

Minnesota Attorney General: Administrative Rules Proceedings

Copyright Notice:

This material may be protected by copyright law (U.S. Code, Title 17). Researchers are liable for any infringement. For more information, visit www.mnhs.org/copyright.

Version 3
August 20, 2018

Our File No. 769

RULE REVIEW CHECKLIST

DATE RULE RECEIVED 1-4-82
DATE FOR REVIEW 1-15-82
DATE DUE 1-25-82

Adopted w/a hearing ✓
Adopted w/o hearing
Temporary rule

Approved 1/19/82 Disapproved Returned to Agency

Resubmitted Due
Approved Disapproved Returned to Agency

Date filed w/Secretary of State 1/19/82 Revisor approved / disapproved

---

✓ Rule as Adopted

✓ Rule as Proposed See SR.

✓ Order Adopting 12.23.81 Date

✓ Notice of Intent to Solicit Outside Opinion 8.19.80

✓ Order for rulemaking
10.1.81 date of Hearing

N/A Certificate of Board's Authorizing Resolution

✓ Notice of rulemaking
✓ Sufficiency

✓ Affidavit of Mailing Notice or rulemaking
8.24.81 At least 30 days prior to hearing/~~adoption~~
Additional Mailing ✓

✓ Mailing list Certificate

✓ Publication in State Register
8.31.81 At least 30/~~20~~ days prior to hearing/~~adoption~~

✓ Hearing Examiner's Report

✓ Chief Hearing Examiner's Report(s)
12.15.81 Approving H.E.'s Report
12.31.81 Approving agency action

✓ Agency's Findings of Fact included in Order Adopting, though not labeled as such

✓ LCRAR Report or agency Affidavit

N/A Certificate of Board's Resolution Adopting Rules

✓ Order Approving Incorporation by Reference

✓ Statement of Need and Reasonableness

N/A Petition for Adoption of a Rule

✓ Record (includes transcript or tape, exhibits, comments received by agency, requests for a hearing, and other relevant materials)

✓ Certificate of Compliance w/Rulemaking Procedures

✓ Affidavit of Mailing Notice of Submission to Attorney General

✓ Notice of Submission to the Attorney General

SF-00006-02

DEPARTMENT ATTORNEY GENERAL

STATE OF MINNESOTA

Office Memorandum

TO : ARTHUR E. NOOT
Commissioner, Department of Public Welfare

DATE: January 19, 1982

ATTN : JOHN SAUER, Mental Illness Program Div.

FROM : Jerry S. Anderson
Special Assistant Attorney General

PHONE: 296-4692

SUBJECT: In the Matter of the Proposed Adoption of the Department of Public Welfare Rule Governing Residential Programs for Adult Mentally Ill Persons (12 MCAR 2.036)

Enclosed herewith are the rules you have submitted for approval. These rules have been approved by this office and filed with the Secretary of State. Please note that they have not been filed with the State Register. This must be done promptly by your agency.

Upon receipt and before transmittal to your agency, however, it is important that you recheck these rules as to:

1. Affixation of stamps of the Attorney General and Secretary of State to the last page of the rules;

2. Coverage by these stamps of all rules submitted; and

3. Inclusion of all pages to the rules in the approved set.

If you have any questions in this regard, please contact me.

Encs.

cc: Ms. Kathy Burek
Mr. Duane Harves

JSA:drw

SF-00006-02

STATE OF MINNESOTA

Office Memorandum

DEPARTMENT of Public Welfare

TO : Judith Wehrwein
Attorney General's Office

DATE: January 4, 1982

RECEIVED
JAN 4 1982
ATTORNEY GENERAL
ADMINISTRATIVE AGENCIES

FROM : John Sauer
Mental Illness Program Division

PHONE: 297 - 2831

SUBJECT: Review of 12 MCAR §2036

Enclosed are documents being submitted for your review as required by 1 MCAR §1.202. This packet of materials ~~are~~ contains those listed in sections A-T of 1 MCAR §1.202. The remaining packets consists of the DPW and Public Exhibits offered at the Public Hearing on October 7, 1981 and related letters and materials.

Please call me if you have any questions.

Department of Public Welfare

Adopted Rule Governing Residential Programs for Adult Mentally Ill Persons (12 MCAR S 2.036)

Rule as Adopted

12 MCAR S 2.036 Licensing of residential facilities for adult mentally ill persons.

A. Applicability.

1. Rule 12 MCAR S 2.036 applies to all providers offering residential care and ~~treatment~~ program services to five or more adult mentally ill persons at one time for more than 30 days in any 12-month period and is based, in part, on Minn. Stat. S 245.782, subds. 6 and 9. This rule applies to mental health residential ~~treatment facilities~~ programs which are Category I programs as defined in B.3. and semi-independent or supportive group living ~~facilities~~ programs which are Category II programs as defined in B.4. This rule applies to mental health residential programs for the adult mentally ill within state hospitals, and adult foster ~~care~~ homes ~~or safe houses~~ with five or more adult residents who are mentally ill. These entities must be licensed as either Category I or Category II ~~facilities~~.

2. Rule 12 MCAR S 2.036 does not apply to programs located within a licensed ~~private~~ hospital ~~which~~ has a ~~psychiatric or chemical dependency program located within the hospital or to a mental health residential program~~, except state institutions under the control of the commissioner; nor does it apply to programs located within a licensed nursing home.

B. Definitions. As used in 12 MCAR S 2.036, the following terms have the meanings given them.

1. Applicant. "Applicant" means an individual, organization, association, partnership, corporation or unit of a state institution which submits an application for licensure under 12 MCAR S 2.036 ~~to provide care and treatment for five or more adult mentally ill persons in a mental health residential program~~.

2. Case management services. "Case management services" means the arranging and coordinating of direct services for a resident with the involvement of the resident. These direct services include, but are not limited to: assuring a diagnosis ~~when needed~~, assessing the resident's strengths and weaknesses in order to determine the resident's needs, developing an individual treatment plan, and evaluating the plan's effectiveness.

3. Category I program. "Category I program" means a mental health residential program which provides ~~intensive treatment for persons who are mentally ill and~~ program services in which there is an emphasis on services being offered on a regular basis within the facility with the use of community resources being encouraged and practiced.

4. Category II program. "Category II program" means a mental health residential program which provides either a transitional semi-independent living arrangement or a supervised group supportive living arrangement for mentally ill persons. This type of program offers a combination of in-house and community resource services with emphasis on securing community resources for most daily programming and employment.

5. Commissioner. "Commissioner" means the Commissioner of the Department of Public Welfare or a duly authorized representative.

6. Community representative. "Community representative" means an individual who represents ~~a broad base of citizen interest~~ citizens' interests and who is neither an employee or board member, nor has any other official affiliation with the mental health residential program.

7. Crisis services. "Crisis services" means a set of activities designed to respond to medical, situational, and psychiatric emergencies.

8. Department. "Department" means the Department of Public Welfare.

9. Full-time. "Full-time" means work time equalling at least 37 1/2 hours per week.

10. Independent living ~~services~~ skills training. "Independent living ~~services~~ skills training" means services which both emphasize development of an individual's skills required to perform increasingly independent daily living functions and which are appropriate to the needs of the individual.

11. Individual program plan. "Individual program plan" or "individual treatment plan" means a written plan of intervention and treatment developed on the basis of assessment results and ~~modified at frequent~~ revised, if necessary, at certain intervals. The plan specifies goals and objectives and a means for their accomplishment, and also identifies responsible staff persons.

12. License. "License" has the meaning given it in Minn. Stat. S 245.782, subd. 11.

13. Living unit. "Living unit" means a set of rooms which are physically self-contained, which have the defining walls extending from floor to ceiling, and which include bedrooms, living rooms or lounge areas, bathrooms and connecting areas.

~~13.~~ 14. Mental health counselor. "Mental health counselor" means an individual who, under the supervision of a mental health therapist or program director, provides treatment for mentally ill residents in a mental health residential program and who meets the requirements of P.7. The specific title of the individual employed in this position is at the discretion of the program as long as the title selection fairly reflects the responsibilities defined in 12 MCAR S 2.036 for a mental health counselor.

~~14.~~ 15. Mental health residential program. "Mental health residential program" or "program" means a planned combination of living conditions, services, and resources for the treatment and rehabilitation of five or more mentally ill adults on a 24-hour per day basis.

~~15.~~ 16. Mental health therapist. "Mental health therapist" means an individual skilled in providing mental

health therapy in a mental health residential program and who meets the requirements of P.6. The specific title of the individual employed in this position is at the discretion of the program as long as the title selection fairly reflects the responsibilities defined in 12 MCAR S 2.036 for a mental health therapist.

~~16.~~ 17. Mental health therapy. "Mental health therapy" means various treatment modalities which may reasonably be expected to improve the resident's condition.

~~17.~~ 18. Mental health worker. "Mental health worker" means an individual who, under the supervision of a mental health counselor, mental health therapist, or program director, provides care, support, or assistance to mentally ill residents in a mental health residential program and who meets the requirements of P.8. Possible job titles for this staff position are resident manager, human services technician, independent living skills worker, and licensed practical nurse. The specific title of the individual employed in this position is at the discretion of the program as long as the title selection fairly reflects the responsibilities defined in 12 MCAR S 2.036 for a mental health worker.

~~18.~~ 19. Mentally ill person. "Mentally ill person" means ~~a person with a functional, nonorganic, emotional disorder which has been diagnosed by a physician or a licensed consulting psychologist, and who has demonstrated by his or her behavior an inability to interpret realistically the environment, cope with independent daily living or form meaningful relationships~~ who has been diagnosed by a physician, a licensed psychologist, or a licensed consulting psychologist as having a condition which results in an inability to interpret the environment realistically and in impaired functioning in primary aspects of daily living such as personal relations, living arrangements, work and recreation; or which is listed in the International Classification of Diseases (ICD-9-CM), code range 290, 293-302.9 or 306-314.9, or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical Manual of

Mental Disorders (DSM-III), Axes I, II or III.

~~19.~~ 20. Motivation and remotivation services. "Motivation and remotivation services" means a set of activities which encourages the development of positive attitudes and self-concept, and which encourages the resident to develop goals and to use available community resources.

~~20.~~ 21. Program director. "Program director" means a person who is responsible for the development and implementation of the mental health residential program and who meets the requirements of P.~~4~~ P.5.

~~21.~~ 22. Provisional license. "Provisional license" has the meaning given it in Minn. Stat. S 245.782, subd. 12.

~~22.~~ 23. Recreation and leisure time services. "Recreation and leisure time services" means a set of activities designed both to meet a resident's personal and therapeutic needs of self-expression, social interaction, and entertainment, and to develop skills and interests that lead to enjoyable and satisfying use of leisure time. A ~~major~~ An objective of ~~these~~ these services is the integration of residents into the recreational mainstream of the community.

~~23.~~ 24. Restraint. "Restraint" means any physical device that limits the free and normal movement of body and limbs.

~~24.~~ 25. Seclusion. "Seclusion" means involuntary removal into a separate room which prevents social contact with other persons.

~~25.~~ 26. Socialization services. "Socialization services" means a set of activities in which residents learn interpersonal relationship and communication skills.

~~26.~~ 27. Social services. "Social services" ~~includes~~ may include psychosocial evaluation; counseling based on social work problem-solving methods; activities designed to assist residents in dealing with tasks of daily living; utilization of community resources; psychotherapy for individuals, families and groups; and education, planning, and advocacy for the social needs of residents.

~~27.~~ 28. Support group services. "Support group services"

means a ~~forum~~ group process designed ~~for~~ to allow residents to participate with other individuals in a ~~group process of~~ sharing feelings, experiences, and constructive feedback.

~~28.~~ 29. Vocational services. "Vocational services" means a set of activities emphasizing development of skills required to perform work functions in a competitive ~~or quasi-competitive~~, semi-competitive or volunteer work setting.

C. Licensing process.

1. License required. No mental health residential program shall operate in Minnesota unless it has a current and valid license or provisional license as required by Minn. Stat. SS 245.781-245.812.

2. Information furnished. Upon written request, each individual, organization, or agency shall be furnished with a copy of 12 MCAR S 2.036 and other pertinent materials such as an application form and instructions for obtaining a license.

3. Application. Persons interested in obtaining licensure under 12 MCAR S 2.036 shall submit to the commissioner ~~a completed~~ an application on forms supplied by the department. The applicant shall either document compliance with all applicable building codes, fire and safety codes, health rules, zoning ordinances, and other applicable rules and regulations or submit documentation that appropriate variances have been granted.

4. Decision. The commissioner shall make a decision on licensure after completion of the following steps:

a. a review of the application;

b. a visit to the program site; and

c. interviews with staff and a ~~random~~ sample of residents ~~and staff, in the case of existing facilities~~.

5. Fee. Each applicant shall pay to the commissioner a nonrefundable fee not to exceed $150 for the costs of processing the license application. Information regarding the specific amount and the timing of the payment shall be made available to the applicant.

6. Renewals. Application for renewal of a license shall

be made on forms furnished by the department at least 30 days prior to the date of expiration of the license.

D. License changes; report. Any changes in the following areas shall be reported in writing to the department at least 20 days prior to the change:

1. a change in licensed capacity;

2. the location of the program;

3. a change in program director;

4. a change in ownership; or

5. major changes in programming. Major changes in programming include such areas as a change in the target population or shifting from the internal provision of services to the external provision of services through a purchase of service contract. Changes in programming which do not have to be reported include such changes as the addition of staff, reassignment of staff, and establishing new groups.

E. Program policy and procedures manual. Each mental health residential program shall develop a written policy and procedures manual. The manual shall contain all materials required by F.-M. The manual shall be available for inspection by the department.

F. Statement of purpose and policies. The manual shall contain a complete statement describing the mental health residential program's philosophy and goals. This statement shall include, but not be limited to, a description of:

~~a.~~ 1. the geographical area to be served;

~~b.~~ 2. the ~~treatment~~ design and methodology of program services; and

~~c.~~ 3. the scope of services offered.

G. Program organization and administration.

1. Advisory committee. Each program shall have an advisory committee which provides for ~~reasonably broad~~ community representation and public participation in its operation. The advisory committee shall have a core group which comprises a quorum. The core group shall include at least one program resident, the facility's administrator, and a community

representative. The advisory committee shall document the procedure whereby residents are assured access to the advisory committee. The committee shall meet at least quarterly. Minutes of the meetings shall be recorded and kept on file at the facility. Each program shall provide to the department a list of names and titles of the members of the advisory committee who are members at the time of submitting an application or renewal of a license under 12 MCAR S 2.036.

2. Governing body. All programs shall have a governing body which is accountable for, and has authority over, the policies and activities of the program. In the case of a program owned by a proprietor or partnership, the proprietor or partners shall be regarded as the governing body for the purpose of this part. Each program shall provide to the department a list of names and titles of the members of its governing body.

3. Designated authority. A program operating within Minnesota with headquarters outside of the state shall have a duly authorized representative with decision-making responsibility designated within this state.

H. Required documentation and reports.

1. Insurance coverage. Each program shall have written documentation of insurance coverage in an amount sufficient to protect the interests of residents and staff. Each program must document the specific types and amounts of coverage and the carrier or carriers.

2. Bonding. Each program shall have written documentation that all employees are bonded or otherwise appropriately insured if they have access to or responsibility for handling money.

3. Financial information. Each program shall make available to the commissioner an annual fee schedule. A new program shall document in writing ~~assurance~~ a plan of funding sufficient to meet total projected program costs for a period of at least one year in addition to start-up costs.

4. Maintenance. Each program shall document that the maintenance and upkeep of the facility is being done by staff

hired by the program or through a written working agreement with an outside person or firm.

5. Non-discrimination policy. Each program shall have a written policy which requires that no resident be discriminated against in admission, termination, or ~~treatment~~ the provision of program services on the basis of race, creed, color, national origin, ~~relation~~ religion, physical handicap, sexual preference, public assistance status or marital status.

6. Each applicant shall document compliance with provisions of Minn. Stat. S 626.557.

~~6.~~ 7. Accident reports. Each program shall have a written policy regarding accidents and missing persons. Each program shall maintain in central files at the facility reports regarding accidents or missing persons if the reports pertain to facility residents.

~~7.~~ 8. Annual comprehensive report. Each program shall give a comprehensive annual report to its governing body ~~and~~, its advisory committee and to the host county. The report shall also be available to the commissioner. The report shall include documentation in at least the following areas:

a. a current organizational chart listing the number of full-time equivalent positions in each ~~category~~ job class;

b. training, staff development, and continuing education activities of staff;

c. administrative policy and procedure changes;

d. program evaluation as required in ~~8.~~ 9.; and

e. a financial report.

~~8.~~ 9. Program evaluation.

a. Process required. Each program shall institute an evaluation process to be conducted on an ongoing basis. ~~An annual report of this evaluation shall be submitted to the program's governing body and advisory committee and to the host county.~~ The evaluation process shall be outcome-based and consistent with the emphasis of 12 MCAR S 2.036 on individual treatment planning. In a format developed by the commissioner, the data and documentation required by b., c., and d. shall be

submitted to the commissioner on an annual, aggregate basis for state-wide summaries and for planning the use of state resources.

b. General data. Each program shall systematically collect data that includes, but need not be limited to: resident demographic data, program service data, and data on concurrent services. Each program shall submit the data to the host county for combination with follow-up data collected by county case workers. ~~In a format developed by the commissioner, the data shall be submitted by each program to the commissioner on an annual, aggregate basis for statewide summaries and for planning the use of state resources.~~

c. Individual data. Each program shall also, for the purpose of examining the program's impact, assess the progress of each resident relative to the resident's individual treatment plan. Progress shall be assessed by rating each resident within 30 days of admission and thereafter at the time of quarterly review on uniform level of functioning scales determined by the commissioner.

d. County technical assistance. Each program shall collaborate with available county technical assistance staff to examine the evaluation results, to assess the overall progress of residents in the program, and to ~~demonstrate~~ document how the results are used in administrative and program development.

e. Data restrictions. Each program shall collect the statistical data described in ~~8.~~ 9. for the purpose of program evaluation. The categories of data shall be compatible with the evaluation requirement of the Community Social Services Act, Minn. Stat. ch. 256E, and shall not require duplicate data collection. Dissemination shall be in accordance with provisions of the Minnesota Government Data Practices Act, Minn. Stat. SS 15.1611-15.1699, and all applicable federal rules or laws.

I. Personnel policies and procedures.

1. General requirements. Each program shall have a written personnel policy and shall make a copy of it available to each employee upon employment and to the department for

review. Personnel policies shall be carried out in accordance with affirmative action policies and equal employment opportunity regulations.

2. Job description. The personnel policy shall contain job descriptions for each position specifying responsibilities, degree of authority to execute job responsibilities, standards of job performance, and qualifications.

