 2007, identifies C1 having a history of asthma under physical limitations. The action plan to reduce or eliminate risk of harm due to the vulnerability states that, "[C1] participates in self administration of medications. Part of the training is to self report symptoms." This diagnosis is not identified on any of the physical examination and health assessments completed by METO.

Notes from the Interdisciplinary Team (IDT) quarterly meeting dated June 1, 2007, state in part that: "Since a visit to the group home, several weeks ago, [C1] has shown a significant increase in target behaviors requiring emergency restraint. [C1] has also expressed slight perseveration on handcuffs and being held." A note on the EUCP report dated August 27, 2007, states, "QMRP to develop R40." As of March 31, 2008, a Rule 40 Addendum to the IPP for the use of controlled procedures has still not been developed.

There were multiple EUCP reports completed by staff persons who initiated the emergency controlled procedures that did not document that all criteria for emergency use were met or that the reviewing and reporting requirements were met for each use (refer to attached table of EUCP reports for C1). In general the reports failed to:

- adequately describe the incident leading to the emergency use;
- document evidence that immediate intervention was needed to protect C1 or others from physical injury or to prevent severe property damage that is an immediate threat to the physical safety of C1 or others;
- document evidence that the controlled procedure used was the least intrusive intervention possible to react effectively to the emergency situation;
- document if or when the EUCP report had been sent to all members of the expanded IDT, and for those involving manual and mechanical restraint if they had been sent to METO's internal review committee for review, within seven calendar days of the emergency use of the controlled procedure; and
- document if or when the expanded IDT conferred on the emergency use of the controlled procedures, including whether the EUCP reports were sent to all members of the expanded IDT and that the expanded IDT defined the target behavior for reduction or elimination in observable and measurable terminology; identified the antecedent or event that gave rise to the target behavior; and if they identified the perceived function the target behavior served; and determined what modifications should be made to the existing individual program plan so as to not require the use of a controlled procedure.

**For C2:**

C2 was admitted to METO on August 28, 2000, under civil commitment and assigned to Home 4, the ICF/MR building. C2 has an Individual Program Plan (IPP) for the use of controlled procedures that was initially developed and approved for use by METO on October 28, 2006. Addendums to the initial IPP were made on February 23, 2007, and September 17, 2007. C2's IPP includes the use of manual and mechanical restraints using Posey© mobile restraint strap with (soft) cuffs at the wrists behind the back and a Ripp© leg hobble at the ankles.

Informed consent for the use of the controlled procedures was given by C2's legal representative, FM2, on October 27, 2007. FM2 checked off on the form that, "I voluntarily consent to the use of the identified controlled procedure(s)." The legal representative's comment section of the form was left blank. This is consistent with all informed consents obtained quarterly since October 28, 2006.

CM2 provided the following information during an interview:

FM2 has not objected to or raised questions or concerns about the use of the controlled procedures by METO for C2 at the time the IDT's annual progress review meetings and has provided voluntary consent for the use of the controlled procedures on an ongoing basis.

FM2 provided the following information during an interview:

FM2 stated that controlled procedures were first implemented two years ago and did not include the use of mechanical restraints. Sometime in the last year the use of manual and mechanical restraints were added to the IPP which includes the use of soft cuffs for the hands and a rip hobble at the ankles. FM2 said that, "No one contacted me about the changes [adding the use of mechanical restraints as a controlled procedure], they were written in the quarterly reports I received. I read about it in the methodology sections. I was surprised to see this so I asked them questions about what they would be doing and why they made the change. They explained the use of the soft Posey cuffs and the rip hobble and that their use would not cause injury to [C2]." FM2 added, "I don't remember discussing the use of the Posey cuffs or the rip hobble, but I did consent to their use." FM2 stated that s/he had not been pressured or coerced into giving consent for the use of the mechanical restraints.

An annual physical examination and health assessment was completed for C2 by METO's attending physician, on August 13, 2007. "Sensorineural hearing loss, bilateral" is listed under medical history and includes the statement, "No contraindication to emergency use of mechanical or manual intervention procedures." This is consistent with past physical examinations and health assessments completed by METO.

A Medical Information in Behavior Management Program Using Controlled Procedures form for C2 signed by METO's attending physician on June 25, 2007, describes the target behaviors to be reduced or eliminated and the type of hold and restraint to be used in response. The physician answered no as to whether there is "any medical evidence that a non-psychiatric medical condition(s) could result in the demonstrating of the target behavior(s) or should be considered in the development of the behavior management program." The physician also answered no as to whether the use of a controlled procedure or manual or mechanical restraints were medically contraindicated.

C2's IPP Rule 40 Addendum Assessment Review provided the following information:

- Under the Medical Conditions section C2's hearing loss identified as well as "severe migraine headaches." Also that, "[T]he onset of a migraine headache may be an antecedent for any of the target behaviors listed above."

