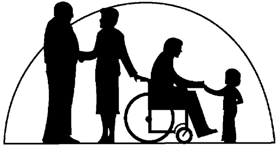

Minnesota Department of **Human Services**

INVESTIGATION MEMORANDUM
Office of Inspector General, Licensing Division
Public Information

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

Report Number: 20143062

Date Issued: September 9, 2014

Name and Address of Facility Investigated:

Meridian Colorado South
4600 Colorado Ave N
Crystal, MN 55422

Meridian Services
9400 Golden Valley Rd
Minneapolis, MN 55427

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

License Number and Program Type:

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

Investigator:

Stephanie Payne
Minnesota Department of Human Services
Office of Inspector General
Licensing Division
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Suspected Maltreatment Reported:

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

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

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

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

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

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

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

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

Summary of Findings:

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

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

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

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

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

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

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

Regarding the documentation on the VA's restraint chair:

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

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

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

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

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

Regarding the use of the VA's restraint chair:

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

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

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

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

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

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

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

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

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

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

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

Related Rules and/or Statutes:

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

Conclusion:

A. Maltreatment:

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

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

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

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

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

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

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

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

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

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

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

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

Related Rules and/or Statutes:

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

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

Conclusion:

A. Maltreatment:

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

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

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

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

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

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

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

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

Action Taken by Facility:

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

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

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

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