3. Job evaluation. The personnel policy shall provide for job performance evaluations conducted on a regular and ongoing basis with a written annual review. As part of the annual performance review, each staff member shall have a growth and development plan. Each program shall develop a policy and establish procedures for resident input into staff evaluations.

4. Conditions of employment. The personnel policy shall describe the employees' conditions of employment, including their benefits, hours of work, methods of promotion, and the general conditions which constitute grounds for dismissal and suspension, ~~and the ways in which staff stress will be recognized and addressed~~.

5. Organizational chart. The personnel policy shall also include a chart or definition of organizational structure indicating lines of authority.

6. Grievance procedure. The personnel policy shall describe a grievance procedure for use by staff. This procedure shall allow the aggrieved party to bring the grievance to the highest level of authority in the operation of the facility. A list of other community resources, such as the Health Facilities Complaint Office in the Department of Health, the Licensing Division in the Department of Public Welfare, and the Department of Human Rights, shall be made available to staff by the facility.

7. Personnel data. Program employee personnel data shall be accessible to the department.

8. Staff orientation. The personnel policy shall include a program of orientation for all new staff and the orientation shall be based on a written plan. At a minimum, the plan of

orientation shall provide for training related to the specific job functions for which the employee was hired, facility policies and procedures, and the needs of mentally ill persons.

9. Staff training. The program shall have a staff development plan, including ~~in-service or outside training~~ continuing education opportunities. The plan shall be ~~developed~~ reviewed annually. The plan shall be relevant to the facility's program and resident population. There shall be at least 15 hours of ~~in-service training, or training through community resources, or both,~~ continuing education annually for each staff person working directly with mentally ill persons. The training shall include, but need not be limited to, the following areas:

a. ~~Red Cross certified~~ first-aid training ~~or equivalent, to be updated at least every three years~~;

b. crisis intervention training for psychiatric emergencies;

c. problems and needs of mentally ill persons and their families;

d. community resources locally available to mentally ill adults;

e. psychotropic medications and their side effects;

f. resident rights;

g. cultural awareness training;

h. rules governing the operation of residential facilities for adult mentally ill persons; ~~and~~

i. staff stress or burnout; and

~~i.~~ j. other topics, such as case management, individualized goal planning, chemical use and abuse, health and nutrition, and services for multiple disability residents.

10. Training for non-direct care staff. Personnel of the program not referenced in this rule shall receive continuing education as appropriate to their role and function within the program.

J. Personnel files.

1. Central training file. The orientation and ~~in-service and training through community resources~~ continuing education

required by I. shall be documented by each program in a central training file. The file shall be available to the department for review. Documentation shall include, but need not be limited to: the date, the subject, the name of the person who conducted the training, the names of staff attending, and the number of hours attended.

2. Individual files. Each program shall maintain a separate personnel file for each employee. The files shall be available to the department for review. Employees shall be able to review their own personnel files, subject to the provisions of the Minnesota Government Data Practices Act, Minn. Stat. SS 15.1611-15.1699. At a minimum, each file shall contain the following:

a. an application for employment or a resume;

b. verification of employee's credentials;

c. an annual job performance evaluation;

d. an annual growth and development plan;

e. documentation of orientation; and

f. a record of training and education activities during employment.

K. Admission, discharge, and transfer policies.

1. Admission criteria. Each program shall develop admission criteria delineating the types and characteristics of persons who can and cannot be served by the program. Intake policies and procedures shall be developed including the role ~~and responsibility~~ of community resources.

2. Discharge and transfer policies. Each program shall develop detailed discharge and transfer policies and procedures. The policies and procedures shall include:

a. a planned discharge or transfer conference with the resident, staff representatives, and others requested by the resident if possible;

b. identification of community resources which directly relate to the continuing needs of the resident;

c. a description of the process by which a discharged or transferred resident would or would not have access to the

staff and other residents in order to facilitate readjustment in the community.

L. Program services. The following services shall be offered either ~~within~~ by the ~~facility~~ program or through a ~~contract~~ working agreement with other community resources:

~~a.~~ 1. case management services;

~~b.~~ 2. crisis services;

~~c.~~ 3. independent living ~~services~~ skills training;

~~d.~~ 4. mental health therapy;

~~e.~~ 5. motivation and remotivation services;

~~f.~~ 6. recreation and leisure time services;

~~g.~~ 7. socialization services;

~~h.~~ 8. support group services;

~~i.~~ 9. social services;

~~j.~~ 10. vocational services; and

~~k.~~ 11. other services if their need is indicated by the resident assessment.

M. Policies and procedures guaranteeing resident rights.

1. Explanation of rights. A written statement of residents' rights and responsibilities shall be developed encompassing 2.-~~10~~ 11. Program staff shall explain to each resident the resident's rights and responsibilities. A written statement of residents' rights and responsibilities shall be given to each resident, and to his or her responsible party ~~within 30 days of~~ if the resident has a legal guardian, on admission. A list of residents' rights and responsibilities shall be posted in a place accessible to the residents and shall be available to the department for review.

2. Grievance procedure. ~~Within 30 days of~~ Upon admission each resident shall be informed of grievance procedures available to the resident, and a copy of the procedures shall be posted in a place accessible to the resident. The grievance procedures shall include the following:

a. An offer of assistance by the ~~facility~~ program staff in development and process of the grievance; and

b. A list of internal resources for use by the

resident, such as the resident council or a grievance committee, and a list of community resources available to the resident, such as the health facilities complaint office in the Department of Health, the Licensing Division in the Department of Public Welfare, and the Department of Human Rights.

3. Resident council. Each program shall have a resident council through which residents have an opportunity to express their feelings and thoughts about the program and to affect policies and procedures of the program. Minutes of council meetings shall be recorded and made available to the program director.

4. Personal funds policy. ~~If~~ Staff ~~supervises~~ will not supervise the use of residents' personal funds or property, unless policies governing the supervision ~~shall be~~ have been written~~.~~ and unless the resident ~~shall sign~~ has signed a consent form prior to the exercise of supervision indicating an awareness of and consent to procedures governing the ~~program's~~ use of the resident's personal funds. In order to encourage independent living skills, any restriction of a resident's personal funds must be documented in the individual treatment plan. Resident fund accounts shall be maintained separately from program fund accounts.

5. Resident compensation. A resident who performs labor ~~which contributes to the operation and maintenance of the facility for which the facility would otherwise employ someone~~ other than labor of a housekeeping nature shall be compensated appropriately and in compliance with applicable state and federal labor laws, including minimum wage and minimum wage reduction provisions. ~~This provision shall not apply to labor of a personal housekeeping nature, nor to labor performed as a condition of residence in a small group living arrangement~~ Labor of a housekeeping nature shall be limited to household chores which a person living in his or her own residence in the community would normally perform.

6. Physician appointments. A resident shall be allowed to see ~~a private~~ his or her physician at any reasonable time.

7. Photographs of residents. ~~Photographs may be taken and used for personal or social purposes unless the resident has indicated his or her objection. Photographs may be taken for informational purposes only upon written consent of the resident~~ A resident shall not have his or her photograph taken for any purpose beyond identification unless he or she consents.

8. Telephone use. Residents shall have access within the facility to a telephone for incoming, local outgoing, and emergency calls. They shall have access within the facility to a pay phone or its equivalent for outgoing long distance calls. Any restriction on resident access to telephones shall be documented in the individual treatment plan.

9. Mail. Residents shall be allowed to receive and send uncensored mail. Any restrictions shall be documented in the individual treatment plan.

10. Restraints. The facility shall have a written policy that defines the uses of restraint, seclusion, and crisis medications as a treatment mode; the staff members who may authorize its use; and a mechanism for monitoring and controlling its use. Physical restraint and seclusion shall be used only when absolutely necessary to protect the resident from injury to himself or to others. Restraint, seclusion, and medications shall not be used as punishment, for the convenience of staff, or as a substitute for a program.

11. Visitors. Residents shall be allowed to receive visitors at reasonable times. They shall be allowed to receive visits at any time from their personal physician, religious advisor, and attorney. The right to receive visitors other than those specified above may be subject to reasonable written visiting rules and hours established by the head of the facility for all residents. The head of the facility may impose limitations on visits to an individual resident only if he or she finds the limitations are necessary for the welfare of the resident and if the limitation and reasons are fully documented in the resident's individual treatment plan.

N. Resident records.

1. Individual program plan development. ~~Each~~ The mental health residential program staff shall ~~develop and complete a written individual program plan for each resident~~, within ten days after admission, write short-term goals with each resident in order to address the resident's immediate needs. The program staff shall, within 30 days of admission, write an individual program plan which contains the components specified in 2. Medical, social, psychological, and psychiatric histories of the resident shall be used in the development of the plan. The plan shall be developed by an interdisciplinary team including the resident, the program staff, a representative of the referring agency and other appropriate resources, such as family, concerned others, and health care providers requested by the resident. Each resident shall be actively involved in developing his or her plan, unless contraindicated. The persons involved in the development of the individual program plan shall be noted on the plan. The extent of the resident's participation in developing the program plan shall also be noted on the plan. The plan and documentation related to it shall be kept in the facility where the mental health program is located.

2. Plan contents. An individual program plan shall contain at least the following components:

a. an assessment, including a strength and need list, of the resident in at least the following areas of life: social, medical, legal, family, leisure and recreation, spiritual or religious, psychological, financial, vocational and educational;

b. the specific problems to be resolved;

c. a list of goals in order of priority;

d. specific, measurable, and time-limited objectives which relate directly to the goals;

e. specific methods, strategies, and resources, including medications, to be used by the staff in assisting the resident to accomplish the goals and objectives;

f. the ~~agency~~ names of community resource personnel, program staff, or other persons designated to assist the resident in implementing the various components of the plan; and

g. notes indicating progress in achieving the goals and objectives.

3. Progress report. A quarterly review of the resident's response to the individual treatment plan and his or her involvement in the facility's overall program shall be written. Copies of this report shall be given to the resident and shall be sent to the representative of the referring agency and other persons deemed appropriate by the program director and resident. The resident's level of participation in the development and the review of the report shall be documented. The report shall be kept at the facility.

4. Discharge or transfer summary. A discharge or transfer summary shall be written for each person transferred or discharged. The summary shall include at least the following information:

a. a brief review of the resident's problems, strengths and needs while a resident of the program;

b. the response of the resident to his or her individual treatment plan and to the facility's overall program;

c. an aftercare plan which identifies the persons, including at least the resident, a program staff member, and a representative of the referring agency, who participated in the development of the aftercare plan; goals and objectives for the first three months after discharge or transfer; and individuals or agencies who will be working with the resident after discharge or transfer; and

d. a forwarding address and telephone number for follow-up contacts.

5. Accidents and missing persons. A copy of any report regarding accidents and missing persons must be documented in the individual's resident record if the resident is involved in the report.

6. Release of information. Private data regarding a resident shall not be used or released by the facility to any person or agency, except pursuant to the Minnesota Government Data Practices Act. The facility shall use written consent

forms for any release of resident information or data.

O. Living unit requirements.

1. ~~Structure. Each living unit of a mental health residential program shall be physically self-contained and shall include bedrooms, living rooms or lounge areas, bathrooms and connecting areas. Walls defining the living unit shall extend from floor to ceiling. These units shall be patterned after a home-like atmosphere, and~~ Furnishings. Each living unit shall include furnishings appropriate to the psychological, emotional, and developmental needs of each resident.

2. Ratios. For ~~existing programs~~ each program, there shall be one living room or lounge area per living unit for every up to 25 residents. ~~For new programs there shall be one living room or lounge area for every 16 residents.~~

3. Program space. There shall be space available for program services as indicated in the individual treatment plans such as an area for learning recreation and leisure time skills, and an area for learning independent living skills, such as laundering and cooking.

4. Gender of residents. The unit or complex of units shall house both male and female residents insofar as this conforms to prevailing cultural norms, unless contraindicated by the facility's overall program plan. The unit shall provide for appropriate separation of male and female residents.

5. Privacy. The living unit shall allow for individual privacy and group socialization. Each resident shall have the opportunity for privacy during assessment, interviews, counseling sessions and visitations.

6. Storage space. Each facility shall provide to each resident storage space for clothing and other personal property, including a secure place for valuables. Each facility may exclude particular kinds of personal property from the facility for reasons of space limitations or safety. Any exclusions shall be documented and included in the policies and procedures manual of the facility.

P. Additional requirements for Category I programs. In

addition to the requirements of A.-O., Category I programs shall meet the requirements of 1.-9.

1. Capacity. ~~Facilities, or treatment units within facilities existing as of July 1, 1980, not exceeding a maximum capacity of 40 beds shall be permitted. Facilities or units having over 40 beds shall have a three year period from the effective date of 12 MCAR S 2.036 to reduce the capacity to 40 beds or less~~ Applicants with facilities existing as of July 1, 1980, with a capacity exceeding 25 beds, shall have a three-year grace period from the effective date of 12 MCAR S 2.036 to reduce capacity to 40 beds or fewer, or to divide the facility into living units which do not exceed 25 beds. Applicants with facilities existing as of July 1, 1980, with a capacity exceeding 25 beds per living unit, shall not increase the total capacity of the facility. New facilities shall not exceed a maximum capacity of 25 beds.

2. Department of Health licensing standards. ~~Each program~~ The facility shall be licensed ~~either~~ as a supervised living facility ~~or as~~, a boarding care ~~facility~~ home, or a hospital.

3. Intake information. Each facility shall maintain in the facility documentation that:

a. a prospective resident has been diagnosed as being mentally ill and requires treatment;

b. the diagnoses are based on medical, social, psychological, and psychiatric information; and

c. medical, social, psychological and psychiatric histories were obtained for each resident.

~~5.~~ 4. Administrator. An individual shall be designated as administrator of the mental health residential program. The administrator shall be responsible for continuous overall operation, including maintenance and upkeep of the facility. In the administrator's absence, a staff member who is familiar with operations of the organization shall be designated to assume the responsibilities of the administrator. An individual who is functioning as administrator but not as program director shall

meet qualifications determined by the governing body which are consistent with the training and education needed to meet the stated goals of the ~~facility~~ program.

~~4.~~ 5. Program director. An individual shall be designated as the program director. The positions of program director and administrator may be filled by the same person. This individual shall meet at least the following qualifications:

a. a master's degree in the behavioral sciences or related field with at least two years of work experience providing services to mentally ill persons, or a bachelor's degree in the behavioral sciences or related field with a minimum of four years of work experience providing services to mentally ill persons; and

b. one year of experience or training in administration or supervision.

6. Mental health therapist. If mental health therapy is provided within the mental health residential ~~treatment facility~~ program, a mental health therapist shall be hired. Persons employed as mental health therapists prior to the effective date of 12 MCAR S 2.036 shall not be required to meet the qualifications of a. and b. Persons employed as mental health therapists after the effective date of 12 MCAR S 2.036 shall be required to meet the qualifications of a. and b. The mental health therapist shall be qualified in at least the following ways:

a. a bachelor's degree ~~in one of the behavioral sciences or related field~~; and

b. a master's degree in the behavioral sciences or related field or two years of advanced level, certificate training in mental health therapy~~; and~~

~~c. One year of experience providing services to mentally ill persons.~~

7. Mental health counselors. If program services other than mental health therapy are provided within the mental health residential ~~treatment facility~~ program, they shall be provided by mental health counselors or mental health workers, or both.

~~Mental health counselors shall meet the following qualifications:~~

~~a. A bachelor's degree in one of the behavioral sciences or related field;~~

~~b. A minimum of one year's experience working with mentally ill persons; and~~

~~c. Supervision by a mental health therapist or the program director.~~ Persons employed as mental health counselors prior to the effective date of 12 MCAR S 2.036 shall not be required to meet any specific education requirements. Persons employed as mental health counselors after the effective date of 12 MCAR S 2.036 shall have at least an Associate of Arts degree in one of the behavioral sciences or a related field or a registered nurse degree.

8. Mental health workers. ~~Mental health workers shall qualify in one of the following ways:~~

~~a. One year of experience working with mentally ill persons;~~

~~b. One year as a resident of a mental health residential program with three months' training relevant to the job responsibilities of a mental health worker; or~~

~~c. Three months of on-the-job training with continued supervision by at least a mental health counselor.~~ Persons employed as mental health workers after the effective date of 12 MCAR S 2.036 shall meet the qualifications as determined by the governing body to be consistent with those needed to meet the stated goals of the program.

9. Staffing ratios. The program shall have sufficient staff to provide the required program services and implement the individual program plans. Staffing patterns shall be developed to ensure 24-hour coverage within the mental health residential ~~treatment facility~~ program and to reflect the need for more staff per number of residents during hours of concentrated programming. The hours of the day devoted to ~~active treatment~~ concentrated programming shall be identified. The following minimum staff-to-resident ratios shall be maintained. The requirements of b. ~~and c.~~ represent full-time equivalencies and

may be prorated based on licensed resident capacity.

a. The number of work hours performed by the program director shall be prorated based on resident capacity with a ratio of ~~1 to 40 (1:40 F.T.).~~ ~~No more than one program director per program is required~~ 40 hours per week to 40 residents. With this ratio, applicants shall be allowed to use one program director to direct more than one program and shall be allowed to use one full-time program director for programs with less than a 40-bed resident capacity. With this ratio, applicants shall not be required to have more than one full-time program director for programs with more than a 40-bed resident capacity. However, applicants or programs with more than a 40-bed capacity shall describe whatever additional assistance they intend to provide for the program director function.

b. The number of work hours performed by the mental health therapist and mental health counselor and mental health worker may be combined in different ways, depending on program needs, to achieve a ratio of one full-time equivalent position for each five residents (1:5 F.T.E., averaged weekly). When the work hours are combined, the facility shall have written documentation that ~~the~~ supervision ~~required by 7.e. and 8.e.~~ is provided.

~~e. The program shall have one quarter-time equivalent in-service training coordinator for each forty residents (1/4:40 F.T.E.). The number of work hours performed by this individual may be combined with those of another program staff position.~~

Q. Additional requirements for Category II programs. In addition to the requirements of A.-O., Category II programs shall meet the requirements of 1. to 8.

1. Capacity. Facilities existing as of July 1, 1980, with a capacity exceeding 25 beds shall have a three-year period from the effective date of 12 MCAR S 2.036 to divide the facility into living units which do not exceed 25 beds. Facilities existing as of July 1, 1980, with a capacity exceeding 25 beds per living unit shall not increase the total capacity of the facility. New facilities shall not exceed a

maximum capacity of 25 beds.

2. Department of Health licensing standards. ~~Each program~~ The facility shall have a board and lodging license from the Minnesota Department of Health or its equivalent from a local health department or a health care license.

3. Intake information. Each facility shall maintain in the facility documentation that:

a. a mental health assessment or reassessment has been completed to determine appropriateness of admission; and

b. medical, social, psychological and psychiatric histories were obtained for each resident.