- Under the Communicative Intent/Function section C2 is identified as being "non-verbal, utilizing a limited amount of American Sign Language and picture /communication boards to communicate [his/her] wants and needs." Also, "Due to [C2's] communication deficits, others in [his/her] environment sometimes have difficulty understanding [him/her], [s/he] may become frustrated by the delay in attaining a desired outcome from the interaction. This frustration may contribute to [his/her] demonstration of target behaviors."

C2's Risk Management Plan identifies C2 as being vulnerable because s/he does not independently inform staff that s/he is ill. The plan to reduce this risk is for staff to observe C2 for signs and symptoms of illness, particularly for migraines, and that staff initiate asking how C2 is feeling.

C2's IPP directs staff persons to use sign language and picture boards when communicating with C2 when implementing the IPP. Additionally, C2 is not required to verbalize him/herself during restraint to be released, and staff are to communicate verbally and through American Sign Language throughout the use of a controlled procedure. The IPP does not direct staff to ask C2 how s/he is feeling or if s/he is experiencing a migraine.

C2's IPP Rule 40 Addendum for the use of controlled procedures (IPP) identifies three categories of target behavior: property destruction, major self injury, and physical aggression. The antecedents identified for these behaviors include minor self-injury and stalking. If C2 exhibits antecedent behavior staff must give a signed and verbal cue to C2 to stop the behavior and staff must communicate through signing and use of the picture board to identify the source of agitation and will remedy the situation if possible. Staff must redirect C2 to an "appropriate alternative (i.e. take deep breaths to calm down, ask staff to help, rocking in a rocking chair, or going for a walk)." If C2 discontinues the antecedent behavior staff must provide behavior specific positive feedback. If C2 does not respond to the less restrictive interventions and proceeds to a target behavior staff must implement the controlled procedures in accordance with the instructions in the IPP which is initiated by staff signing, "stop the behavior" and a verbal and signed prompt must be given that C2 should lie down on the floor in a prone position. If C2 refuses to lie down, "staff will use approved therapeutic techniques to restrain [him/her] on the floor in a prone position." Once the mechanical restraints are applied staff must roll C2 onto his/her side.

A review of 18 "Documentation for Implementation of Approved Aversive and/or Deprivation Procedures" reports completed by staff following the use of a controlled procedure with C3 between April 15, 2007 and October 28, 2007, provided the following information:

For a controlled procedure implemented on April 15, 2007, the reports states that staff cued C2 to stop [antecedent behavior] and staff "asked [him/her] to go to [his/her] room to calm down." Being sent to his/her room is not identified as a less intrusive intervention to be implemented prior to implementing a controlled procedure.

Prior to the development and approval of the IPP for the planned use of controlled procedures, emergency use of controlled procedures (EUCP) were implemented at least twice, once on February 22, 2006, and again on October 6, 2006. It was not documented for the October 6, 2006, emergency use that the property destruction was severe enough to create an immediate threat to the physical safety of the person or others. Neither report form documented if or when the expanded IDT conferred on the emergency use of the controlled procedures, including whether the EUCP reports were sent to all members of the expanded IDT and that the expanded IDT defined the target behavior for reduction or elimination in observable and measurable terminology; identified the antecedent or event that gave rise to the target behavior; if they identified the perceived function the target behavior served; and determined what modifications should be made to the existing individual program plan so as to not require the use of a controlled procedure.

| Date | Mechanical or Manual Restraint | Duration | Behavior |
|---|---|---|---|
| 02/22/2006 | Mechanical "cuffs and Hobble" | 6 min | flipping tables co-workers were sitting at; banging head on floor; kicking at staff |
| 10/06/2006 | Mechanical "cuffs and Hobble" | 11 min | destroying things in his/her room |

The purpose statement of METO's Emergency Use of Controlled Procedures (Manual and Mechanical Restraint) Procedure Number 3503, dated November 26, 2007, states in part that, "Exception: The only controlled procedure as defined in Minnesota Rules 9525.2740 that can be used in an emergency with a

client assigned to the ICF-MR building shall be manual restraint. Staff may use emergency manual, and if necessary, mechanical restraint, with clients assigned to Non ICF-MR buildings." However, in both the EUCPs implemented for C2 mechanical restraints were used.

**For C3:**

C3 was admitted into METO on August 9, 2005, under civil commitment and assigned to Home 8, a non-ICF/MR building. C3 has an Individual Program Plan (IPP) for the use of controlled procedures that was initially developed and approved for use on August 29, 2005. Addendums to the initial IPP were made on September 1, 2005, and August 3, 2007. C3's IPP includes the use of manual and mechanical restraints using a Posey® mobile restraint strap with (soft) cuffs and metal handcuffs to be used at the wrists behind the back, a Ripp® leg hobble at the ankles, and mobile restraints using a Posey® transportation belt at the waist with wrists locked into wrist restraints.

For each of the last four informed consents obtained from C3's legal representative for the use of the controlled procedures, dated March 8, 2007, through January 11, 2008, C3's legal representative consistently checked off on the informed consent form that consent was given voluntarily or that consent was given according to the conditions identified by the legal representative in the comment section of the consent form. In each situation where the legal representative indicated consent was given according to comments, the comment section of the form was left blank.

CM3 provided the following information during an interview:

C3's legal representatives visit C3 a couple of times a year but have not attended any of the interdisciplinary team (IDT) meetings at METO for C3 and have not raised concerns or questions regarding the use of controlled procedures for C3 by METO. C3's legal representatives have provided voluntary consent for the initial IPP proposing the use of a controlled procedure and have renewed consent for ongoing use of the controlled procedures on a quarterly basis since then.

C3's physical examination and health assessments dated August 10, 2005; July 19, 2006; and August 17, 2007, each identified "past history of asthma" under the medical history. Each was conducted and signed by METO's Registered Nurse (RN) / Certified Nurse Practitioner (CNP).

C3's physical examination and health assessment dated August 10, 2005, includes the statement; "No contraindication to emergency manual restraint. May hold prone until control is gained and then place in side-lying position." A handwritten note on this document signed by the RN/CNP dated December 14, 2005, states, "No contraindication to emergency use of mechanical or manual intervention measures. Should be held side-lying after initial control is obtained."

C3's physical examination and health assessments dated July 19, 2006, and August 17, 2007, include the statement, "No contraindication to emergency use of mechanical or manual intervention measures. Should be held side-lying after initial control is gained."

A Medical Information in Behavior Management Program Using Controlled Procedures form for C3 signed by METO's attending physician on February 9, 2006, describes the target behaviors to be reduced or eliminated and the type of hold and restraint to be used in response. The physician answered no as to whether there is "any medical evidence that a non-psychiatric medical condition(s) could result in the demonstrating of the target behavior(s) or should be considered in the development of the behavior

management program." The physician also answered no as to whether the use of a controlled procedure or manual or mechanical restraints were medically contraindicated.

C3's IPP Rule 40 Addendum for the use of controlled procedures (IPP) identifies three categories of target behavior: verbal threats of physical aggression, physical aggression, and property destruction. The IPP does not identify specific antecedents for these behaviors. However, the IPP does state in part that, "[C3] has a history of aggression and of threatening others with weapons and a past history of assault. Based upon the information available upon admission, [C3's] threats are best viewed as serious and, if not immediately controlled, imminently dangerous to staff." And, "Historically [C3] has engaged in significant aggression which has frequently resulted in injury to family, peers and/or caregivers. The team determined that early intervention in the escalation cycle would have the greatest likelihood of decreasing the frequency and intensity of aggression. Verbal aggression was noted to frequently occur prior to aggression so it was specifically targeted for skill replacement. Due to [C3's] physical size as well as [his/her] aptitude for injuring others, the team determined that manual restraint is not the safest mode of restraint for [C3] due to the difficulty in applying consistent, constant pressure. National data also suggest that manual restraint poses a greater risk of serious injury to clients. Mechanical restraints were therefore evaluated by the team. Due to [C3's] size and strength, it was determined that of the restraint modalities likely to be effective, handcuffs and a hobble would be the simplest, quickest, and least intrusive method of restraint."

The IPP does not identify any other antecedent to verbal aggression. However, when C3 makes a verbal threat, the IPP directs staff to first verbally redirect C3 to "use self-control, per [his/her] social skills program, and identify and resolve whatever conflict or upset has resulted in the threat" prior to implementing the use of a controlled procedure. If the redirection fails and the threats of physical aggression continue, staff are directed to implement the use of the mechanical restraints which is initiated with "a verbal cue to get down on the floor/ground." And, "At least three staff will restrain and immobilize [C3] prone on the floor using approved TI/PST [Therapeutic Intervention/Personal Safety Techniques] techniques [sic]." Once the mechanical restraints are applied, "Staff may suggest that [s/he] roll to [his/her] side if that is more comfortable for [him/her] that [sic] being prone."

A review of 22 "Documentation for Implementation of Approved Aversive and/or Deprivation Procedures" reports completed by staff following the use of a controlled procedure with C3 between June 7, 2007 and November 18, 2007, provided the following information:

On June 6, 2007, two separate reports were completed for the implementation of a single controlled procedure. The first report documented the procedure as starting at 11:30a.m. and ending at 12:20p.m., lasting a total of 50 minutes, at the end of which the steel "hand cuffs removed @ 12:20 & still in soft cuffs." It is not clearly stated that leg hobbles were used but notation on the first report states that at 12:15p.m., "criteria not met -ankle released," which would indicate that leg hobbles were used. The second report documents the restraint starting at 12:25p.m. and ending at 12:40p.m. when C3 "met release criteria." The second report states that the antecedent behavior was, "Rule 40 - Released from cuffs (hard), put in soft cuffs." The second report states the procedure lasted 15 minutes.