4. Medical information. Each program with a board and lodging license shall require that a physical exam be done 30 days prior to admission or within three days following admission. Each resident shall have an annual physical and dental examination. Records shall be kept of annual medical and dental examinations, including records on all prescription medications the resident is taking. Records shall also be maintained regarding the general medical condition of the resident, including any disabilities and limitations.

~~6.~~ 5. Administrator. An individual shall be designated as administrator of the mental health residential program. The administrator shall be responsible for continuous overall operation, including maintenance and upkeep of the facility. In the administrator's absence, a staff member who is familiar with operations of the organization shall be designated to assume the responsibilities of the administrator. An individual who is functioning as administrator but not as program director shall meet qualifications determined by the governing body which are consistent with the training and education needed to meet the stated goals of the ~~facility~~ program.

~~5.~~ 6. Program director. An individual shall be designated as the program director. The positions of program director and administrator may be filled by the same person. This individual shall meet at least the following qualifications:

a. a master's degree in the behavioral sciences or

related field and at least one year of work experience providing services to mentally ill persons, or a bachelor's degree in behavioral sciences or related field with a minimum of two years' work experience providing services to mentally ill persons; and

b. one year of experience or training in administration or supervision.

7. Mental health therapists, counselors and workers. If program services are offered within the facility, they shall be provided by mental health therapists, mental health counselors, or mental health workers~~, or both~~. The minimum qualifications for these positions shall be consistent with those of Category I specified in P.6., P.7. and P.8.

8. Staffing ratios. The facility shall have sufficient staff to provide the required program services and implement the individual program plans. Staffing patterns shall be developed to ensure 24-hour coverage within the mental health residential ~~treatment facility~~ program and to reflect the need for more staff per number of residents during hours of concentrated programming. The hours of the day devoted to ~~treatment~~ concentrated programming shall be identified. The following minimum staff-to-resident ratios shall be maintained. The requirement of b. represents a full-time equivalency and may be prorated based on licensed resident capacity.

a. The number of work hours performed by the program director shall be prorated based on resident capacity with the ratio of ~~1 to 40 (1:40 F.T.). No more than one program director per program is required~~ 40 hours per week to 40 residents. With this ratio, applicants shall be allowed to use one program director to direct more than one program and shall be allowed to use one full-time program director for programs with less than a 40-bed resident capacity. With this ratio, applicants shall not be required to have more than one full-time program director for programs with more than a 40-bed resident capacity. However, applicants or programs with more than a 40-bed capacity shall describe whatever additional assistance they intend to provide

for the program director function.

b. The number of work hours performed by the mental health therapist, mental health counselor, and mental health worker may be combined to achieve a ratio of one full-time equivalent staff position for each ten residents (1:10 F.T.E., averaged weekly). When the work hours are combined, the facility shall have written documentation that ~~the~~ supervision ~~required by P. 7. e. and P. 8. e.~~ is provided.

R. Variances. A residential program may request in writing a variance of a specific provision of 12 MCAR S 2.036. The request for a variance must cite the specification of the rule in question; reasons for requesting the variance; the period of time, not to exceed one year, the licensee wishes to have the provision varied; and the equivalent measures planned for assuring that programmatic needs of residents are met. Variances granted by the commissioner shall specify in writing the time limitation and required equivalent measures to be taken to assure that programmatic needs are met. ~~Variances denied by~~ The commissioner shall specify in writing the reasons for the denial of a variance. No variance shall be granted that would threaten the health, safety, or rights of residents.

S. Appeals. Revocation, suspension or denial of a license may be appealed pursuant to Minn. Stat. ch. 15.

Repealer. 12 MCAR S 2.036 which was effective February 4, 1974, is repealed.

OFFICE OF THE REVISOR OF STATUTES

Certificate of Approval of Adopted Rules

Agency: Department of Public Welfare

Rule Numbers: 12 MCAR S 2.036

Rule Title: Adopted Rule Governing Residential Programs for Adult Mentally Ill Persons

Type of Rules: Permanent X

Temporary _____

Documents Incorporated by Reference:

1. International Classification of Diseases (ICD-9-CM), Code range 290, 293-302.9 or 306-314.9.
2. Statistical Manual of Mental Disorders (DSM-III), Axes I, II or III, published by the American Psychiatric Association.

The attached Rules are approved as to form.

Steven C. Cross
Revisor of Statutes

APPROVED AS TO LEGALITY
1/18 1982
WARREN SPANNAUS, ATTORNEY GENERAL
BY _____
SPECIAL ASSISTANT ATTORNEY GENERAL

Name: Lorna M. Breiter
Lorna M. Breiter
Title: Assistant Revisor

Phone: 296-2778

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED
JAN 19 1982
Joan Anderson Growe
Secretary of State
4:03 P.M.

DPW-82-004-RL

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF PUBLIC WELFARE

In the Matter of the Proposed Adoption of the Department of Public Welfare Rule Governing the Licensure of Residential Facilities of Adult Mentally Ill Persons, 12 MCAR § 2.036.

ORDER OF THE CHIEF HEARING EXAMINER

After previous review by the Chief Hearing Examiner of the above-entitled matter, the agency has submitted an order adopting three additional changes which are either typographical, grammatical or clarifying in nature. These changes to Section M.4., M.11., and R. of the rule have been reviewed by the Chief Hearing Examiner, and are approved in all respects. The Chief Hearing Examiner specifically finds there is no substantial change as defined in Minn. Stat. § 15.0412, subd. 4-4f (1980).

Dated: January 19, 1982

DUANE R. HARVES
Chief Hearing Examiner

SF-00006-02

STATE OF MINNESOTA

Office Memorandum

DEPARTMENT ATTORNEY GENERAL

TO : JERRY S. ANDERSON
Special Assistant
Attorney General

DATE: 1/18/82

FROM : ELLEN C. DUBUQUE
Special Assistant
Attorney General

PHONE: 6-2418

SUBJECT: DPW Rule 36
(12 M.C.A.R. § 2.036)

Subsequent to the adoption of the above-captioned rule, the Commissioner has found three sections of the adopted rule which contain typographical or grammatical errors. Therefore, the Commissioner has adopted an amended order which makes minor changes which he finds to be insubstantial. The Amended Order, which is attached, is not intended to vacate the initial order, but merely supplement it.

Please contact me if you have questions.

ECD:fw
Enclosure

STATE OF MINNESOTA

COUNTY OF RAMSEY

ARTHUR E. NOOT, COMMISSIONER

DEPARTMENT OF PUBLIC WELFARE

In the Matter of the Proposed Adoption of the Department of Public Welfare Rule Governing the Licensure of Residential Facilities for Adult Mentally Ill Persons (12 MCAR 2.036)

AMENDMENT TO ORDER ADOPTING RULE

The Commissioner of Public Welfare hereby amends his Order Adopting Rule for DPW Rule 36, dated December 23, 1981. This amendment to the Order addresses Sections M.4., M.11., and R., and adds Findings 24, 25 and 26 to the Order. This amendment is intended to supplement the Order Adopting Rule and no part of that Order is vacated by this amendment.

The Commissioner's Order Adopting Rule is hereby amended and supplemented by addition of the following Findings:

24. The Commissioner finds that deletion of the word "program's" from the first sentence of Section M.4., is necessary and reasonable because, initially, it was included inadvertently, by a typographical error, and creates an ambiguity in the clear meaning of the section. The Commissioner finds this deletion is not a substantial change. The Commissioner hereby orders the amendment to Section M.4. which shall read, in relevant part, as follows:

> ". . . indicating an awareness of and consent to procedures governing the ~~program's~~ use of the resident's personal funds.

25. The Commissioner finds that deletion of the word "medical" from the last sentence of Section M.11. is necessary and reasonable because, initially, it was included inadvertently, by a typographical error, and creates an ambiguity in the clear meaning of the section. The Commissioner finds this deletion is not a substantial change. The Commissioner hereby orders the

amendment to Section M.11., which shall read, in relevant part, as follows:

> . . . The head of the facility may impose limitations on visits to an individual resident only if he or she finds the limitations are necessary for the ~~medical~~ welfare of the resident and . . . .

26. The Commissioner finds that deletion of the fourth sentence in Section R. and replacement of it with a new sentence as set out below is necessary and reasonable because the sentence as initially proposed is grammatically improper and creates an ambiguity in meaning. The Commissioner finds that the amendment is not a substantial change. The Commissioner hereby orders the amendment to Section R. as follows:

> ~~Variances-denied-by-the-commissioner-shall-specify in-writing-the-reasons-for-the-denial.~~--The Commissioner shall specify in writing the reasons for the denial of a variance.

IT IS THEREFORE ORDERED, that the Rule identified as Rule 36 of the Rules of the Minnesota Department of Public Welfare, as adopted on December 23, 1981, is hereby amended as set forth herein.

Dated: January 18, 1982.

STATE OF MINNESOTA
Department of Public Welfare

ARTHUR E. NOOT
Commissioner

OFFICE OF THE REVISOR OF STATUTES

Certificate of Approval of Adopted Rules

Agency: Department of Public Welfare

Rule Numbers: 12 MCAR S 2.036

Rule Title: Adopted Rule Governing Residential Programs for Adult Mentally Ill Persons

Type of Rules: Permanent X

Temporary _____

Documents Incorporated by Reference:

1. International Classification of Diseases (ICD-9-CM), Code range 290, 293-302.9 or 306-314.9.

2. Statistical Manual of Mental Disorders (DSM-III), Axes I, II or III, published by the American Psychiatric Association.

The attached Rules are approved as to form.

Steven C. Cross
Revisor of Statutes

Name: Lorna M. Breiter
Lorna M. Breiter

Title: Assistant Revisor

Phone: 296-2778

Department of Public Welfare

Adopted Rule Governing Residential Programs for Adult Mentally Ill Persons (12 MCAR S 2.036)

Rule as Adopted

12 MCAR S 2.036 Licensing of residential facilities for adult mentally ill persons.

A. Applicability.

1. Rule 12 MCAR S 2.036 applies to all providers offering residential care and ~~treatment~~ program services to five or more adult mentally ill persons at one time for more than 30 days in any 12-month period and is based, in part, on Minn. Stat. S 245.782, subds. 6 and 9. This rule applies to mental health residential ~~treatment facilities~~ programs which are Category I programs as defined in B.3. and semi-independent or supportive group living ~~facilities~~ programs which are Category II programs as defined in B.4. This rule applies to mental health residential programs for the adult mentally ill within state hospitals, and adult foster ~~care~~ homes ~~or safe houses~~ with five or more adult residents who are mentally ill. These entities must be licensed as either Category I or Category II ~~facilities~~.

2. Rule 12 MCAR S 2.036 does not apply to programs located within a licensed ~~private~~ hospital ~~which has a psychiatric or chemical dependency program located within the hospital or to a mental health residential program~~, except state institutions under the control of the commissioner; nor does it apply to programs located within a licensed nursing home.

B. Definitions. As used in 12 MCAR S 2.036, the following terms have the meanings given them.

1. Applicant. "Applicant" means an individual, organization, association, partnership, corporation or unit of a state institution which submits an application for licensure under 12 MCAR S 2.036 ~~to provide care and treatment for five or more adult mentally ill persons in a mental health residential program~~.

2. Case management services. "Case management services" means the arranging and coordinating of direct services for a resident with the involvement of the resident. These direct services include, but are not limited to: assuring a diagnosis ~~when needed~~, assessing the resident's strengths and weaknesses in order to determine the resident's needs, developing an individual treatment plan, and evaluating the plan's effectiveness.

3. Category I program. "Category I program" means a mental health residential program which provides ~~intensive treatment for persons who are mentally ill and~~ program services in which there is an emphasis on services being offered on a regular basis within the facility with the use of community resources being encouraged and practiced.

4. Category II program. "Category II program" means a mental health residential program which provides either a transitional semi-independent living arrangement or a supervised group supportive living arrangement for mentally ill persons. This type of program offers a combination of in-house and community resource services with emphasis on securing community resources for most daily programming and employment.

5. Commissioner. "Commissioner" means the Commissioner of the Department of Public Welfare or a duly authorized representative.

6. Community representative. "Community representative" means an individual who represents ~~a broad base of citizen interest~~ citizens' interests and who is neither an employee or board member, nor has any other official affiliation with the mental health residential program.

7. Crisis services. "Crisis services" means a set of activities designed to respond to medical, situational, and psychiatric emergencies.

8. Department. "Department" means the Department of Public Welfare.

9. Full-time. "Full-time" means work time equalling at least 37 1/2 hours per week.

10. Independent living ~~services~~ skills training. "Independent living ~~services~~ skills training" means services which both emphasize development of an individual's skills required to perform increasingly independent daily living functions and which are appropriate to the needs of the individual.

11. Individual program plan. "Individual program plan" or "individual treatment plan" means a written plan of intervention and treatment developed on the basis of assessment results and ~~modified at frequent~~ revised, if necessary, at certain intervals. The plan specifies goals and objectives and a means for their accomplishment, and also identifies responsible staff persons.

12. License. "License" has the meaning given it in Minn. Stat. S 245.782, subd. 11.

13. Living unit. "Living unit" means a set of rooms which are physically self-contained, which have the defining walls extending from floor to ceiling, and which include bedrooms, living rooms or lounge areas, bathrooms and connecting areas.

~~13.~~ 14. Mental health counselor. "Mental health counselor" means an individual who, under the supervision of a mental health therapist or program director, provides treatment for mentally ill residents in a mental health residential program and who meets the requirements of P.7. The specific title of the individual employed in this position is at the discretion of the program as long as the title selection fairly reflects the responsibilities defined in 12 MCAR S 2.036 for a mental health counselor.

~~14.~~ 15. Mental health residential program. "Mental health residential program" or "program" means a planned combination of living conditions, services, and resources for the treatment and rehabilitation of five or more mentally ill adults on a 24-hour per day basis.

~~15.~~ 16. Mental health therapist. "Mental health therapist" means an individual skilled in providing mental

health therapy in a mental health residential program and who meets the requirements of P.6. The specific title of the individual employed in this position is at the discretion of the program as long as the title selection fairly reflects the responsibilities defined in 12 MCAR S 2.036 for a mental health therapist.

~~16.~~ 17. Mental health therapy. "Mental health therapy" means various treatment modalities which may reasonably be expected to improve the resident's condition.

~~17.~~ 18. Mental health worker. "Mental health worker" means an individual who, under the supervision of a mental health counselor, mental health therapist, or program director, provides care, support, or assistance to mentally ill residents in a mental health residential program and who meets the requirements of P.8. Possible job titles for this staff position are resident manager, human services technician, independent living skills worker, and licensed practical nurse. The specific title of the individual employed in this position is at the discretion of the program as long as the title selection fairly reflects the responsibilities defined in 12 MCAR S 2.036 for a mental health worker.

~~18.~~ 19. Mentally ill person. "Mentally ill person" means a person ~~with a functional, nonorganic, emotional disorder which has been diagnosed by a physician or a licensed consulting psychologist, and who has demonstrated by his or her behavior an inability to interpret realistically the environment, cope with independent daily living or form meaningful relationships~~ who has been diagnosed by a physician, a licensed psychologist, or a licensed consulting psychologist as having a condition which results in an inability to interpret the environment realistically and in impaired functioning in primary aspects of daily living such as personal relations, living arrangements, work and recreation; or which is listed in the International Classification of Diseases (ICD-9-CM), code range 290, 293-302.9 or 306-314.9, or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical Manual of

Mental Disorders (DSM-III), Axes I, II or III.

~~19.~~ 20. Motivation and remotivation services. "Motivation and remotivation services" means a set of activities which encourages the development of positive attitudes and self-concept, and which encourages the resident to develop goals and to use available community resources.

~~20.~~ 21. Program director. "Program director" means a person who is responsible for the development and implementation of the mental health residential program and who meets the requirements of ~~P. 4~~ P.5.

~~21.~~ 22. Provisional license. "Provisional license" has the meaning given it in Minn. Stat. S 245.782, subd. 12.

~~22.~~ 23. Recreation and leisure time services. "Recreation and leisure time services" means a set of activities designed both to meet a resident's personal and therapeutic needs of self-expression, social interaction, and entertainment, and to develop skills and interests that lead to enjoyable and satisfying use of leisure time. A ~~major~~ An objective of ~~these~~ these services is the integration of residents into the recreational mainstream of the community.

~~23.~~ 24. Restraint. "Restraint" means any physical device that limits the free and normal movement of body and limbs.

~~24.~~ 25. Seclusion. "Seclusion" means involuntary removal into a separate room which prevents social contact with other persons.

~~25.~~ 26. Socialization services. "Socialization services" means a set of activities in which residents learn interpersonal relationship and communication skills.

~~26.~~ 27. Social services. "Social services" ~~includes~~ may include psychosocial evaluation; counseling based on social work problem-solving methods; activities designed to assist residents in dealing with tasks of daily living; utilization of community resources; psychotherapy for individuals, families and groups; and education, planning, and advocacy for the social needs of residents.

~~27.~~ 28. Support group services. "Support group services"

means a ~~forum~~ group process designed ~~for~~ to allow residents to participate with other individuals in ~~a group process of~~ sharing feelings, experiences, and constructive feedback.

~~28.~~ 29. Vocational services. "Vocational services" means a set of activities emphasizing development of skills required to perform work functions in a competitive ~~or quasi-competitive~~, semi-competitive or volunteer work setting.

C. Licensing process.

1. License required. No mental health residential program shall operate in Minnesota unless it has a current and valid license or provisional license as required by Minn. Stat. SS 245.781-245.812.

2. Information furnished. Upon written request, each individual, organization, or agency shall be furnished with a copy of 12 MCAR S 2.036 and other pertinent materials such as an application form and instructions for obtaining a license.

3. Application. Persons interested in obtaining licensure under 12 MCAR S 2.036 shall submit to the commissioner ~~a completed~~ an application on forms supplied by the department. The applicant shall either document compliance with all applicable building codes, fire and safety codes, health rules, zoning ordinances, and other applicable rules and regulations or submit documentation that appropriate variances have been granted.

4. Decision. The commissioner shall make a decision on licensure after completion of the following steps:

a. a review of the application;

b. a visit to the program site; and

c. interviews with staff and a ~~random~~ sample of residents ~~and staff, in the case of existing facilities~~.

5. Fee. Each applicant shall pay to the commissioner a nonrefundable fee not to exceed $150 for the costs of processing the license application. Information regarding the specific amount and the timing of the payment shall be made available to the applicant.

6. Renewals. Application for renewal of a license shall

be made on forms furnished by the department at least 30 days prior to the date of expiration of the license.

D. License changes; report. Any changes in the following areas shall be reported in writing to the department at least 20 days prior to the change:

1. a change in licensed capacity;

2. the location of the program;

3. a change in program director;

4. a change in ownership; or

5. major changes in programming. Major changes in programming include such areas as a change in the target population or shifting from the internal provision of services to the external provision of services through a purchase of service contract. Changes in programming which do not have to be reported include such changes as the addition of staff, reassignment of staff, and establishing new groups.