Minnesota Rules, part 9525.2750, subpart 1, item I, requires that when mechanical restraint is used the person must be given an opportunity for release from the mechanical restraint and for motion and exercise of the restricted body parts for at least ten minutes out of every 60 minutes that the mechanical restraints are used. Further, C3's IPP states in part that, "[S]hould the mechanical restraint exceed one hour, [C3] MUST be provided with the opportunity to freely move each limb that is being restricted for ten minutes. Should [C3] aggress at any time upon release, a new episode of restraint will be initiated."

Based on the documentation provided in the two reports the total time of the single procedure was 65 minutes; that soft cuffs were applied during the first report period and their use continued through the second; and that during the 65 minute procedure there is no documentation that C3 was given an opportunity for release from the mechanical restraint and for motion and exercise of the restricted body parts for at least ten minutes out of every 60 minutes that the mechanical restraints are used.

Neither report documented whether a staff person remained with C3 during the time C3 was in the mechanical restraint restricting three or more limbs.

**For C4:**

C4 was admitted into METO on November 6, 2006, under civil commitment and assigned to Home 8, a non-ICF/MR building. C4 has a current Individual Program Plan (IPP) for the use of controlled procedures initially developed on November 22, 2006. Addendums to the IPP were made on December 6, 2006, May 7, 2007, and August 22, 2007. C4's IPP includes the use of manual and mechanical restraints using Posey© mobile restraint strap with (soft) cuffs and metal handcuffs at the wrists behind the back and a Ripp© leg hobble at the ankles.

The informed consent forms for the IPP signed by C4's legal representative on February 10, 2007, April 27, 2007, July 23, 2007, and September 16, 2007, all were checked that informed consent was given voluntarily. The comment section of each informed consent form was left blank by the legal representative. The informed consent form signed by C4' legal representative on October 13, 2007, indicated the information was provided orally both at a meeting and by telephone but did not indicate when the required information was provided orally.

CM4 provided the following information during an interview:

C4's legal representatives were involved in every step of the development of the IPP and have voluntarily given consent for the use of the controlled procedures without coercion by METO. The legal representatives feel C4 receives excellent care at METO and, "If they felt [C4] wasn't being taken care of they would not hesitate to contact me or anyone to else to raise concerns." And, "If the family felt [s/he] was [s/he] was being mistreated in any way they would let me or someone else know"

FM4 provided the following information during an interview:

Consent has been given voluntarily for the use of the controlled procedures at METO. The procedures are used only when needed and when less restrictive measures are not successful. Some controlled procedures previously used by METO have been discontinued as they are no longer needed "because [s/he] has improved over the last year." FM4 reported that if staff were implementing controlled procedures improperly that, "We go every weekend and know most of the staff. If something were happening we would probably notice."

C4's physical examination and health assessment completed by METO's RN/CNP on November 8, 2006, identified C4's seizure disorder and a brain stem dermoid tumor under the medical diagnoses and included the statement, "No contraindication to emergency use of mechanical or manual intervention measures." C4's physical examination and health assessment dated October 29, 2007, also lists seizure disorder and the brain stem dermoid tumor under diagnoses and includes the statement, "No contraindication to the use of mechanical or manual restraint procedures."

A Medical Information in Behavior Management Program Using Controlled Procedures form for C4 signed by METO's attending physician on June 25, 2007, describes the target behaviors to be reduced or eliminated and the type of hold and restraint to be used in response. The physician answered no as to whether there is "any medical evidence that a non-psychiatric medical condition(s) could result in the demonstrating of the target behavior(s) or should be considered in the development of the behavior management program." The physician also answered no as to whether the use of a controlled procedure or manual or mechanical restraints were medically contraindicated.

C4's IPP Rule 40 Addendum for the use of controlled procedures (IPP) identifies three categories of target behavior: physical aggression, property destruction, and self injurious behaviors. The antecedents identified for these behaviors include "signs of agitation (running, checking doors, ignoring staff directions, loud vocalizations)." If C4 exhibits antecedent behavior staff must give a verbal cue to C4 to stop the behavior and staff must attempt to identify the source of C4's agitation and remedy the situation if possible. Staff must redirect C4 to an appropriate alternative behavior. If C4 does not respond to the less intrusive interventions and proceeds to a target behavior staff must implement the controlled procedures in accordance with the instructions in the IPP which is initiated with a "verbal prompt to 'stop the behavior' and to lie down on the floor in a prone position." If C4 refuses to lie down on his own staff must "use approved therapeutic techniques to restrain him/her on the floor in a prone position." Once the mechanical restraints are applied staff must roll C4 to a side-lying position.

The IPP did not include documentation describing how intervention procedures incorporating positive approaches and less intrusive procedures have been tried, how long they were tried in each instance, and possible reasons why they were unsuccessful in controlling the behavior concern. The LH simply stated "Alternative Training" and that the factors limiting effectiveness were "communication deficits."

A review of 18 "Documentation for Implementation of Approved Aversive and/or Deprivation Procedures" reports completed by staff following the use of a controlled procedure with C4 between September 4, 2007 to October 14, 2007, provided the following information:

For controlled procedures implemented on 09/11/2007, 09/17/2007, 09/19/2007, 09/21/2007, 09/27/2007, 09/30/2007, 10/05/2007, 10/08/2007, two on 10/11/2007, and 10/15/2007, there was no documentation that staff attempted to help C4 identify the source of agitation that lead to the antecedent behavior or to remedy the situation. In these incidents staff only directed C4 to stop whatever antecedent behavior had been documented.

For a controlled procedure implemented on 09/21/2007 there was documentation indicating that the staff person's behavior or direction may have caused the target behavior when C4 was directed to take a shower instead of a bath. There was not documentation why C4 could not choose between a bath or a shower to justify this choice being eliminated.

Prior to implementation of the IPP for the planned use of controlled procedures, emergency use of controlled procedures (EUCP) occurred eight times between November 8, 2006 to December 2, 2006. During that same period there were four instances of emergency initiation of a psychotropic medication - Haldol 5mg, Ativan 2mg, and Benadryl 50 IM. METO failed to meet the reviewing and reporting requirements for the EUCPs. There was evidence that when staff persons implemented an EUCP with C4, that the reporting and review requirements were not followed. There was no evidence in the materials reviewed that documented that the case manager conferred with METO about the initial EUCP.

**For C5:**

C5 was admitted to METO on August 10, 2007, under civil commitment and assigned to Home 1, a Non-ICF/MR Building. C5 has an IPP for the use of controlled procedures initially developed on September 24, 2007. C5's IPP includes manual and mechanical restraints using time out and "therapeutic interventions" as needed to "escort [C5] to [his/her] room/quiet table."

C5's IPP for the use of a controlled procedure did not include a report from C5's primary physician identifying whether there is any medical evidence that a non-psychiatric medical condition(s) could result in the demonstrating of the target behavior(s) or should be considered in the development of the behavior management program; or whether the use of a controlled procedure or manual or mechanical restraints were medically contraindicated.

METO's notes from the "45-Day Meeting" form [initial IDT meeting required 45-days after service initiation] dated September 24, 2007, stated that C5's legal representatives "were notified that the frequent implementation of emergency controlled procedures required to manage [C5's] risk to self and others necessitates a programmatic response." Also, that "although [FM5] previously noted preference for the Time Out procedure, at this meeting [s/he] appeared disturbed by the idea of Time Out." However, C5's legal representative was reassured that s/he would receive a written program to review prior to implementation of any IPP for the use of a controlled procedure, but was "notified that in the meantime, the emergency use of controlled procedures would continue to be implemented per policy as needed to keep [C5] and others safe.".

On the informed consent form for the IPP signed by FM5 on October 11, 2007, FM5 wrote that informed consent for the use of controlled procedures was being given "to the Rule 40 addendum w/o [sic] use of any mechanical devices and/ or mechanical restraints." The informed consent form does not identify alternative procedures that have been attempted, considered, and rejected as not being effective or feasible. Instead it identifies the less intrusive measures staff will take prior to implementing the controlled procedure. The consent form also does not identify the *extent to which* the target behavior is expected to change as a result of implementing the procedures.

FM5 provided the following information during an interview:

FM5 did feel as if s/he was being forced to sign the consent form for the use of the controlled procedures. FM5 found the use of manual or mechanical restraints personally aversive. However, FM5 reviewed the IPP and signed the consent on October 11, 2007, for the use of room time out only with the contingency stated in the comment section that s/he only agreed "to the Rule 40 addendum w/o [sic] use of any mechanical devices and/ or mechanical restraints."

CM5 provided the following information during an interview:

CM5 felt that FM5 had not been coerced into providing consent; s/he felt METO had given FM5 the option of consenting to an IPP for the use of a controlled procedure. In addition, CM5 indicated that FM5 took "forever" to sign the consent for the IPP and there was no force used to obtain the consent.



FM5 provided the following information from e-mail correspondence between FM5, CM5, and P1:

In an e-mail dated October 3, 2007, from a facility staff person (P1) to FM5 regarding documents requiring signature by the legal representative states in part, "It is imperative that you return these documents, with signature ASAP."

In an e-mail dated October 4, 2007, from P1 to FM5, regarding the same documents identified in the October 3, 2007, e-mail states in part: "[C5's] treatment is stalled because we do not have signed signatures on anything we have given you. I will be calling [CM5] again today to begin [C5's] treatment."