E. Program policy and procedures manual. Each mental health residential program shall develop a written policy and procedures manual. The manual shall contain all materials required by F.-M. The manual shall be available for inspection by the department.

F. Statement of purpose and policies. The manual shall contain a complete statement describing the mental health residential program's philosophy and goals. This statement shall include, but not be limited to, a description of:

~~a.~~ 1. the geographical area to be served;

~~b.~~ 2. the ~~treatment~~ design and methodology of program services; and

~~c.~~ 3. the scope of services offered.

G. Program organization and administration.

1. Advisory committee. Each program shall have an advisory committee which provides for ~~reasonably broad~~ community representation and public participation in its operation. The advisory committee shall have a core group which comprises a quorum. The core group shall include at least one program resident, the facility's administrator, and a community

representative. The advisory committee shall document the procedure whereby residents are assured access to the advisory committee. The committee shall meet at least quarterly. Minutes of the meetings shall be recorded and kept on file at the facility. Each program shall provide to the department a list of names and titles of the members of the advisory committee who are members at the time of submitting an application or renewal of a license under 12 MCAR S 2.036.

2. Governing body. All programs shall have a governing body which is accountable for, and has authority over, the policies and activities of the program. In the case of a program owned by a proprietor or partnership, the proprietor or partners shall be regarded as the governing body for the purpose of this part. Each program shall provide to the department a list of names and titles of the members of its governing body.

3. Designated authority. A program operating within Minnesota with headquarters outside of the state shall have a duly authorized representative with decision-making responsibility designated within this state.

H. Required documentation and reports.

1. Insurance coverage. Each program shall have written documentation of insurance coverage in an amount sufficient to protect the interests of residents and staff. Each program must document the specific types and amounts of coverage and the carrier or carriers.

2. Bonding. Each program shall have written documentation that all employees are bonded or otherwise appropriately insured if they have access to or responsibility for handling money.

3. Financial information. Each program shall make available to the commissioner an annual fee schedule. A new program shall document in writing ~~assurance~~ a plan of funding sufficient to meet total projected program costs for a period of at least one year in addition to start-up costs.

4. Maintenance. Each program shall document that the maintenance and upkeep of the facility is being done by staff

hired by the program or through a written working agreement with an outside person or firm.

5. Non-discrimination policy. Each program shall have a written policy which requires that no resident be discriminated against in admission, termination, or ~~treatment~~ the provision of program services on the basis of race, creed, color, national origin, ~~relation~~ religion, physical handicap, sexual preference, public assistance status or marital status.

6. Each applicant shall document compliance with provisions of Minn. Stat. S 626.557.

~~6.~~ 7. Accident reports. Each program shall have a written policy regarding accidents and missing persons. Each program shall maintain in central files at the facility reports regarding accidents or missing persons if the reports pertain to facility residents.

~~7.~~ 8. Annual comprehensive report. Each program shall give a comprehensive annual report to its governing body ~~and~~, its advisory committee and to the host county. The report shall also be available to the commissioner. The report shall include documentation in at least the following areas:

a. a current organizational chart listing the number of full-time equivalent positions in each ~~category~~ job class;

b. training, staff development, and continuing education activities of staff;

c. administrative policy and procedure changes;

d. program evaluation as required in ~~8.~~ 9.; and

e. a financial report.

~~8.~~ 9. Program evaluation.

a. Process required. Each program shall institute an evaluation process to be conducted on an ongoing basis. ~~An annual report of this evaluation shall be submitted to the program's governing body and advisory committee and to the host county.~~ The evaluation process shall be outcome-based and consistent with the emphasis of 12 MCAR S 2.036 on individual treatment planning. In a format developed by the commissioner, the data and documentation required by b., c., and d. shall be

submitted to the commissioner on an annual, aggregate basis for state-wide summaries and for planning the use of state resources.

b. General data. Each program shall systematically collect data that includes, but need not be limited to: resident demographic data, program service data, and data on concurrent services. Each program shall submit the data to the host county for combination with follow-up data collected by county case workers. ~~In a format developed by the commissioner, the data shall be submitted by each program to the commissioner on an annual, aggregate basis for statewide summaries and for planning the use of state resources.~~

c. Individual data. Each program shall also, for the purpose of examining the program's impact, assess the progress of each resident relative to the resident's individual treatment plan. Progress shall be assessed by rating each resident within 30 days of admission and thereafter at the time of quarterly review on uniform level of functioning scales determined by the commissioner.

d. County technical assistance. Each program shall collaborate with available county technical assistance staff to examine the evaluation results, to assess the overall progress of residents in the program, and to ~~demonstrate~~ document how the results are used in administrative and program development.

e. Data restrictions. Each program shall collect the statistical data described in ~~8.~~ 9. for the purpose of program evaluation. The categories of data shall be compatible with the evaluation requirement of tge Community Social Services Act, Minn. Stat. ch. 256E, and shall not require duplicate data collection. Dissemination shall be in accordance with provisions of the Minnesota Government Data Practices Act, Minn. Stat. SS 15.1611-15.1699, and all applicable federal rules or laws.

I. Personnel policies and procedures.

1. General requirements. Each program shall have a written personnel policy and shall make a copy of it available to each employee upon employment and to the department for

review. Personnel policies shall be carried out in accordance with affirmative action policies and equal employment opportunity regulations.

2. Job description. The personnel policy shall contain job descriptions for each position specifying responsibilities, degree of authority to execute job responsibilities, standards of job performance, and qualifications.

3. Job evaluation. The personnel policy shall provide for job performance evaluations conducted on a regular and ongoing basis with a written annual review. As part of the annual performance review, each staff member shall have a growth and development plan. Each program shall develop a policy and establish procedures for resident input into staff evaluations.

4. Conditions of employment. The personnel policy shall describe the employees' conditions of employment, including their benefits, hours of work, methods of promotion, and the general conditions which constitute grounds for dismissal and suspension~~, and the ways in which staff stress will be recognized and addressed~~.

5. Organizational chart. The personnel policy shall also include a chart or definition of organizational structure indicating lines of authority.

6. Grievance procedure. The personnel policy shall describe a grievance procedure for use by staff. This procedure shall allow the aggrieved party to bring the grievance to the highest level of authority in the operation of the facility. A list of other community resources, such as the Health Facilities Complaint Office in the Department of Health, the Licensing Division in the Department of Public Welfare, and the Department of Human Rights, shall be made available to staff by the facility.

7. Personnel data. Program employee personnel data shall be accessible to the department.

8. Staff orientation. The personnel policy shall include a program of orientation for all new staff and the orientation shall be based on a written plan. At a minimum, the plan of

orientation shall provide for training related to the specific job functions for which the employee was hired, facility policies and procedures, and the needs of mentally ill persons.

9. Staff training. The program shall have a staff development plan, including ~~in-service or outside training~~ continuing education opportunities. The plan shall be ~~developed~~ reviewed annually. The plan shall be relevant to the facility's program and resident population. There shall be at least 15 hours of ~~in-service training, or training through community resources, or both,~~ continuing education annually for each staff person working directly with mentally ill persons. The training shall include, but need not be limited to, the following areas:

a. ~~Red Cross certified~~ first-aid training ~~or equivalent, to be updated at least every three years~~;

b. crisis intervention training for psychiatric emergencies;

c. problems and needs of mentally ill persons and their families;

d. community resources locally available to mentally ill adults;

e. psychotropic medications and their side effects;

f. resident rights;

g. cultural awareness training;

h. rules governing the operation of residential facilities for adult mentally ill persons; ~~and~~

i. staff stress or burnout; and

~~i.~~ j. other topics, such as case management, individualized goal planning, chemical use and abuse, health and nutrition, and services for multiple disability residents.

10. Training for non-direct care staff. Personnel of the program not referenced in this rule shall receive continuing education as appropriate to their role and function within the program.

J. Personnel files.

1. Central training file. The orientation and ~~in-service and training through community resources~~ continuing education

required by I. shall be documented by each program in a central training file. The file shall be available to the department for review. Documentation shall include, but need not be limited to: the date, the subject, the name of the person who conducted the training, the names of staff attending, and the number of hours attended.

2. Individual files. Each program shall maintain a separate personnel file for each employee. The files shall be available to the department for review. Employees shall be able to review their own personnel files, subject to the provisions of the Minnesota Government Data Practices Act, Minn. Stat. SS 15.1611-15.1699. At a minimum, each file shall contain the following:

a. an application for employment or a resume;

b. verification of employee's credentials;

c. an annual job performance evaluation;

d. an annual growth and development plan;

e. documentation of orientation; and

f. a record of training and education activities during employment.

K. Admission, discharge, and transfer policies.

1. Admission criteria. Each program shall develop admission criteria delineating the types and characteristics of persons who can and cannot be served by the program. Intake policies and procedures shall be developed including the role ~~and responsibility~~ of community resources.

2. Discharge and transfer policies. Each program shall develop detailed discharge and transfer policies and procedures. The policies and procedures shall include:

a. a planned discharge or transfer conference with the resident, staff representatives, and others requested by the resident if possible;

b. identification of community resources which directly relate to the continuing needs of the resident;

c. a description of the process by which a discharged or transferred resident would or would not have access to the

staff and other residents in order to facilitate readjustment in the community.

L. Program services. The following services shall be offered either ~~within~~ by the ~~facility~~ program or through a ~~contract~~ working agreement with other community resources:

~~a.~~ 1. case management services;

~~b.~~ 2. crisis services;

~~c.~~ 3. independent living ~~services~~ skills training;

~~d.~~ 4. mental health therapy;

~~e.~~ 5. motivation and remotivation services;

~~f.~~ 6. recreation and leisure time services;

~~g.~~ 7. socialization services;

~~h.~~ 8. support group services;

~~i.~~ 9. social services;

~~j.~~ 10. vocational services; and

~~k.~~ 11. other services if their need is indicated by the resident assessment.

M. Policies and procedures guaranteeing resident rights.

1. Explanation of rights. A written statement of residents' rights and responsibilities shall be developed encompassing 2.~~-10~~ 11. Program staff shall explain to each resident the resident's rights and responsibilities. A written statement of residents' rights and responsibilities shall be given to each resident, and to his or her responsible party ~~within 30 days of~~ if the resident has a legal guardian, on admission. A list of residents' rights and responsibilities shall be posted in a place accessible to the residents and shall be available to the department for review.

2. Grievance procedure. ~~Within 30 days of~~ Upon admission each resident shall be informed of grievance procedures available to the resident, and a copy of the procedures shall be posted in a place accessible to the resident. The grievance procedures shall include the following:

a. An offer of assistance by the ~~facility~~ program staff in development and process of the grievance; and

b. A list of internal resources for use by the

resident, such as the resident council or a grievance committee, and a list of community resources available to the resident, such as the health facilities complaint office in the Department of Health, the Licensing Division in the Department of Public Welfare, and the Department of Human Rights.

3. Resident council. Each program shall have a resident council through which residents have an opportunity to express their feelings and thoughts about the program and to affect policies and procedures of the program. Minutes of council meetings shall be recorded and made available to the program director.

4. Personal funds policy. ~~If~~ Staff ~~supervises~~ will not supervise the use of residents' personal funds or property, unless policies governing the supervision ~~shall be~~ have been written~~.~~ and unless the resident ~~shall sign~~ has signed a consent form prior to the exercise of supervision indicating an awareness of and consent to procedures governing the program's use of the resident's personal funds. In order to encourage independent living skills, any restriction of a resident's personal funds must be documented in the individual treatment plan. Resident fund accounts shall be maintained separately from program fund accounts.

5. Resident compensation. A resident who performs labor ~~which contributes to the operation and maintenance of the facility for which the facility would otherwise employ someone~~ other than labor of a housekeeping nature shall be compensated appropriately and in compliance with applicable state and federal labor laws, including minimum wage and minimum wage reduction provisions. ~~This provision shall not apply to labor of a personal housekeeping nature, nor to labor performed as a condition of residence in a small group living arrangement~~ Labor of a housekeeping nature shall be limited to household chores which a person living in his or her own residence in the community would normally perform.

6. Physician appointments. A resident shall be allowed to see ~~a private~~ his or her physician at any reasonable time.

7. Photographs of residents. ~~Photographs may be taken and used for personal or social purposes unless the resident has indicated his or her objection. Photographs may be taken for informational purposes only upon written consent of the resident~~ A resident shall not have his or her photograph taken for any purpose beyond identification unless he or she consents.

8. Telephone use. Residents shall have access within the facility to a telephone for incoming, local outgoing, and emergency calls. They shall have access within the facility to a pay phone or its equivalent for outgoing long distance calls. Any restriction on resident access to telephones shall be documented in the individual treatment plan.

9. Mail. Residents shall be allowed to receive and send uncensored mail. Any restrictions shall be documented in the individual treatment plan.

10. Restraints. The facility shall have a written policy that defines the uses of restraint, seclusion, and crisis medications as a treatment mode; the staff members who may authorize its use; and a mechanism for monitoring and controlling its use. Physical restraint and seclusion shall be used only when absolutely necessary to protect the resident from injury to himself or to others. Restraint, seclusion, and medications shall not be used as punishment, for the convenience of staff, or as a substitute for a program.

11. Visitors. Residents shall be allowed to receive visitors at reasonable times. They shall be allowed to receive visits at any time from their personal physician, religious advisor, and attorney. The right to receive visitors other than those specified above may be subject to reasonable written visiting rules and hours established by the head of the facility for all residents. The head of the facility may impose limitations on visits to an individual resident only if he or she finds the limitations are necessary for the medical welfare of the resident and if the limitation and reasons are fully documented in the resident's individual treatment plan.

N. Resident records.

1. Individual program plan development. ~~Each~~ The mental health residential program staff shall ~~develop and complete a written individual program plan for each resident~~, within ten days after admission, write short-term goals with each resident in order to address the resident's immediate needs. The program staff shall, within 30 days of admission, write an individual program plan which contains the components specified in 2. Medical, social, psychological, and psychiatric histories of the resident shall be used in the development of the plan. The plan shall be developed by an interdisciplinary team including the resident, the program staff, a representative of the referring agency and other appropriate resources, such as family, concerned others, and health care providers requested by the resident. Each resident shall be actively involved in developing his or her plan, unless contraindicated. The persons involved in the development of the individual program plan shall be noted on the plan. The extent of the resident's participation in developing the program plan shall also be noted on the plan. The plan and documentation related to it shall be kept in the facility where the mental health program is located.

2. Plan contents. An individual program plan shall contain at least the following components:

a. an assessment, including a strength and need list, of the resident in at least the following areas of life: social, medical, legal, family, leisure and recreation, spiritual or religious, psychological, financial, vocational and educational;

b. the specific problems to be resolved;

c. a list of goals in order of priority;

d. specific, measurable, and time-limited objectives which relate directly to the goals;

e. specific methods, strategies, and resources, including medications, to be used by the staff in assisting the resident to accomplish the goals and objectives;

f. the ~~agency~~ names of community resource personnel, program staff, or other persons designated to assist the resident in implementing the various components of the plan; and

g. notes indicating progress in achieving the goals and objectives.

3. Progress report. A quarterly review of the resident's response to the individual treatment plan and his or her involvement in the facility's overall program shall be written. Copies of this report shall be given to the resident and shall be sent to the representative of the referring agency and other persons deemed appropriate by the program director and resident. The resident's level of participation in the development and the review of the report shall be documented. The report shall be kept at the facility.

4. Discharge or transfer summary. A discharge or transfer summary shall be written for each person transferred or discharged. The summary shall include at least the following information:

a. a brief review of the resident's problems, strengths and needs while a resident of the program;

b. the response of the resident to his or her individual treatment plan and to the facility's overall program;

c. an aftercare plan which identifies the persons, including at least the resident, a program staff member, and a representative of the referring agency, who participated in the development of the aftercare plan; goals and objectives for the first three months after discharge or transfer; and individuals or agencies who will be working with the resident after discharge or transfer; and

d. a forwarding address and telephone number for follow-up contacts.

5. Accidents and missing persons. A copy of any report regarding accidents and missing persons must be documented in the individual's resident record if the resident is involved in the report.

6. Release of information. Private data regarding a resident shall not be used or released by the facility to any person or agency, except pursuant to the Minnesota Government Data Practices Act. The facility shall use written consent

forms for any release of resident information or data.

O. Living unit requirements.

1. ~~Structure. Each living unit of a mental health residential program shall be physically self-contained and shall include bedrooms, living rooms or lounge areas, bathrooms and connecting areas. Walls defining the living unit shall extend from floor to ceiling. These units shall be patterned after a home-like atmosphere, and~~ Furnishings. Each living unit shall include furnishings appropriate to the psychological, emotional, and developmental needs of each resident.

2. Ratios. For ~~existing programs~~ each program, there shall be one living room or lounge area per living unit for ~~every~~ up to 25 residents. ~~For new programs there shall be one living room or lounge area for every 16 residents.~~

3. Program space. There shall be space available for program services as indicated in the individual treatment plans such as an area for learning recreation and leisure time skills, and an area for learning independent living skills, such as laundering and cooking.

4. Gender of residents. The unit or complex of units shall house both male and female residents insofar as this conforms to prevailing cultural norms, unless contraindicated by the facility's overall program plan. The unit shall provide for appropriate separation of male and female residents.

5. Privacy. The living unit shall allow for individual privacy and group socialization. Each resident shall have the opportunity for privacy during assessment, interviews, counseling sessions and visitations.

6. Storage space. Each facility shall provide to each resident storage space for clothing and other personal property, including a secure place for valuables. Each facility may exclude particular kinds of personal property from the facility for reasons of space limitations or safety. Any exclusions shall be documented and included in the policies and procedures manual of the facility.

P. Additional requirements for Category I programs. In

addition to the requirements of A.-O., Category I programs shall meet the requirements of 1.-9.

1. Capacity. ~~Facilities, or treatment units within facilities existing as of July 1, 1980, not exceeding a maximum capacity of 40 beds shall be permitted. Facilities or units having over 40 beds shall have a three year period from the effective date of 12 MCAR S 2.036 to reduce the capacity to 40 beds or less~~ Applicants with facilities existing as of July 1, 1980, with a capacity exceeding 25 beds, shall have a three-year grace period from the effective date of 12 MCAR S 2.036 to reduce capacity to 40 beds or fewer, or to divide the facility into living units which do not exceed 25 beds. Applicants with facilities existing as of July 1, 1980, with a capacity exceeding 25 beds per living unit, shall not increase the total capacity of the facility. New facilities shall not exceed a maximum capacity of 25 beds.

2. Department of Health licensing standards. ~~Each program~~ The facility shall be licensed ~~either~~ as a supervised living facility ~~or as~~, a boarding care ~~facility~~ home, or a hospital.

3. Intake information. Each facility shall maintain in the facility documentation that:

a. a prospective resident has been diagnosed as being mentally ill and requires treatment;

b. the diagnoses are based on medical, social, psychological, and psychiatric information; and

c. medical, social, psychological and psychiatric histories were obtained for each resident.