In an e-mail dated October 5, 2007, from CM5 to FM5, states in part: "It is my understanding that you have received the information [all documents addressed in 10/04/2007 e-mail from SP3 to FM5], and returned the forms with your signatures. If you have not done this yet, it is very important that you do sign the forms and return them to METO ASAP. I understand and agree that you should have time to review the plans before you give your consent. However, it is very important that you give your consent to allow METO to work with your [son/daughter] in order to help [him/her] resolve some of [his/her] issues." And "I spoke to [P1] today and it is my understanding that your [son's/daughter's] therapist will not work with [him/her] until you have consented to the plans. In addition, METO may take the stance that if the plans are not approved, then they could have [him/her] discharged from their facility. I certainly hope it does not come to that."

The IPP Rule 40 Addendum for the use of controlled procedures (IPP) as consented to by FM5 provided the following information:

The antecedents identified for these behaviors include signs that C5: "may be frustrated or agitated." "Staff will encourage [C5] to use a skill learned in START group, SAFE group, individual therapy, or [s/he] may choose an activity provided by [his/her] Occupational Therapy Assessment." If C5 refuses, staff will ask C5 whether there is anything C5 wants to talk about." If C5 refuses to use calming techniques and engages in any of the target behaviors, the criteria has been met for implementation of the controlled procedure at which point staff deliver a verbal prompt to "stop the behavior."

The IPP then allows for the use of time out and the use of "approved therapeutic techniques to escort [C5] into [his/her] room/quiet table." The IPP did not provide for release from time out as required, specifically that "release is contingent on the person's stopping or bringing under control the behavior that precipitated the time out and must occur as soon as the behavior that precipitated the time out abates or stops." Under "Staff Response" for the "Behavior" section of the IPP, staff are directed to do the following:

> "1. Deliver a verbal prompt to stop the behavior . . . . " and
> "2. If [s/he] complies, inform [him/her] that 5 minutes of calm is expected before Time Out is discontinued."

This contradicts the directives under "Staff Response" for the "Release Criteria" section of the IPP, which directs staff to do the following:

> "1. After [C5] stops the behavior(s) that precipitated the Time Out, inform [him/her] that [s/he] has met the criteria to discontinue Time Out and advise [him/her] that [s/he] may leave [his/her] bedroom/quiet table."

C5's IPP Rule 40 Addendum for the use of controlled procedures (IPP) identifies four categories of target behavior: Major self-injurious behavior, physical aggression, major property destruction, and "AWOL" (absent without leave).

A review of the "Documentation for Implementation of Approved Aversive and/or Deprivation Procedures" reports completed by staff following the use of a controlled procedure with C5 between October 22, 2007 and December 5, 2007, provided the following information:

Only one in six uses of controlled procedures included use of time out. The other five occurrences included the use of manual and mechanical restraints

| Date | Mechanical or Manual Restraint | Duration | Effort to lessen every 15 min | Behavior | Time Out Used |
|---|---|---|---|---|---|
| 10/22/2007 | EUCP<br>manual-arm bar take down, prone hold; mechanical-cuffs and hobble<br><br>No documented attempt to use time out | 27 min | no | unable to go to church; physical aggression (undefined)<br><br>Staff tried "negotiation" and "offered positive alternatives" | no |
| 10/22/2007 | EUCP<br>manual-arm bar take down, prone hold<br><br>No documented attempt to use time out | 2 min | n/a | yelling; physical aggression (undefined)<br><br>Staff tried "negotiation" and "positive alternatives" | no |
| 11/01/2007 | EUCP<br>manual-arm bar take down, prone hold<br><br>No documented attempt to use time out | 4 min | n/a | arguing w/ peer & not accepting redirection from staff person (SP); shoved SP<br><br>Staff tried "negotiation" and "offered positive alternatives"<br><br>form states "met release criteria" but there is no "release criteria" identified in the IPP | no |
| 11/02/2007 | EUCP<br>manual-arm bar take down, prone hold<br><br>No documented attempt to use time out | 2 min | n/a | AWOL, attempt to hit DP; physical aggression - AWOL<br><br>Staff "tried block exit" "negotiation" and | no |
| 11/14/2007 | IPP AS WRITTEN<br>time out | 6 min | n/a | swinging fists at staff<br><br>Staff tried "verbal prompt to calm" and to use "skills per Rule 40" | yes |
| 12/05/2007 | EUCP<br>manual-arm bar take down<br><br>No documented attempt to use time out | 5 min | n/a | struck peer on back right shoulder; during escort to room for time out C5 struck the staff<br><br>Staff "attempted to talk with C5 | no |

Documentation for each use of a mechanical restraint was completed on METO's "Documentation for Emergency Use of Controlled Procedure." The two EUCP forms dated October 22, 2007, and the one

dated November 1, 2007, do not indicate that immediate intervention was required to protect the physical safety of the person or others and the use of those controlled procedures did not meet the criteria for emergency use.