~~5.~~ 4. Administrator. An individual shall be designated as administrator of the mental health residential program. The administrator shall be responsible for continuous overall operation, including maintenance and upkeep of the facility. In the administrator's absence, a staff member who is familiar with operations of the organization shall be designated to assume the responsibilities of the administrator. An individual who is functioning as administrator but not as program director shall

meet qualifications determined by the governing body which are consistent with the training and education needed to meet the stated goals of the ~~facility~~ program.

~~4.~~ 5. Program director. An individual shall be designated as the program director. The positions of program director and administrator may be filled by the same person. This individual shall meet at least the following qualifications:

a. a master's degree in the behavioral sciences or related field with at least two years of work experience providing services to mentally ill persons, or a bachelor's degree in the behavioral sciences or related field with a minimum of four years of work experience providing services to mentally ill persons; and

b. one year of experience or training in administration or supervision.

6. Mental health therapist. If mental health therapy is provided within the mental health residential ~~treatment facility~~ program, a mental health therapist shall be hired. Persons employed as mental health therapists prior to the effective date of 12 MCAR S 2.036 shall not be required to meet the qualifications of a. and b. Persons employed as mental health therapists after the effective date of 12 MCAR S 2.036 shall be required to meet the qualifications of a. and b. The mental health therapist shall be qualified in at least the following ways:

a. a bachelor's degree ~~in one of the behavioral sciences or related field~~; and

b. a master's degree in the behavioral sciences or related field or two years of advanced level, certificate training in mental health therapy~~; and~~

~~c. One year of experience providing services to mentally ill persons~~.

7. Mental health counselors. If program services other than mental health therapy are provided within the mental health residential ~~treatment facility~~ program, they shall be provided by mental health counselors or mental health workers, or both.

~~Mental health counselors shall meet the following qualifications:~~

~~a. A bachelor's degree in one of the behavioral sciences or related field;~~

~~b. A minimum of one year's experience working with mentally ill persons; and~~

~~c. Supervision by a mental health therapist or the program director.~~ Persons employed as mental health counselors prior to the effective date of 12 MCAR S 2.036 shall not be required to meet any specific education requirements. Persons employed as mental health counselors after the effective date of 12 MCAR S 2.036 shall have at least an Associate of Arts degree in one of the behavioral sciences or a related field or a registered nurse degree.

8. Mental health workers. ~~Mental health workers shall qualify in one of the following ways:~~

~~a. One year of experience working with mentally ill persons;~~

~~b. One year as a resident of a mental health residential program with three months' training relevant to the job responsibilities of a mental health worker; or~~

~~c. Three months of on-the-job training with continued supervision by at least a mental health counselor.~~ Persons employed as mental health workers after the effective date of 12 MCAR S 2.036 shall meet the qualifications as determined by the governing body to be consistent with those needed to meet the stated goals of the program.

9. Staffing ratios. The program shall have sufficient staff to provide the required program services and implement the individual program plans. Staffing patterns shall be developed to ensure 24-hour coverage within the mental health residential ~~treatment facility~~ program and to reflect the need for more staff per number of residents during hours of concentrated programming. The hours of the day devoted to ~~active treatment~~ concentrated programming shall be identified. The following minimum staff-to-resident ratios shall be maintained. The requirements of b. ~~and c.~~ represent full-time equivalencies and

may be prorated based on licensed resident capacity.

a. The number of work hours performed by the program director shall be prorated based on resident capacity with a ratio of ~~1 to 40 (1:40 F.T.).~~ ~~No more than one program director per program is required~~ 40 hours per week to 40 residents. With this ratio, applicants shall be allowed to use one program director to direct more than one program and shall be allowed to use one full-time program director for programs with less than a 40-bed resident capacity. With this ratio, applicants shall not be required to have more than one full-time program director for programs with more than a 40-bed resident capacity. However, applicants or programs with more than a 40-bed capacity shall describe whatever additional assistance they intend to provide for the program director function.

b. The number of work hours performed by the mental health therapist and mental health counselor and mental health worker may be combined in different ways, depending on program needs, to achieve a ratio of one full-time equivalent position for each five residents (1:5 F.T.E., averaged weekly). When the work hours are combined, the facility shall have written documentation that ~~the~~ supervision ~~required by 7.c. and 8.c.~~ is provided.

~~c. The program shall have one quarter-time equivalent in-service training coordinator for each forty residents (1/4:40 F.T.E.). The number of work hours performed by this individual may be combined with those of another program staff position.~~

Q. Additional requirements for Category II programs. In addition to the requirements of A.-O., Category II programs shall meet the requirements of 1. to 8.

1. Capacity. Facilities existing as of July 1, 1980, with a capacity exceeding 25 beds shall have a three-year period from the effective date of 12 MCAR S 2.036 to divide the facility into living units which do not exceed 25 beds. Facilities existing as of July 1, 1980, with a capacity exceeding 25 beds per living unit shall not increase the total capacity of the facility. New facilities shall not exceed a

maximum capacity of 25 beds.

2. Department of Health licensing standards. ~~Each program~~ The facility shall have a board and lodging license from the Minnesota Department of Health or its equivalent from a local health department or a health care license.

3. Intake information. Each facility shall maintain in the facility documentation that:

a. a mental health assessment or reassessment has been completed to determine appropriateness of admission; and

b. medical, social, psychological and psychiatric histories were obtained for each resident.

4. Medical information. Each program with a board and lodging license shall require that a physical exam be done 30 days prior to admission or within three days following admission. Each resident shall have an annual physical and dental examination. Records shall be kept of annual medical and dental examinations, including records on all prescription medications the resident is taking. Records shall also be maintained regarding the general medical condition of the resident, including any disabilities and limitations.

~~6.~~ 5. Administrator. An individual shall be designated as administrator of the mental health residential program. The administrator shall be responsible for continuous overall operation, including maintenance and upkeep of the facility. In the administrator's absence, a staff member who is familiar with operations of the organization shall be designated to assume the responsibilities of the administrator. An individual who is functioning as administrator but not as program director shall meet qualifications determined by the governing body which are consistent with the training and education needed to meet the stated goals of the ~~facility~~ program.

~~5.~~ 6. Program director. An individual shall be designated as the program director. The positions of program director and administrator may be filled by the same person. This individual shall meet at least the following qualifications:

a. a master's degree in the behavioral sciences or

related field and at least one year of work experience providing services to mentally ill persons, or a bachelor's degree in behavioral sciences or related field with a minimum of two years' work experience providing services to mentally ill persons; and

b. one year of experience or training in administration or supervision.

7. Mental health therapists, counselors and workers. If program services are offered within the facility, they shall be provided by mental health therapists, mental health counselors, or mental health workers~~, or both~~. The minimum qualifications for these positions shall be consistent with those of Category I specified in P.6., P.7. and P.8.

8. Staffing ratios. The facility shall have sufficient staff to provide the required program services and implement the individual program plans. Staffing patterns shall be developed to ensure 24-hour coverage within the mental health residential ~~treatment facility~~ program and to reflect the need for more staff per number of residents during hours of concentrated programming. The hours of the day devoted to ~~treatment~~ concentrated programming shall be identified. The following minimum staff-to-resident ratios shall be maintained. The requirement of b. represents a full-time equivalency and may be prorated based on licensed resident capacity.

a. The number of work hours performed by the program director shall be prorated based on resident capacity with the ratio of ~~1 to 40 (1:40 F.T.). No more than one program director per program is required~~ 40 hours per week to 40 residents. With this ratio, applicants shall be allowed to use one program director to direct more than one program and shall be allowed to use one full-time program director for programs with less than a 40-bed resident capacity. With this ratio, applicants shall not be required to have more than one full-time program director for programs with more than a 40-bed resident capacity. However, applicants or programs with more than a 40-bed capacity shall describe whatever additional assistance they intend to provide

for the program director function.

b. The number of work hours performed by the mental health therapist, mental health counselor, and mental health worker may be combined to achieve a ratio of one full-time equivalent staff position for each ten residents (1:10 F.T.E., averaged weekly). When the work hours are combined, the facility shall have written documentation that ~~the~~ supervision ~~required by P. 7. e. and P. 8. e.~~ is provided.

R. Variances. A residential program may request in writing a variance of a specific provision of 12 MCAR S 2.036. The request for a variance must cite the specification of the rule in question; reasons for requesting the variance; the period of time, not to exceed one year, the licensee wishes to have the provision varied; and the equivalent measures planned for assuring that programmatic needs of residents are met. Variances granted by the commissioner shall specify in writing the time limitation and required equivalent measures to be taken to assure that programmatic needs are met. Variances denied by the commissioner shall specify in writing the reasons for the denial. No variance shall be granted that would threaten the health, safety, or rights of residents.

S. Appeals. Revocation, suspension or denial of a license may be appealed pursuant to Minn. Stat. ch. 15.

Repealer. 12 MCAR S 2.036 which was effective February 4, 1974, is repealed.

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE

In the Matter of the Proposed Adoption of the Department of Public Welfare Rule Governing Residential Programs for Adult Mentally Ill Persons (12 MCAR §2.036)

STATEMENT OF NEED AND REASONABLENESS

INTRODUCTION AND BACKGROUND

Deinstitutionalization History/Statistics

The need in Minnesota for licensure of facilities for adult mentally ill persons relates directly to a national trend to rely less on large institutions and more on community programs to provide care and treatment for mentally ill adults. This trend, often called "deinstitutionalization", has created a need for an expanded system of outpatient services and residential programs. A number of factors have contributed to this movement, both nationwide and on the local level.

President Kennedy's national initiative in 1963, to move half of the nation's state mental hospital populations to community treatment programs, was a step in the right direction. Admittances to state hospitals dropped steadily and dramatically, from over one half million in the 1950's to 191,000 in 1970; a 67% nationwide decrease.

However, although the hospital populations had decreased substantially, the number of persons still needing mental health services did not. Despite Kennedy's initiative, as of 1970, fewer than half of the needed community-based mental health centers were developed and few states adequately addressed the need for a system of residential treatment programs. What began as a humanitarian effort had evolved into a tragedy for many, due to the thousands of mentally ill persons who were forced to reside in substandard facilities which offered little or no mental health care and treatment.

Minnesota's policies regarding the state's mentally ill population underwent a major change six years prior to President Kennedy's national initiative. In 1957, the passage of community mental health program legislation by the Minnesota Legislature underscored a shift in Minnesota from the treatment approach which was generally regarded as "warehousing" patients in state institutions to one providing alternative community-based care and treatment.

State hospital daily census figures clearly indicate the effects of this shift toward deinstitutionalization. In 1962, the mentally ill population of Minnesota's state mental institutions numbered 8,709. By January, 1980, this figure had dropped to 1,530; less than 20% of the 1962 total.

However, these census figures represent only a portion of Minnesota's mentally ill population needing residential programs. Current estimates place the total number of chronically mentally ill persons in Minnesota between 18,000 and 22,000 residing in 300 to 350 facilities. Additionally, another 10,000 to 20,000 are living independently. Of these totals, approximately 9,400 have mental health needs appropriate for placement in Rule 36 licensed facilities. A statewide estimate by the Department of

Public Welfare indicates only one of every ten mentally ill persons requiring a supervised living situation is residing in a licensed residential program. In 1980, there were only 472 residents in seven Rule 36 licensed facilities. Two state hospitals accounted for 318 of this total.

The average length of hospitalization at state institutions is less than five months. Calculations using the June 1980 per diem, of $74.05, produce a total for four months of $9,009. This figure approximates the cost of 12 months' treatment in a community-based halfway house. Admittedly, residential programs may not be appropriate for all persons currently receiving treatment in state hospitals. For these patients, Rule 36 licensure of mental health units in the state's institutions will strengthen standards for quality mental health treatment and care. However, the existence of mental health programs in residential facilities could shorten hospital stays and eliminate unnecessary admittance to state hospitals.

The 1968 revision of the Hospitalization and Commitment Act, codified at Minn. Stat., Chapt. 253A, also contributed to the shift in emphasis from hospital treatment to community programs. Changes in the act made involuntary hospitalization less common, therefore increasing the need for community-based alternatives.

A number of significant court decisions have also contributed substantially to changes in the mental health system. These cases, including Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966), Wyatt v. Stickney, 325 F. Supp. 781 (N.D., Ala. 1971), Wyatt v. Aderhold, 503 F.2d 1305 (5th Cir. 1974), and the recent consent decree in Vickerman, et al. v. Peterson, et al., Civ. 4-78-153, D. Minn. (1980), have increased support for the principles of "least restrictive alternative" in choosing appropriate mental health treatment, and the "right to treatment", as well as choosing the concept of community-based treatment.

An additional development contributing to this shift from hospital to community has been the discovery and widespread use of psychiatric medications. In many instances, introduction of these drugs has eliminated the need for long-term hospital care.

Another issue central to the current emphasis on residential programs rather than hospitals, is cost. The Department of Public Welfare evaluation of the Sharing Life in the Community (SLIC) program indicates a 47.4% decrease in psychiatric costs of the SLIC program. Psychiatric costs for the non-SLIC clients experienced a 6.6% increase for that same period. (SLIC is a community-based treatment program located in South St. Paul serving Dakota, Ramsey and Washington counties.) (A copy of the evaluation referred to above will be offered as a part of the record, and will be available for inspection.)

Current Status

The Public Welfare Licensing Act 245.812 grants authority to the Commissioner of Public Welfare to establish rules governing licensure of all residential facilities housing five or more mentally ill adults. Although Rule 36 was first promulgated in September, 1974, and implementation began in January, 1976, only seven of approximately 150 existing facilities are

currently licensed. This figure poses a dramatic comparison to the 72 residential programs for chemically dependent persons and 258 programs for the mentally retarded that are currently licensed. The reasons for this contrast are explained below.

The dilemma faced by the State of Minnesota in attempting to implement Rule 36 has been multi-faceted. In the past, the rule has been viewed by facility operators as unrealistic because of the additional cost for staff and physical rehabilitation and the lack of stable public funding sources to reimburse expenses. Traditional sources of income for mentally ill persons, e.g., Minnesota Supplemental Aid and General Assistance (Minn. Stat. Ch. 256D), and Supplemental Security Income (Title XVI of the Social Security Act), cover room and board costs but cannot be used by a facility to pay for treatment staff and mental health program costs. The Medical Assistance program (Title XIX of the Social Security Act) which covers medical costs incurred by mentally ill persons, does not cover services for institutionalized mentally ill as it does for some other institutionalized disability groups. Title XIX regulations prohibit Medical Assistance reimbursement to persons residing in "institutions for mental diseases", defined, in part, by Department of Health and Human Services guidelines as any facility where mentally ill residents comprise more than 50% of the resident population. According to Department of Health and Human Services practice, this definition includes state institutions and community-based residential facilities for mentally ill persons.

In addition to the dilemma posed by a lack of funds, other problems have stymied implementation of Rule 36. One problem involved interpretation of the rule itself. The initial interpretation of Rule 36 and response from facility operators was that the rule appeared to specify only one level of programming. Operators thought they were to be held accountable for the same standard of treatment for all residents even though the level of disability and services needed varied widely from resident to resident. In addition, utilization of funding sources became an issue for facilities serving more independent residents, ones who were capable of receiving services in the community.

In May of 1980, public and private concern about the many problems inherent in the existing Rule 36 resulted in the initiation of a revision process. A task force was established under the direction of the Department of Public Welfare's Mental Health Program Division including representation from numerous agencies, organization, consumer group and professionals. (A copy of the list of task force members will be introduced as a part of the hearing record, and will be available for inspection.) The goal of the task force was to produce an enforceable rule with major programmatic changes and a realistic funding recommendation. Though the Rule 36 revision process represented a composite of views from various areas of expertise, the resulting product represents a unified philisophical and practical view that persons disabled by chronic mental illness are entitled to a full continuum of mental health services designed to meet a broad spectrum of treatment needs.

Minimum standards designed to ensure quality of service and accountability are imperative to a system of residential programs. Flexibility, however, is an important aspect of this design in that it allows for the variety of mental health needs. The revised Rule 36 effectively incorporates this flexibility within parameters of minimum standards.

Authority for DPW Rule 36

The following is an explanation of each statutory section which provides authority for the promulgation of Rule 36, either directly or indirectly as specified.

1. Minn. Stat. §246.01 establishes the Commissioner of Public Welfare as the state agency, as defined by the Social Security Act of the United States and the laws of Minnesota, for all purposes relating to mental health and mental hygiene, including the administration of the state hospitals.

2. Minn. Stat. §246.013 directs the Commissioner, in performance of the duties imposed upon him by the laws of Minnesota, to bring to the measure prescribed by Section 246.012, the care and treatment of the mentally ill as speedily as is possible, and to, thereafter, subject to the authority of the legislature with respect to appropriations, maintain said standards in the care and treatment of the mentally ill. The minimal measure of service is defined by Minn. Stat. §§246.012; 246.013; and 246.014, paragraphs (2), (7), (9) and (10).

3. Minn. Stat. §245.61-.70 establishes the authority of county boards to make grants for local mental health programs, allows any city, town or public or private corporation to apply to a county board for assistance in establishing and funding mental health services programs, requires that plans and budgets shall be approved by the county board or boards, and authorizes periodic review of budgets and expenditures. It also establishes additional duties of the Commissioner relating to these mental health services programs: prescribing standards for qualification of personnel, quality of professional service, and in-service training, requires review and evaluation of the programs, requires mental health clinics to establish written treatment plans, establish mechanisms for continuing education, and establishes Minn. Stat. §§15.1611 - 15.1699 as the criteria regarding data privacy. Although Minn. Stat. §§245.61-.69 expressly relates to local mental health programs, it does establish responsibility, authority, intent and mechanisms for allocation of funds and provisions of service to adult mentally ill persons that is reflected in the proposed revised Rule 36. Specifically, Minn. Stat. §245.69 authorizes the Commissioner to promulgate rules prescribing standards for qualification of personnel and quality of professional services and any other rules and regulations the Commissioner deems necessary to carry out the purposes of Minn. Stat. §245.61-.69.

4. Minn. Stat. §245.70 designates the Commissioner and the Minnesota Department of Public Welfare as the state agency to establish and administer a statewide plan for the construction, equipment, maintenance, and operation of any facilities for the care, treatment, diagnosis or rehabilitation of the mentally ill, which are or may be required as a condition for benefits under any federal law. Additionally, this section gives the Commissioner authority to receive, administer and expend funds from any source, for the mentally ill.