C5's IPP include provisions for the use of time out and the use of "therapeutic intervention techniques" to escort C5 to time out when needed. The informed consent obtained for the use of the controlled procedure explicitly stated that the consent did not include consent to the use of mechanical restraints or devices. There was no evidence that METO attempted to revise the IPP and receive approval to include manual and mechanical restraints. No evidence that the EUCP reports were sent to the expanded IDT for review or that the expanded IDT conferred on the emergency uses as required.

Prior to the development and approval of the IPP for the planned use of controlled procedures, emergency use of controlled procedures (EUCP) occurred 15 times between August 10, 2007 and September 13, 2007. For four of those reported uses it was not clearly documented that immediate intervention was required to protect the person or others from harm or to prevent severe property damage that is an immediate threat to the physical safety of the person or others.

- EUCP report dated September 11, 2007, identified "property destruction - throwing & tipping over chairs" as the behavior necessitating the emergency use of manual and mechanical restraints which included using a prone hold and leg hobbles. There is no documentation that the procedure was necessary to prevent severe property damage that is an immediate threat to the physical safety of the person or others.
- EUCP report dated September 13, 2007, identified "physical aggression toward staff" as the reason necessitating the emergency use of manual and mechanical restraints, which included use of "ankle hand cuff and leg hobble" but there is no further documentation of what C5 was doing that required immediate intervention to protect others from harm.
- EUCP reports dated September 9 and 10, 2007, identified "AWOL" and "trying to go AWOL" as the reason necessitating the emergency use of manual restraint. In both instances C5 was outside but it was not documented whether C5 was near the entrance of the campus (METO's campus is fenced at the perimeter) and at risk of leaving the campus and entering the street unsafely.
- For all EUCP reports it was not clearly documented if or when the EUCP report had been sent to all members of the expanded IDT, and for those involving manual and mechanical restraint if they had been sent to METO's internal review committee for review, within seven calendar days of the emergency use of the controlled procedure.
- For all EUCP reports it was not documented if or when the expanded IDT conferred on the emergency use of the controlled procedures, including whether the EUCP reports were sent to all members of the expanded IDT and that the expanded IDT defined the target behavior for reduction or elimination in observable and measurable terminology; identified the antecedent or event that gave rise to the target behavior; if they identified the perceived function of the target behavior served; and determined what modifications should be made to the existing individual program plan so as to not require the use of a controlled procedure.

**Dispositions:**

Allegation 1: METO uses coercion to obtain informed consent for the use of controlled procedures by telling legal representatives that unless they consent to the use of the controlled procedure METO will not serve the consumer.

Following interviews with case managers and family members/legal representatives and a review of informed consent documents, it is not evident that METO coerced legal representatives into giving consent for the use of controlled procedures for consumers C2-C4. For C5 there was evidence that METO disregarded the conditions of informed consent obtained from FM5, but it is inconclusive as to whether METO used coercion to obtain the consent from FM5.

- Disposition: Inconclusive.

Allegations 2: METO's Individual Program Plans (IPPs) developed for the use of controlled procedures do not meet the required standards for assessment, content, and review, including the failure to obtain a report from the physician on whether there are existing medical conditions that could result in the demonstration of behavior for which a controlled procedure may be proposed or should be considered in the development of an IPP for controlled procedure use.

A review of the IPPs for C2-C5 was conducted and it was determined that their IPPs were not in full compliance with the requirements under rule part 9525.2760.

- Disposition: Violations determined.

Allegation 3: METO staff use controlled procedures for staff convenience and not based on the standards and conditions for use of the procedures, e.g., consumers are told that if they do not stop in engaging a behavior that a controlled procedure will be used and that no efforts to teach an alternative behavior are used.

A review of the IPPs and the controlled procedure implementation reports for consumers C2-C5 was conducted and it could not be determined that staff implemented controlled procedures for staff convenience; however, it was determined that the facility was not in full compliance with requirements under rule part 9525.2750.

- Disposition: Violations determined.

Allegation 4: METO staff implement controlled procedures on an emergency basis for staff convenience without the consumers behavior meeting the criteria for use, i.e., immediate intervention is needed to protect the person or others from physical injury or to prevent severe property damage that is an immediate threat to the physical safety of the person or others, and METO fails to complete the required review and reporting when a controlled procedure is used on an emergency basis.

For consumers C1, C2, C4, and C5, EUCP reports were reviewed and it was determined that for some emergency uses, the controlled procedures were not implemented, reviewed, or reported as required under rule part 9525.7770.

- Disposition: Violations determined.

**Action Taken by Program:**

- The program revised the *Documentation for Emergency Use of Controlled Procedure* (Form 31025, dated January 2008) to incorporate conferring with the EIDT by the QMRP following an EUCP.
- The program revised the *Emergency Use of Controlled Procedures (Manual and Mechanical Restraint)* (Policy Number 3503, effective February 7, 2008), placing increased emphasis on

Table 1
Consumer 1
Documented Emergency Use of Controlled Procedures

| Date | Mechanical or Manual Restraint | Duration | Behavior |
|---|---|---|---|
| 08/11/2005 | manual - arm bar take down | 15 min | Attempted to grab and hit staff person (SP) |
| 08/15/2005 | manual - arm bar take down | 1 min | Moving in on SP, tapping SP on shoulder |
| 08/26/2005 | manual - arm bar take down | 20 min | Running AWOL from work station x2 |
| 09/08/2005 | manual - prone hold | 5 min | Shoved SP |
| 09/26/2005 | manual - arm bar take down | 1 min | Striking out at SP x2 |
| 10/31/2005 | manual - arm bar take down | 2 min | Hit SP with back of hand |
| 11/02/2005 | manual - arm bar take down | 3 min | Hit SP with open hand |
| 11/07/2005 | manual - arm bar take down | 2 min | Came at SP with hand raised |
| | | | |
| 06/15/2006 | manual & mechanical - cuffs & hobble | 39 min | Physical aggression (undefined) |
| | | | |
| 03/26/2007 | manual & mechanical - cuffs & hobble | 15 min | Kicked wall with force |
| 05/07/2007 | manual - arm bar take down | 20-30 sec | Stood on SP's toes |
| 05/19/2007 | manual & mechanical - cuffs & hobble | 50 min | Came at SP, tried to push SP over |
| 05/24/2007 | manual & mechanical - cuffs | 50 min | Physical aggression (undefined) |
| 05/28/2007 | manual & mechanical - cuffs & hobble | 12 min | Shoved SP |
| 05/30/2007 | manual & mechanical - mech not ID'd | 50 min | Shoved SP |
| 05/30/2007 | manual & mechanical - cuffs & hobble | 17 min | Poking SP, moving in on peer |
| 05/31/2007 | manual - arm bar take down | 1 min | Pushed SP x2 |
| 06/02/2007 | manual - arm bar take down | 1 min | Touched SP, was blocked, came at SP again / Physical aggression (undefined) |
| 06/02/2007 | manual - arm bar take down | 1 min | Poked SP, was blocked, came at SP again / Physical aggression (undefined) |
| 06/04/2007 | manual - arm bar take down | 1 min | Touched SP, was blocked, came at SP again / Physical aggression (undefined) |
| 06/12/2007 | manual - arm bar take down | 1 min | Threw keys at SP's head |
| 06/21/2007 | manual & mechanical - cuffs & hobble | 14 min | Kicked door, staff began to empty C1's room, C1 slammed drawer on SP's fingers |
| 06/26/2007 | manual & mechanical - cuffs & hobble | 27 min | Banging head on door with force |
| 06/26/2007 | manual - arm bar take down | 2 min | Pinching SP, Banging head on door with force |
| 08/23/2007 | manual - arm bar take down | 11 min | Grabbing at SP; Physical aggression (undefined) |
| 08/27/2007 | manual - arm bar take down | 12 min | Trying to touch peers & SP and slamming furniture ["QMRP to develop R40"] |

**Initial & Date**

Omb. Review _____
Dir. of Client Svc. Review _____
Children's Spec. or MRS Review _____
Intake to Data Base _____

# Appendix D

# Informational Web Site Links

# Informational Web Sites

TASH http://www.tash.org

National Association of Councils on Developmental Disabilities
http://www.nacdd.org

National Down Syndrome Society http://wwwndss.org

Autism National Committee http://www.autcom.org

The Arc of the United States http://www.thearc.org

# Appendix E

# Original Table of Restraints from the 10/29/2007 Site Visit

# METO Chart Review October 29, 2007**

| Record # | Rule 40 Restraint/Emergency Restraint* | |
|---|---|---|
| 1 | 13 | |
| 2 | 4 | |
| 3 | 23 | |
| 4 | 1 | |
| 5 | 2 | |
| 6 | 19 | |
| 7 | | |
| 8 | 17 | |
| 9 | 18 | |
| 10 | 16 | |
| 11 | 61 | |
| 12 | 42 | |
| 13 | 8 | |
| 14 | 10 | |
| 15 | 15/37 | |
| 16 | 3 | |
| 17 | | |
| 18 | 3 | |
| 19 | | |
| 20 | 13 | |
| 21 | 1 | |
| 22 | | |
| 23 | | |
| 24 | 15 | |
| 25 | 53/2 | |
| 26 | 1 | |
| 27 | 1 | |
| 28 | 1 | |
| 29 | 12 | |
| 30 | 1 | |
| 31 | | |
| 32 | | |
| 33 | | |
| 34 | | |
| 35 | | |
| 36 | | |
| 37 | 1 | |
| 38 | | |
| 39 | | |
| 40 | | |

*Numbers in Blue (Left) are Rule 40 procedures, numbers in Red (Right) are classified as emergency use of restraints

** These numbers only came from the current working files. Many of the clients had archived records showing many more restraints when a further review was completed. For example one client had 299 restraints in 2006.