5. Minn. Stat. §245.781-.812, Public Welfare Licensing Act, establishes the authority of the Commissioner to regulate by means of licensure, day care and residential facilities, services and agencies, including those serving the mentally ill and emotionally disturbed and providing day treatment and day services.

a. Specifically, Minn. Stat. §245.783, Subd. 1, prescribes how an applicant shall apply. The Commissioner is responsible under Subd. 2 for processing applications, and under Subd. 3 for conducting a study of the applicant.

b. Minn. Stat. §245.801, Subd. 3 gives the Commissioner authority to suspend, revoke or make probationary a license if the operator fails to comply with applicable laws or rules and regulations of the Commissioner.

c. Minn. Stat. §245.802 authorizes the Commissioner to develop and promulgate rules for the operation and maintenance of day care and residential facilities and agencies, and granting, suspending, revoking and making licenses probationary.

d. Minn. Stat. §254.804 provides that the Commissioner shall study and evaluate operators and applicants for a license.

6. Minn. Stat. §256E.02 of the Community Social Services Act, codified at Minn. Stat. Ch. 256E, states, "It is the purpose of the 'community social services act' to establish a system of planning for and providing community social services administered by the boards of county commissioners of each county under the supervision of the commissioner of public welfare." Minn. Stat. §256E.06 states the duties of the Commissioner are to include supervision of the community social services administered by the counties through standard setting, technical assistance and evaluation of the community social services programs. Rule 36 is an attempt in part to ensure that adequate and effective services are provided to adult mentally ill persons.

7. In conformance with Minn. Stat. §256E.01-.11, the Department, through the Rule 36 licensure process, will assist the counties in establishing a network of community support services that will assist disabled persons in maintaining themselves in community settings and will actively seek federal and state funds for this purpose.

8. A recent statutory amendment which provides support for this rule can be found in Laws of 1981, ch. 360, §14, Subd. 1, which requires the commissioner to establish a statewide program to assist counties in ensuring provision of services to adult mentally ill persons and to make grants to county boards to provide community-based services to mentally ill persons through facilities licensed under Minn. Stat. §245.781-.813.

9. Public Law 96-63, Title III, which requires the state to describe procedures which will eliminate inappropriate placement in institutions of persons with mental illness problems, and to assist counties in developing necessary alternatives;

10. Several non-statutory bases can also be identified as supporting promulgation of this rule, including Minnesota's participation in the U.S. Public Health Services Act (Section 314g), the federal Manpower Development Project; and the federal Community Support Project. The latter is an effort designed to develop a model aftercare system for ex-mental patients. All of these acknowledge the need for residential treatment facilities that provide at least a minimum level of program for adult mentally ill persons. Without an adequate residential component, these efforts cannot be successful, nor can the objectives of the rule be met without these components of the continuum.

More specifically, a clear statement of intent and support can be found in the Minnesota Legislature's appropriation of two million dollars in 1979 to fund nonresidential services for adult mentally ill persons and requirement that the Department develop and promulgate a rule to govern administration of the grants. That mechanism is commonly known as Rule 14 and is regarded as the nonresidential counterpart to the residential component, Rule 36. The 1981 session of the Minnesota Legislature then refunded Rule 14 with a two year appropriation of 5 million dollars.

Lastly, the 1981 Minnesota Legislature also appropriated 4.9 million dollars specifically to fund the services required by proposed Rule 36. The legislature understood that revisions would be proposed through the public hearing process and that the revised rule, once promulgated, would ensure at least a minimum standard of a revised Rule 36.

11. Lastly, the Department of Public Welfare intends to apply the standards set by Rule 36 to residential programs within the state hospitals. This encourages uniform treatment of all persons in residential facilities, including state hospital-based programs. In effect, this prevents a double standard.

Statement of Purpose

Rule 36 establishes a commonly understood and acceptable philosophical, legal and programmatic base for the provision of the required services to adult mentally ill persons. It is acknowledged that the rule sets forth minimum standards, that the adult mentally ill are entitled to protection of their human rights and that services must be provided in relation to individual needs. These purposes are consistent with current social policy as found in statute as well as commonly held views of appropriate treatment practice.

The following gives a statement of need and reasonableness for each section of Rule 36. The outline format used parallels that of the rule itself.

A. Applicability

1. This section is necessary in order to ensure that providers of care and treatment to adult mentally ill persons clearly understand who is or is not required to meet provisions of this rule. Further, it acknowledges the historical concern expressed by providers that the original Rule 36 allowed only one level of programming. They thought they were to be held accountable for the same standard or kind of care and treatment for all residents even though the level of disability and services needed varied greatly from resident to resident. This also created problems in utilization of funding sources, particularly for those facilities serving a more independent group of residents. Therefore, this rule establishes two categories of programs, one reflecting the need for intensive, essentially in-house care and treatment, the other for a more semi-independent living model where many services and activities are provided by external community resources. While the rule sets certain standards applicable to both categories, the differences are reflected in staff-to-resident ratios, types of staff, the manner in which services are provided, and the per diem rates that were developed. Further, commonly used descriptive language is included to clarify the types of programs that meet the statutory definitions.

It is necessary to clarify for personnel of state hospitals, adult foster homes and safehouses, that they come under the provisions of this rule only if they have five or more residents in their program. In particular, many adult foster care homes and safehouses have four or less residents, so the number of adult mentally ill residents, rather than the language used to describe the facility, becomes the determining factor.

2. This section simply states clearly the types of programs that are exempted from licensure under 12 MCAR §2.036. The exemption for private hospitals is found in Minn. Stat. §245.791(5). The decision to exempt nursing homes reflects the need to set a priority for use of the limited monies available to fund Rule 36 programs. Several cost control measures were enacted in the 1981 session of the Minnesota Legislature. This exemption also controls costs by limiting Rule 36 licensure for the time being, to non-nursing home residential programs. From a cost control standpoint, the exemption becomes particularly important in view of the current Title XIX eligibility criteria which state that persons residing in an institution for mental diseases are not eligible for Medical Assistance.

B. Definitions

This section is designed to establish common usage of language, particularly that of "mental illness", to clarify those words or phrases that may have several interpretations, or those that need exact definitions in order to be consistent with statutory language.

1. Applicant. The statutory bases for this definition are found in Minn. Stat. §245.782, Subds. 4 and 6.

2. Case management services. This is the commonly used and agreed upon definition used in the mental health and social service field.

3. and 4. Categories of program. As indicated previously, a major problem in implementing existing Rule 36 was the assumption that all programs had to offer the same combination and intensity of services. The creation of two categories reflects the fact that there are at least two distinct categories of clientele, and a need for corresponding categories of programs.

5. Commissioner. Based on Minn. Stat. §245.782, Subd. 8.

6. Community representative. This is the commonly accepted definition with the standard exemption relating to persons having any formal relationship with the type of program being offered.

7. Crisis services. This is common usage in the human service delivery system.

8. Department. This classifies the entity of state government, as distinguished from that of the Health Department or Fire Marshal, which is responsible for enforcement of the program licensure requirement. "Department" is used as an abbreviation for Department of Public Welfare throughout the rule.

9. Full-time. This reflects the prevailing work week of staff in residential programs.

10. Independent living services. This is common usage in the field and is especially relevant to the rule since a major objective of the care and treatment provided is for the residents to progress to a higher level of independence. By definition, Category II facilities provide either a "transitional semi-independent or a supervised group supportive living arrangement".

11. Individual program plan. Although there is some disagreement within the field as to the specific components of an IPP, this definition has the majority support of practitioners and Task Force members. This plan uses a process model which requires continuing review and modification, and which requires designation of staff responsibility in implementation of the plan. Further, it reflects a current, although controversial expectation that the resident be involved in his or her treatment plan as a matter of sound mental health practice. This creates a sense of ownership and shared responsibility for the resident and avoids the client assuming a dependent role that providers are so often accused of encouraging. Lastly, it provides the basis for a valid evaluation mechanism.

12. License. This clarifies the use of the term as specific to program rules.

13. Mental health counselor. This definition, along with 15. and 17. is needed to provide a common meaning to the terms as used in the rule. This definition is common usage in the field, including the requirement that the person work under the supervision of a therapist or program director. In combination with the therapist and mental health worker, the counselor provides a continuum of skill levels to address the mental health needs of residents. This job position is specifically distinguishable from that of the mental health therapist and worker by training and experience.

14. Mental health residential program. This definition reflects the totality of components that must be offered by a facility in order to be licensed under this rule. The phrase "combination of" is the key language since it emphasizes the need to develop a treatment plan tailored to the needs of each resident which in turn increases the potential effectiveness of the program. In essence, this definition is accepted in the field as reflecting sound treatment practice, yet allowing for some program flexibility within each facility.

15. Mental health therapist. The same rationale is used for this definition as is used for mental health counselor, with the commonly accepted distinction that, by virtue of training and experience, the therapist can function independently and without supervision.

16. Mental health therapy. This definition is necessary to clarify that the rule is not intended to require a specific model of therapy. It allows providers to adopt a therapeutic regimen best suited to its philosophy and resident needs, but still provides that any regimen adopted must be effective.

17. Mental health worker. The same rationale is used here as for mental health counselor and therapist.

18. Mentally ill person. This is the commonly accepted definition in the field. This baseline is essential from both an intake, program and individual treatment plan standpoint since these facilities hold themselves out as providing care and treatment to persons with functional mental illness (non-organic) as opposed to senility or problems created by brain damage. Further, the mental illness must be primary, rather than secondary, to chemical dependency or mental retardation. Lastly, since most of the persons having organic brain syndrome reside in nursing homes, it was necessary in order to be consistent with the decision to exempt nursing homes from licensure, to exclude organic mental illness from the definition applicable to this rule. The cost represented by inclusion simply would be prohibitive as explained in Section A.2.

19. Motivation and remotivation services. This term is common usage in the field. It is necessary to include it in the rule both for clarity and as a means of emphasizing the focus of the residential facilities.

20. Program director. This is standard administrative language used in the field to distinguish these responsibilities from those of other staff required by the rule.

21. Provisional license. This definition is necessary to distinguish it from that of license. It specifies the circumstances under which it can be issued so as to protect the health, rights and safety of residents.

22. Recreation and leisure time services. This definition casts recreation and leisure time in a therapeutic context rather than the all-too-common practice of keeping residents busy to fill time. Recreation and use of leisure time is a major mental health issue in our society. Therefore, it is only reasonable to address it here, particularly to establish its purpose.

23. Restraint. This section is designed specifically for purposes of this rule and has support of both providers and consumers involved in the care and treatment of adult mentally ill persons. In non-Rule 36 facilities providing services to a different clientele, it may not be acceptable.

24. Seclusion. The rationale used here is essentially the same as that for restraint. It is intended to set a base line limiting criteria rather than to be in any way permissive.

25. Socialization services. This is common language used in the field which reflects both the kind of functional emphasis programs must have and the fact that a variety of terms can be used to describe services that are not necessarily completely discrete.

26. Social services. This constitutes a generic definition of many of the methods, activities and processes that need to be in place in an effective program. Again, although it is not necessarily discrete, it does recognize an important body of knowledge and skill commonly known as Social Work.

27. Support group services. This is commonly used language in the field, yet is necessary to include both for purposes of clarity and to emphasize that a facility must have formally available a group process for sharing feelings, experiences and constructive feedback.

28. Vocational services. This definition, although commonly used in the field, is included here to emphasize not only the objective of residents moving toward working in a competitive job setting, but also the validity of preparing them for a quasi-competitive job situation. This gradual movement toward a more independent living and job status is consistent with the continuum this rule represents.

C. Licensing process

This section of Rule 36 implements Minnesota Statutes governing licensure. Its intent is to ensure a comprehensive protection of the individual served.

1. License required. The need for a current and valid license is established in Minn. Stat. §245.783, Subd. 1, and is required as ongoing protection of the individual served.

2. Information furnished. This section ensures that the applicant shall receive the necessary and correct forms, as well as information for understanding the licensing process. This requirement is in compliance with Minn. Stat. §245.783, Subd. 1.

3. Application. This reiterates the need for compliance with Minn. Stat. §245.783, Subd. 1. This section also ensures that the health and safety of the resident is protected, as well as the community. It brings the rule into compliance with Minn. Stat. §§245.783 and 245.812 which require other regulatory agencies to report to the Commissioner regarding compliance with fire, safety, building, and health codes. It is also in compliance with the cooperative agreement established April 18, 1973 between the Department of Public Welfare and the Department of Health. The agreement specifies that the Health Department is responsible for the establishment of health and safety standards for residential facilities, and that the Department of Welfare will establish program standards specific to mentally ill residents.

4. Decision. Minn. Stat. 245.783 requires the Commissioner to conduct a study of the applicant. This section spells out the steps of the study. It is meant to ensure a decision based on first-hand knowledge of the facility and its residents, as well as on formal applications.

5. Fee. The establishment of a fee not to exceed $150.00 is authorized by Minn. Stat. §245.811. This fee is established to cover the actual costs of the Department in processing the license.

6. Renewals. Application for renewal is required 30 days prior to expiration. This is the minimum amount of time necessary to enable the licensing division to process the application.

D. License changes; report. Licensure is not a one-time obligation but a means of ensuring quality of continued care. Therefore, a specific program is licensed for a definite period of time based on its ability to provide the minimum standard of care and treatment required by the rule. Since each of the factors mentioned in this section could have an impact on the quality of care provided, and since the Commissioner has responsibility for ensuring a standard of care prescribed by the rule, it is not only reasonable, but consistent with Minn. Stat. §245.783, Subds. 5 and 6 to include these provisions.

E. Program policy and procedures manual. This requirement is based on sound management practice, establishes a baseline for accountability and provides the Department's licensing staff with a central source for review and analysis.

F. Statement of purpose and policies. An organization must have a written purpose and reason for existence if it is to be held accountable to maintain minimum standards, and to survive and be effective. That purpose is defined in its philosophy. The means of accomplishing that purpose are defined in operational policies and goals. This section of the rule requires that the program offered is defined in an attempt to keep its services focused. This requirement helps the program develop its purpose rather than trying to become all things to all persons. And, it helps consumers choose an appropriate program for their client. Because of the diversity of needs of the mentally ill, there must also be varied programs available.

G. Program organization and administration.

1. Advisory committee. Support for this requirement is found both in the Mental Health Act, Minn. Stat. §245.68(j) and common practice in the field. Most agencies and many residential facilities have advisory committees and find them both workable and useful. The quorum includes a resident representative who speaks on behalf of all the residents. This ensures resident input into the program. The quorum also includes a community representative, who speaks on behalf of the community in which the facility is located, and the facility administrator. Access to committees is an essential step in the grievance process for residents and ensures them an opportunity to be heard. Grievance procedures are required by Supervised Living Facility review. Minutes are kept as a means of review for licensure.

2. Governing body. This section ensures accountability of and accessibility to the governing body. A board is ultimately accountable, not the program director or administrator. Authority for policy development is commonly placed at this level in organizations. The Department must have this structure for any effective negotiation regarding the license to occur.

3. Designated authority. This requirement is necessary and reasonable to ensure both accountability and immediacy of response to issues involving the operation of the facility and/or resident concerns.

H. Required documentation and reports.

1. Insurance coverage. Programs will vary in services offered and types of residents served. Therefore, the amount of insurance coverage is left to the operator. The rule specifies it must be in an amount sufficient to protect the interests of residents and staff. Documentation of coverage will allow a check and balance system at the time of licensure and renewal.

2. Bonding. This requirement is intended to protect against residents having to be moved or receiving less than a minimum standard of care when a facility suffers an economic loss due to mishandling of monies by its employees. Further, it serves as a safeguard against the state or local government having to appropriate or allocate additional monies, close a facility or transfer residents in situations in which money has been mishandled.

3. Financial information. Sufficient funding is essential for the program to operate. Guarantees of sufficient funding protect both the resident and the taxpayer.

4. Maintenance. This requirement is meant to ensure that facilities will be maintained at the level mandated by Minn. Stat. §246.014 so that the physical environment is comfortable and attractive. It is also consistent with the health and safety standards of the Department of Health. The purpose of this inclusion is to prevent facilities being housed in older buildings without the means or resources to ensure upkeep.

5. Nondiscrimination policy. This section ensures that no persons shall be discriminated against in the provision of treatment. It is in keeping with the Civil Rights Act of 1964, and is consistent with Minn. Stat. §245.69.

6. Accident reports. It is current practice in both the public and private hospital systems and Rule 34 to document policies and procedures regarding accidents and missing persons. This practice serves as a protection for both the provider and the resident.

7. Annual comprehensive report. Annual reports are a means of guaranteeing a complete assessment of the program by management and is a means of increasing accountability. It is also a readily accessible means of review by the Commissioner for licensure, the advisory committee, and the public.

8. Program evaluation.

a. through d. The rights of patients defined in Minn. Stat. §253A.17 include the right to an individualized treatment plan describing problems in behavioral terms with goals and objectives which are measurable and time-limited. In order to assure that the resident is receiving the kind of care and treatment needed; that knowledgable decisions are made regarding appropriateness of current placement, movement to a less restrictive/ higher level of independent living situation, or even admission/ readmission to a hospital if necessary; it is reasonable to require facilities to provide this type of data. In short, they must demonstrate the effectiveness of their programs. And, in addition to justification in terms of residents, this kind of data assists policymakers and administrators in deciding the most appropriate use of limited funds by providing a baseline for cost comparison, as well as cost effectiveness analysis. Lastly, it provides answers to taxpayers' questions about the expenditure of public funds.

e. Support for program evaluation is found in Minn. Stat. §256E.10 and is required in relation to this rule by Laws of 1981, ch. 360, §14, Subd. 4. Although the legislature, in making its appropriation, did not specify the exact form the Commissioner must use, it clearly required him to report back as to the effectiveness of the program. Since the primary method for collecting data regarding social services has already been developed and is being used by the counties, it is reasonable to adopt that system rather than create a new one.

I. Personnel policies and procedures.

The purpose of this section is to define the basic structure of minimum requirements for personnel policies for licensed facilities. These policies are necesary to clarify staff responsibility, ensure the protection of employee rights and promote the effective management of residential mental health programs. Minn. Stat. §245.69 gives the Commissioner authority to set program standards that guarantee professional care by qualified personnel.

1. General requirements. Issuance of personnel policies to each incoming employee will serve to clarify the conditions of employment. It is necessary to insure employment safeguards for women and minorities pursuant to the following:

a. The United States Constitution;

b. The Civil Rights Acts of 1866 and 1871;

c. The Equal Pay Act of 1963;

d. The Civil Rights Act of 1964 (as amended by the Equal Employment Opportunity Act of 1972);

e. The Age Discrimination in Employment Act of 1967;

f. Several Executive Orders (11246, 11345 and 11478); and

g. Case law.

Current literature on Industrial and Personnel Psychology reiterates and supports these safeguards. "...Americans today would agree that unfair discrimination is ethically and legally improper, and that government and private employers alike should strive to promote equal employment opportunity for all."[1]

2. Job description. The development of job descriptions is justified by program inspection provisions in Minn. Stat. §245.804, Subd. 2.

3. Job evaluation. The development of job evaluation criteria is also justified by Minn. Stat. §245.804, Subd. 2. Staff growth and development plans will encourage employees to gain knowledge and skills necessary to attain goals and objectives of the program. This will benefit the treatment program by providing an influx of new and innovative ideas.

A policy defining procedures for resident input to staff evaluations promotes an open process allowing residents to express both positive and negative opinions about their mental health program and the staff providing the services. Resident responses will provide valuable information about the effectiveness of the program and could alert management and inspection personnel to problems and abuses.

4. Conditions of employment. Personnel guidelines dealing with benefits, hours of work, promotions and dismissal policies will enable programs to be administered in a consistent and effective manner.

Working in the field of mental health treatment is an emotionally intense experience. Many lay, as well as professional caregivers, experience what is commonly called "burn out". Policies addressed to this issue will assist program administrators in providing for mental health needs of the staff, as well as of the residents.

5. and 6. Organizational chart and grievance procedure. These two sections ensure that employees are given the right to bring grievances to their employer. Knowledge of the organizational hierarchy, as well as proper grievance procedures and community resources will allow employees to submit complaints through acceptable channels.

---

[1] Contemporary Issues in Applied Psychology and Personnel Management, Chapter 2 "The Law and Personnel Management".

7. Personnel data. In exercising his powers to license, renew, suspend, revoke or grant provisional licenses under Minn. Stat. §245.804, Subd. 1, the Commissioner is required to study and evaluate operators and applicants for a license. Minn. Stat. §245.804, Subd. 2, requires the operator or applicant to cooperate with an evaluation or inspection by providing access to its facilities, records and staff, including references and other information about the character and qualifications of the personnel of the facility. This access is essential if the Department is to make a determination as to whether or not the personnel meet the requirements set forth in this rule.

8. Staff orientation. Minn. Stat. §245.69 state that it is the duty of the Commissioner to set standards for personnel qualifications, as well as quality of professional service and in-service training. This section defines these minimum training standards and outlines implementation through staff orientation and annual staff development plans.

Section 8. is also supported, although more indirectly, by Minn. Stat. §256E.10 (CSSA). Performance criteria and program objectives are to be used in the county evaluation of mental health services. The standards in this section of the rule reflect and clarify these criteria and objectives.

Written guidelines for staff orientation are necessary to ensure a uniform understanding of job performance expectations. Orientation materials and presentations will clarify responsibilities of each staff position and familiarize employees with the program's treatment philosophy. A common understanding of program goals and objectives will enhance efforts to create a team approach to mental health treatment. Residents will benefit most from programs offering such consistency and clear treatment objectives.

9. Staff training. Training opportunities encourage staff to stay abreast of current treatment developments and bring innovative ideas into the program. In-service and out-service training sessions can also be effective means for resolving personnel and treatment dilemmas or training deficits.

Knowledge acquired in the listed areas will assist staff in dealing with the myriad of problems they will be confronted with in their jobs. As many of the topic areas (a-i) usually are not covered in formal educational programs, it is imperative that mental health facilities provide adequate training on-the-job or through community resources. This section is supported by Minn. Stat. §245.813 by ensuring the well-being and safety of residents, Minn. Stat. §245.61(b) authorizing county boards to make grants to mental health programs for informational and educational services, and Minn. Stat. §245.69(a) conferring on the Commissioner the power to promulgate rules and standards for quality of professional service and in-service training and educational leave programs for program personnel.

J. Personnel files.

1. Central training file. This section provides for documentation of compliance with I.8. and 9.

2. Individual files. This section is authorized by Minn. Stat. §245.804, Subd. 2, and is found in all program rules. Sections c., d., e. and f. document compliance with all standards and requirements contained in Section I.

K. Admission, discharge and transfer policies. This ensures clarity of preadmission criteria, a multidisciplinary approach to the resident's treatment and follow-up care. The intent of Section K. is to prevent "dumping" the resident after treatment into the community with no further provisions for help. "Dumping" results in misuse of funds and resources and to aid in the neglect of a vulnerable adult.

L. Program Services. The combination of services to be provided within Category I will vary from program to program because of the differing needs of residents and the acknowledged fact that an adequate system of care and treatment must have a variety of models available. No two residents are exactly alike and therefore no two programs should be exactly alike. Linking residents to appropriate community services and resources will be the primary goal of staff in these programs. Many of the program services (a,b,d,f,g,h,i) are explicitly required by Minn. Stat. §246.014. The implicit requirement is contained in Minn. Stat. §246.014, Subd. 2, which mandates that staff must be adequately trained to provide the most modern medical, psychiatric and social care.

M. Policies and procedures guaranteeing resident rights.

1. Explanation of rights. Minnesota has a Patient's Bill of Rights in statutory form, Minn. Stat. §144.651. Using the statute as a baseline, the rights of residents are further amplified in the rule, and a requirement made that residents be informed of their rights. Further, since rights also have responsibilities, it is reasonable to make residents aware what is expected of them.

2. Grievance procedure. It is standard policy within the state hospital system and common practice in some residential facilities to develop, post, and implement grievance procedures in relation to resident rights. In addition, all state hospitals in Minnesota have a formal patient advocate system which included the posting of a patient rights handbook, giving one to each resident and explaining its contents. This patient advocate and rights sytem has worked well. This requirement in the rule is consistent with this well established practice in the hospitals and some community facilities.

Further, it is standard practice in business, based on sound management principles and/or union contracts, to provide this kind of information and assistance to employees. Government, likewise, has a variety of mechanisms that offer assistance to employees in developing and processing grievances. From a purely humanitarian standpoint, no less should be afforded the adult mentally ill residents of these facilities.

3. Resident council. The resident council assures resident input into the program designed to help them. It is in keeping with numerous research studies documenting the positive correlation of self-determination with increased client independence and health.[2]

4. Personal funds policy. Policies governing supervision of resident's funds are required in order to protect the resident and his/her money from mismanagement, loss, and misuse.

5. Resident compensation. Historically, residents of state hospitals were often required to perform labor that was not designed or required as part of standard housekeeping responsibilities, nor necessarily as having any therapeutic value or relationship to an individualized treatment plan. This practice served as a means of keeping costs down. Although abuse of resident labor is not widespread today, this standard is intended as a reasonable way to protect against exploitation of residents, and acknowledges there are tasks that legitimately can be required as a normal share of housekeeping needs.

Further support for the standard can be found in Minnesota's hospital system where a patient pay and wage reduction plan is required, based on the Handicapped Worker Regulations of the Fair Labor Standards Act, 29 C.F.R. §529 (1977), Minn. Stat. §177.28, Subd. 5; and the current Joint Commission on Accreditation of Hospitals' Standards. Many of the adult mentally ill persons who now reside in community-based residential facilities would be in state hospitals were it not for Minnesota's emphasis on deinstitutionalization. These persons need the protection of this provision wherever they reside.

---

[2]Martin, Patricia Yancey and Segal, Brian -- "Bureaucracy, Size, and Staff Expectations for Client Independency in Halfway Houses", Journal of Health and Social Behavior 1977, Vol. 18 (Dec.): pp. 376-390.

"Wilder et al. (1968) note, for example, the undesirable client outcomes associated with staff utilization of a nurturant approach to client management in halfway houses for former mental patients. The nurturant approach, which defines clients as sick, dependent, and basically helpless, requires that staff assume most of the responsibility for the residents which, the authors claim, foster client dependency on the halfway house and staff.

In contrast, Wilder et al. (1968) document the greater effectiveness of the high expectations approach which defines the client as 'healthy' and entails the requirement that residents assume primary responsibility for themselves. In anticipation of the skills and behaviors needed upon discharge, this approach emphasizes client self-responsibility and self-sufficiency. Similar research by Ellsworth et al. (1971), Kish et al. (1971) and Gove and Lubach (1969) supports this position. They find that requiring residents to assume responsibility for themselves and to make decisions regarding the management of the treatment setting is associated with greater client success in terms of a shorter length of stay inside and a longer one outside of the facility." p. 379

6. Physician appointments. This is consistent with the well-established principle of a resident's right to choose his or her vendor particularly covering medical care. All facilities have arrangements for emergency medical care. None have in-house full time physicians. Precedent for ensuring resident choice of vendor is found in Minn. Stat. §253A.17, Subd. 6, which states that "...the patient's personal physician ... shall be permitted to visit the patient at all reasonable times..."

7. Photographs of residents. This section simply ensures that residents retain control over the taking and use of their photograph. It is based on the Minnesota Govern-ment Data Practices Act. Specifically, Minn. Stat. §15.163, Subd. 4, states, "Private or confidential data on an individual shall not be collected, stored, used or disseminated by political subdivisions, statewide systems or state agencies for any purposes other than those stated to the individual".

8. Telephone use. The requirement is based on standard practice found in most mental illness residential facilities and all chemical dependency treatment facilities. It acknowledges that some residents need a period of initial adjustment, free from interference and harassment. Or, they may need time to accept the fact of being in a residential facility, to concentrate on understanding why they are there, or to develop a commitment to the program. These needs exist, therefore access is limited. Since it constitutes a restriction of a right, it is reasonable to limit the use of the policy and require documentation. The requirement also suggests that overall management of a facility may require establishing reasonable hours for general access to phones and length of time for calls.

9. Mail. There is ample basis for this requirement which acknowledges each resident's civil right to privacy and freedom to express and receive ideas. Paragraph (17) of the Patients Bill of Rights, Minn. Stat. §144.651, states that "every resident may associate and communicate privately with persons of his choice, and send and receive his personal mail unopened, unless medically contraindicated and documented by his physician in the medical record". This requirement also acknowledges that there can be circumstances of a therapeutic nature that justify not allowing mail to be received or sent, or warranting censorship. As a protection against infringement on this right, the burden for establishing cause rests with the facility and must be documented in the individual treatment plan.

10. Restraints. For purposes of this rule, it is intended to acknowledge that restraint or seclusion of a resident may sometimes be necessary for safety reasons, yet to clearly define both the circumstances under which it is permissable and the forms it may take. Most importantly, the section is intended to limit, rather than encourage, to be restrictive, rather than permissive. It is viewed very simply as one means of ensuring the protection of resident's rights without prohibiting the use of medications where appropriate for treatment programs.

N. Residents Records

1. Individual program plan development. The standard practice in state and community facilities; whether they are private or public, whether they serve the mentally ill, chemically dependent or mentally retarded, and

no matter what the age of the residents; is to require an individualized treatment plan. Support for the requirement is found in case law (the Wyatt Decrees in 1971 and 1974 address this issue: see page 2 of Statement of Need), and is expressly required by Minn. Stat. §253A.17, Subd. 9, for those persons hospitalized as mentally ill. In addition, it clearly relates to the rationale for section A.8.e. of the rule relating to evaluation. Further, and more specifically, since the mentally ill person has often been helped by agencies, professionals, and family systems, a total picture of treatment must be obtained from all involved persons. This is in keeping with the multidisciplinary approach to care and helps to ensure that the treatment plan is comprehensive. This is consistent with accepted practices of psychiatric treatment attested to by professionals from many disciplines. And, since the resident obviously will be affected by the treatment, it is important to document the extent of participation in order to show the residents agreement or disagreement, and to serve as a written basis for tracking the resident's response and progress.

2. Plan contents. The individual program plan is based on a holistic approach and conforms to Minn. Stat. §253A.17, Subd. 9. And, since the stated objective of Rule 36 facilities is to enable the resident to progress to a more independent, less restrictive living situation, it is reasonable to require the plan to focus on an individual's strengths, wellness and ability factors, rather than just illness or problems.

3. Progress report. Quarterly progress reports are again mandated in Minn. Stat. §253A.17, Subd. 9, and are reasonable to include in Rule 36 residences primarily because a resident's treatment needs never remain constant. Progress must be evaluated and adjustments made in the treatment plan when indicated. The only way to ensure that residents don't get lost, forgotten or locked into a static plan is to require the quarterly progress reports. Further, they encourage the resident's participation, which promotes resident involvement and responsibility in getting well and encourages growth and independence. Copies of the report are given to the resident and are sent to the referring agencies and departments as a means of allowing a check system to ensure quality of care, appropriate use of money, and continued financial support of the resident.

4. Discharge or transfer summary. A discharge and aftercare plan is required for the purpose of ensuring continuity of care and maintenance of health and wellness. It also ensures accountability and ongoing responsibility. As such, it protects both the resident and the taxpayer and is in keeping with Minn. Stat. §626.557 protecting vulnerable adults.

5. Accidents and missing persons. Documentation of policies and procedures regarding accidents and missing persons is consistent with current practice in the public and private hospital systems and Rule 34, and serves as a protection for both the provider and the resident.

6. Release of information. In conformance with the Government Data Practices Act, no information will be given out without written permission of the person concerned.

O. Living unit requirements.

1. Structure. Minn. Stat. §245.802 authorizes the Commissioner of Public Welfare to promulgate rules and regulations to set standards for the operation and maintenance of residential facilities. The living unit is one important component in the operation of a residential treatment facility.

Mentally ill persons often enter the mental health system as young adults never having had the opportunity to learn skills necessary for independent living. A common characteristic of chronic mental illness which is probably exacerbated by institutional care is a general inability to cope with activity stresses of daily living outside a mental health facility.

This section of the rule sets minimum standards for a treatment setting most closely resembling normal apartments (within obvious financial and structural limitations of group living). A "home-like" environment will allow residents to learn the skills, such as grocery shopping, cooking and housekeeping, money management, and personal hygiene, that are necessary for a more independent life style.

2. Ratios. It is the primary purpose of this section to limit unit size to encourage leisure-time activities and create a home-like atmosphere for residents. A larger ratio of residents per living room/lounge area was allowed for existing programs where structural limitations and high reconstruction costs would make a lower ratio unattainable. Enforcement of a lower ratio would result in many large existing programs being out of compliance with Rule 36 standards. The resulting nonlicensure would make these programs subject to penalties defined in Min. Stat. §245.803. As a result, hundreds of mentally ill residents could be displaced from their homes.

3. Program space. Services should be provided in settings most appropriate to the residents' needs. This section of the rule provides for access to household appliances (e.g., kitchen and laundry), group recreation space, and rooms suitable for individual, as well as group counseling and training sessions. These provisions may be necessary to implement residents' individualized program or treatment plans.

4. Gender of residents. Separation of men and women by units may be structurally impossible in many facilities and to some would reflect an institutional setting rather than a more real life atmosphere. Additionally, various program objectives may contraindicate separation. Each facility will be responsible for determining appropriate room assignments with consideration given to societal norms as well as individual residents' right to privacy.

5. Privacy. Privacy in group living is often difficult to obtain. This section recognizes the residents' rights to privacy and for formal, as well as informal activities.

6. Storage space. Although many residents have a limited amount of clothing and personal property, it is essential for both privacy and security reasons to provide this space and capability. It is also valid,

from a safety, therapeutic and management of space standpoint to allow a facility to exclude certain kinds of personal property, yet require that the exclusion be defined and documented when invoked.

P. Additional requirements specific to Category I programs.

1. Capacity. Capacity was determined in keeping with the concept of normalization which was reformulated by Wolfensberger (1972) as "utilization of means which are as culturally normative as possible, in order to establish and/or maintain personal behaviors and characteristics which are as culturally normative as possible".[3] Forty was allowed as the maximum number for already existing facilities or treatment units within existing facilities for four basic reasons. First it recognizes the fact that a number of facilities already exist that are at or near this figure; second, that several of the larger facilities that grossly exceed forty can be reorganized programmatically to meet this standard; third, while these facilities already exist, there simply isn't enough money available to rebuild or renovate to bring them down in capacity to the ideal of twenty-five that is being required for new facilities; fourth, on the assumption that an existing facility can meet program requirements of this rule and relevant health and life/safety standards, allowing a phase-in period to reduce size was viewed as a lesser evil than the reinstitutionalization which would result from the closure of these facilities.

Twenty-five was chosen by the task force as the maximum for new facilities in keeping with the principle of normalization and the realities of cost factors but also allowing for the benefits of large numbers. Current research has shown that residents in larger homes engaged in more social behavior than those in smaller homes. Larger homes were defined in this research study as those having 18 - 20 persons.[4]

2. Department of health licensing standards. A requirement for a SLF license or boarding care license was retained from the existing rule to ensure protection of the health and safety of the residents and because discussions and negotiations with the Department of Health indicated that waivers will be granted to mental health residential facilities that would allow more home-like atmosphere and promotion of independent living skills.

3. Intake information. Since Category I facilities will be providing services to adult mentally ill persons needing intensive care and treatment, the fact that the demand is greater than beds available and precautions need to be taken to place persons in the least restrictive alternative, as well as control costs, this type of intake information is required to help ensure that the person referred is appropriate for the facility, meets the criteria for admission, and shows the potential to benefit from the services offered. The intent is to offset misdiagnoses and deliberate lack of information for the purpose of gaining admission.

---

[3]Wolfensberger, W. The Principle of Normalization in Human Services. Toronto National Institute on MR 1972.

[4]Landesman-Dwyer, Sharon U Sacket, Gene P. "Relationship of Size to Resident and Staff Behavior in Small Community Residences" AJMD, Vol 85, July 1980, No. 1: pp. 6-17.

4. Program director. The reasoning for qualifications of various staff was based on two factors: 1) concern for the best possible care for the residents,[5] as well as 2) the practical reality of recruiting persons in the rural areas of the state. Therefore, a program director would ideally have a master's degree in the behavioral sciences with experiences in working with the mentally ill. Where this is not feasible, and where there are candidates well qualified because of experience, a bachelor's degree plus experience also qualifies. Experience working with the mentally ill is considered essential by mental health professionals for managing a program for the mentally ill.

Expecting one year of experience in administration or supervision before becoming a director is in keeping with accepted practice of management policies.

5. Administrator. Since there are facilities that will have a person functioning as administrator who will not also be the program director, it is necessary and reasonable to expect that minimum qualifications be established. However, rather than spelling them out in detail, experience has shown that it is sufficient to allow the governing board to decide the qualifications since it will act in its own best interests and thus ensure effective administration of the facility.

6. Mental health therapist. Requiring that the mental health therapists be trained beyond having a bachelor's degree in the provision of treatment is in keeping with Minn. Stat. §§246.014, with the recommendations of the President's Commission on Mental Health,[6] with the quality assurance provisions of the professional organizations (American Nursing Association, National Association of Social Workers, American Psychiatric Association), as well as with the Wyatt Decree.

7. and 8. Mental health counselor and mental health worker. These requirements are in keeping with accepted psychiatric personnel policies, and with the President's Commission on Mental Health.[7]

9.a. and b. Staffing ratios. The staffing ratios are based on a combination of existing ratios used by facilities currently meeting the recommended standard and compromise amongst Task Force members where strong arguments were forwarded for both higher and lower ratios. The ratios designated are for those programs dealing with high functioning mentally ill persons and are not meant to suggest that all programs are to be limited to this number.

---

[5]"Relationship of Size to Resident and Staff Behavior in Small Community Residences", Landesman-Dwyer, Sharon and Sackett, Gene P., American Journal of Mental Deficiency, July, 1980, Vol. 85 #1: pp. 6-17. "Baker et al. concluded from a national survey of community residential alternatives that the quality of staff is the most important determinant of success in residential programming."

[6]Report to the President from the President's Commission on Mental Health, Vol. I, 1978, Washington, D.C.: pp 35-41, 67-69.

[7]Ibid

The minimum numbers were used to offset the need for hiring staff where they would not be needed --and thus creating an overly expensive system of reimbursement. In a continuum of care, there must be programs operating to help the more disturbed and more chronic population of persons, as well as the higher functioning persons. The former will, by necessity, demand higher staff-to-resident ratios.[8]

c. An inservice training coordinator is required to ensure that the mandated staff training programs are provided.

Q. Additional requirements specific to Category II programs.

1. Capacity. This section grants special status to existing large facilities where, for structural and cost reasons, an immediate decrease in facility size and resident population is not possible. Ideally, programs should not exceed a 25 bed capacity. (See below.) As it would be impossible for most larger existing facilities to immediately comply with this standard, a maximum living unit size, within each facility, will be enforced. This will allow large facilities now providing housing for mentally ill adults to comply with Minn. Stat. §245.783. Noncompliance resulting in non-licensure would force displacement of hundreds of mentally ill residents and/or penalties on the facilities pursuant to Minn. Stat. §245.803. Limited unit size will enhance program efforts to simulate home-like atmosphere and encourage increased resident/staff interaction.

The three year grace period represented a compromise between the two extremes of immediate compliance and no change. The grace period allows a realistic implementation schedule but requires eventual compliance. This is reasonable since the funding proposal to the legislature and the preliminary funding rule authorized expenditure of monies for renovation/ physical upgrading purposes to bring a facility into conformance with requirements of the rule. If funding had been limited strictly to direct service costs, the rule would not include this requirement. Further, the authorizing legislation, Laws of 1981, Ch. 360, §16, Subd. 7 amended Minn. Stat. §245.812, 1980, by adding a subdivision that grants facilities established on or before July 1, 1980 until July 1, 1984 to come into compliance with the provisons of Minn. Stat. §245.812.

---

[8]Martin and Segal, p.p. 378 and 381-382. "...a higher staff/client ratio is consistently reported to be positively associated with desirable staff and/or client outcomes (e.g., staff attitudes, behaviors, client discharge rates; see Cohen & Streuning, 1965; Moos, 1972a; Holland, 1973)." p. 378

"...Holland (1973) contends that a higher staff/client ratio is indicative of the fact that staff are able to spend more time with clients and thereby enhance their chances for rehabilitation (and/or release). Research by Becker (1969) and by Linn (1970) supports this interpretation. Both find that clients who spend a greater proportion of time with staff are observed to be released more quickly and to remain in the community longer. Becker (1969) claims that the staff/client ratio is a proxy measure for quality of service rendered by staff. Where the staff/client ratio is higher, therefore, we expect staff members to demand more from the organization's clients." pp 381-382

Since renovation/physical upgrading monies will be available, it was then determined by members of the Task Force, Department fiscal management personnel, providers and county staff, that three years was a reasonable length and a necessary interval for all parties. Plans need to be drawn, requests made to counties and then to the state for funding, and actual structural changes made and inspected. Hennepin County, for example, currently has established a minimum processing period of eighteen months. Several facilities are already in the process of architectural studies.

The effective date of July 1, 1980 was set for two reasons, the first being simply to recognize the current existence of a large number of facilities and to create a fixed point in time for management purposes. The second, and most important reason was to formalize the unanimous position (of the Department, providers, advocates, the Governor's office and legislature) that first priority must be given to ensuring the health and life/safety of current residents, as well as the minimum programmatic requirements of the rule. Although the need for new beds is well documented, given the tight economy, the decision was made to focus on existing facilities this biennium. This decision is reflected by Laws of 1981, Ch. 360, §14, Subd. 2 which reads: "the commissioner shall give first priority to residential facilities for adult mentally ill persons operating as of July 1, 1980, to meet licensing requirements of the commissioner pursuant to sections 245.781 to 245.813".

Without the 25 bed limit limitation, some providers will simply expand their number of beds as a means of gaining additional revenue.

This section also sets the maximum resident capacity for new programs. The capacity figure chosen for this category reflects the current trend toward smaller, home-like programs as opposed to large scale institutions. In addition, two currently licensed Rule 36 programs operate at approximately this capacity lending justification for the limit chosen.

2. Department of health licensing standards. This section insures that all Rule 36 licensed facilities will also meet health standards appropriate to the level of care provided (as authorized in Minn. Stat. §245.802). Compliance with health standards will safeguard the physical well-being of residents. Failure of the facilities to do so results in penalties pursuant to Minn. Stat. §245.813, Subd. 1.

There is a specific set of Health Department regulations that apply to Supervised Living Facilities that will create some difficulties for Rule 36 facilities. The SLF regulations were initially developed with regard to facilities for the mentally retarded; their applicability to that type of facility is not in dispute. The issue arises when the same standards are applied to facilities for the mentally ill and chemically dependent. For example, even though MI residential facilities have, as an objective, the movement of residents to a higher level of independent living, they would be required under literal application of the SLF standards to have commercial kitchen equipment and to restrict residents from its use. Even if residents could learn to cook on commercial equipment, few if any will have that kind available to them in an apartment or their own home. (There are other physical plan/safety requests that have the same effect, that of being contrary to the stated purpose for which these facilities exist. A detailed written analysis is available on request.)

In essence, both the Department of Public Welfare and the Department of Health acknowledge that SLF as currently written does not differentiate between the three major types of facilities to which it applies, and that it does need revision. The Health Department has agreed to consider granting blanket waivers on the four or five most inappropriate requirements. If that will not be done, then a commitment to quickly process individual requests for waivers would constitute a reasonable compromise. These waivers do not affect life/safety considerations.

3. and 4. Intake information and medical information. Records will be maintained to assist staff in assessing residents' needs (individual program plan), for responding to psychiatric or medical crises and to maintain information essential for aftercare planning and program evaluation. (Supported by Minn. Stat. §256E.05, Subd. 3(d)). These additional records need to be maintained in order to assure the appropriateness of admission; for obtaining assistance quickly at times of psychiatric or medical crises, since staff ratios and skill level of staff is less in this category; and also to provide for substantive aftercare planning and evaluation. There is support for this requirement in Minn. Stat. §256E.05.

Intake information is necessary to determine the appropriateness of the program for the individual resident referred.

A medical examination is necessary to detect physical disorders or illness harmful to the resident or potentially harmful to fellow residents. Records of examinations, conditions and medications are necessary for crisis situations, as well as routine medical concerns.

5. Program director. This section allows flexibility for educational equivalency while guaranteeing training and experience or a bachelor's degree with two years' experience. This provision allows rural areas to fill positions where there exists a shortage of applicants with masters degrees. Though conclusive research does not exist to support these equivalency guidelines,[9] Minnesota health professionals consider mental health work experience essential to managing a program for mentally ill persons.

6. and 7. Administrator and mental health counselors and workers. See the comments for this section of Category I.

8. Staffing ratios. The minimum ratio of staff-to-residents is lower in this category than in Category I because most mental health services will be provided in the community rather than at the residential facilities.

---

[9]Evaluation of Education and Experience as a Selection Device Apart, State of Illinois 75IL05.

Staffing ratios and patterns defined in this section will provide 24-hour coverage. This will guarantee that staff is available for crisis situations, as well as evening activities. These ratios represent a minimum staffing standard based on literature, clinical judgment and provider experience and are not intended to limit programs where the needs of residents necessitate increased staffing. For purposes of the hearing, oral testimony will be provided.

R. Variances. Under Minn. Stat. §15.0412, Subd. 1a, the Department may only grant a variance if procedures and standards for the granting thereof are promulgated in rule. This section does this.

S. Appeals. This acknowledges the statutory right of providers to appeal decisions made by the licensing authority and makes reference to the mechanism established.

The Department intends to support the Statement of Need and Reasonableness with the following expert witnesses. Accompanying this list is a summary of their testimony.

Dr. George Pettersen, Commissioner, Minnesota Department of Health, or designee - relationship between program and health standards; importance of both in ensuring a minimum level of care for adult mentally ill persons.

Rep. John Brandl, co-author Rule 36 appropriation bill - social policy, legal and fiscal implications of the rule.

Ginny Dayton, chairperson, Rule 36 Citizen Advisory Task Force, or designee - reflection of proposed rule as a community effort.

Tish Halloran, Director, Hennepin County Mental Health Division - historical context of the rule from a program development, implementation and continuum of care perspective as viewed from both the state and local level.

Mila Hundley, Treatment Director, SLIC, Inc. - rationale for the definitions used in the rule.

Harriet Grinstead, Executive Director, Hope Transition, Inc., and Roger Lynn, Executive Director, Wellspring Therapeutic Community, Inc. - applicability of the requirements relating to the licensing process, license changes, program policy and procedures manual, statement of purpose and policies, program organization and management, documentation and reports, personnel policies, and procedures and personnel files from an administrator/provider perspective.

Bill Johnson, consumer, and Roger Lynn - rationale for resident rights requirements.

Marge Wherley, Resident Program Consultant, Hennepin County Mental Health Division - rationale for the admission, discharge and transfer policies, the program service requirements, living unit requirements, and an explanation of and rationale for the creation of two categories of program.

Bob Ryan, Administrator, Guild Hall, Inc. - applicability of the evaluation and resident records requirements and assisting Marge Wherley in her presentation.

* Bill Conley, Director of Public Affairs, Mental Health Association of Minnesota, and/or Steve Becker, Legislative Public Affairs Coordinator, Mental Health Advocates Coalition - summation of key social policy, legal and fiscal issues and concerns related to the development and implementation of the standards.

Sept. 3, 1981
date

Commissioner, Department
of Public Welfare,
Minnesota

BROEKER, HARTFELDT, HEDGES & GRANT
ATTORNEYS AT LAW

2850 METRO DRIVE-SUITE 800
MINNEAPOLIS (BLOOMINGTON) MINNESOTA 55420
TEL. (612) 854-5263

JAMES WILSON PLAZA, SUITE L-106
131 W. WILSON STREET
MADISON, WISCONSIN 53703
TEL. (608) 255-2180

JOHN M. BROEKER
WILL HARTFELDT
STEVEN R. HEDGES
DAVID A. GRANT
STEVE M. MIHALCHICK
BARBARA J. BLUMER
BECKY A. COMSTOCK
EILEEN M. ROBERTS
TERRI A. HAGEMEYER
SCOTT G. HARRIS
JAMES W. INGISON

WISCONSIN OFFICE
KATHRYN M. COLLINS*

*ADMITTED IN WISCONSIN

ALL OTHERS ADMITTED IN MINNESOTA

REPLY TO Minnesota OFFICE

January 18, 1982

RECEIVED
JAN 18 1982
ATTORNEY GENERAL
ADMINISTRATIVE AGENCIES

Mr. Jerry Anderson
Special Assistant Attorney
General
Office of the Attorney
General
530 State Office Building
435 Park Street
St. Paul, MN 55155

Re: In the Matter of the Proposed Adoption of the Department of Public Welfare Rule Governing Residential Programs for Adult Mentally Ill Persons (12 MCAR §2.036), Docket No. 82-004-RL

Dear Mr. Anderson:

On behalf of our client, Hoikka House, we wish to comment on the legality of the above-proposed Rule which was submitted to the Office of the Attorney General on January 4, 1982, by the Minnesota Department of Public Welfare for review as to form and legality. We also wish to thank you for allowing us an extension of time for submitting these comments.

This letter should be read in conjunction with three letters submitted by us on behalf of Hoikka House to Hearing Examiner Luis on October 21, 1981. All three letters have been made a part of the record in this matter. For your convenience, we have attached copies of the letters hereto and marked them

Exhibits A through C. Exhibit A deals with general comments on proposed Rule 36; Exhibit B describes the role of Hoikka House in the care and treatment of the mentally ill; and Exhibit C discusses the relationship of facility size to effective programing. All of these Exhibits, but particularly Exhibits A and C, contain commentary relating to the form and legality of proposed Rule 36. The purpose of this letter is to extract and expand on some of the material in the Exhibits to help focus attention on legal points with the hope that you will go through the Exhibits thoroughly as well.

For purposes of simplicity, the following terminology will be used throughout this letter:

Term	Definition
DPW	Minnesota Department of Public Welfare
Rule 36	Department of Public Welfare proposed Rule 36 (12 MCAR §2.036)
Statement	Statement of Need and Reasonableness filed by DPW in support of Rule 36
Enabling Law	Minnesota Statutes §§245.781 through 245.812
Funding Law	Laws 1981, Chapter 360
Section	Various sections being proposed as part of Rule 36.

By way of background, Hoikka House is located at 238 Pleasant Avenue, St. Paul, Minnesota 55102. It is a facility providing care and residential services to mentally ill adults. Hoikka has served mentally ill adults since the early 1960's. Hoikka currently has 117 beds, divided between two levels of living quarters. A third level houses kitchen and dining facili-

ties, recreation room, and other community areas. To meet the various needs of its residents, Hoikka House utilizes a goal-directed, individualized program for each resident. The reputation of Hoikka House within the community and the health care profession is one of excellence.

If Rule 36 is approved in its present form, the effect on Hoikka House will be significant. Hoikka House will be forced to make major structural changes in its facility in order to comply with Rule 36, which requires separate living units for every 25 residents. A living unit is defined as a set of physically self-contained rooms. Hoikka House will not be able to subdivide its facility into five "living units" without incurring massive construction and remodeling costs, and without causing a long period of upheaval, confusion and inconvenience for its residents. If Hoikka House does not divide its facility into 25-bed living units, its only other option under Rule 36 is to reduce its total capacity to 40 beds or to sell the facility or use it for other purposes. (Section P.1.) This would mean a loss of from 77 to 117 beds to Hoikka House, to its residents, and to the community. If Rule 36 is adopted, Hoikka House and other facilities similarly situated will have three years from the effective date of the rule to meet these capacity requirements. (Section P.1.)

For the following reasons, Rule 36 must be disapproved.

I.

RULE 36 MUST BE DISAPPROVED
BECAUSE IT IS UNREASONABLE

The Attorney General must disapprove a rule if it is unreasonable. 1 MCAR §1.206 D.5. Rule 36 is unreasonable for the reasons set forth below and therefore must be disapproved.

Rule 36 is unreasonable because it will cause unjustified hardships on Hoikka House and like facilities. Rule 36 requires facilities existing as of July 1, 1980, with individual capacities exceeding 25 beds to reduce their individual capacities to 40 beds or less, or to divide the facilities into living units which do not exceed 25 beds each. (Section P.1.)

Hoikka House has 117 beds. Within three years from the effective date of Rule 36, it will have to reduce its overall capacity to 40 beds, or divide its facility into separate living units of 25 beds each. A "living unit" is defined as "a set of rooms which are physically self-contained, which have the defining walls extending from floor to ceiling, and which include bedrooms, livingrooms or lounge areas, bathrooms and connecting areas". (Section B.) As stated above, Hoikka House will have to incur substantial remodeling and construction costs in order to comply with Section P.1. This severe impact is not justified by the record herein. Indeed, it represents a taking of property without due process of law.

The need for imposing the capacity requirements in Section P.1. is not supported by the record and therefore the requirements are unreasonable. The record shows a clear lack of evidence supporting the rationale for the 25-bed living unit requirement. The studies relied upon by the task force and DPW in determining that a maximum group size of 25 would be most beneficial to mentally ill persons, do not support the proposition that smaller facilities are better. Most of those studies deal with the mentally retarded, not the mentally ill, and are not comparable to the facility or programs operated by Hoikka House. Further, the conclusions set forth in the studies show that in many cases, smaller group sizes were or could be detrimental to the treatment of the mentally ill. See Exhibit C. Even Hearing Examiner Luis recognized this lack of evidence. He stated in his report, "[t]he Department of Public Welfare has presented very little concrete evidence to suggest that capacity figures selected by it are any more reasonable than higher or lower figures". Report of the Hearing Examiner, page 18. In spite of this lack of evidence, the Hearing Examiner approved the living unit requirement relying on the "years of experience" of the task force, which enabled them to arrive at a figure that is "reasonable, both programmatically and from a practical standpoint". Report of the Hearing Examiner, page 18. It seems the Hearing Examiner waived the evidence requirement in support of the living-unit requirement and blindly relied on the expertise of the task force. This itself is unreasonable, especially when it has not been shown that the figure used is reasonable - either programmatically or practically. Further, the Hearing Examiner rejected the "years of experience" and "expertise" of the task

force approach when reviewing the staffing requirements at Section P. There, the Hearing Examiner stated "[w]hile the Hearing Examiner did give a great deal of deference to task force expertise in determining capacity limits for living units, this was done because the Hearing Examiner believes that the capacity requirements will only affect a relatively small number of facilities, primarily large existing facilities. In addition, that is a building, materials and construction problem, not a human one". [emphasis added] Report of the Hearing Examiner, page 19. Thus, the Hearing Examiner approved the 25-bed living unit requirement, which by his own statement is not supported by concrete evidence. The harsh result it will impose on Hoikka House and other facilities is justified according to the Hearing Examiner because only a small number of facilities are affected and altering the life style and surroundings of 117 mentally ill residents is not a human problem. This rationale is obviously erroneous. Because there is no concrete evidence to suggest that the 25-bed living unit is any more beneficial than the existing environment at Hoikka House, and because the living-unit requirement will cause an undue burden on Hoikka House and its residents, Rule 36 is unreasonable. This burden could lead to a cessation of operation by Hoikka House and effectively exclude a well-accepted treatment program for its 117 residents.

Rule 36 is also unreasonable because Hoikka House will not be able to comply with it. DPW has claimed adequate funding will be available to Hoikka House to make the necessary structural changes. This is not true. DPW has obtained a 4.9 million dollar appropriation for this biennium which provides a maximum of 75 percent of funding for implementing Rule 36 programmatic and physical plant standards. Counties are expected, but not required, to pick up 25 percent of the Rule 36 costs. See Section 14, subd. 2 of the Funding Law. The State share of funds cannot be used for anything other than programmatic costs; they are not available for required renovation or construction. The costs of construction must be paid from local matching funds. See Exhibit A, pages 6-7. Hoikka House has been informed by Ramsey County that it does not intend to provide such funds. The result is Hoikka House will not be able to comply with Rule 36 because it is too costly. It should be noted that DPW has not enforced the existing Rule 36 because it was too costly to the facilities. The proposed Rule 36, which requires even greater expenditures, and provides no funding, is totally unreasonable.

Rule 36 is also unreasonable because it does not exclude from licensure facilities federally certified as Intermediate Care Facilities (ICF's). Under Section 15 of the Funding Law, the basis exists for determining that Hoikka House, and other ICF's should be excluded. That statute provides, in relevant part:

> A residential facility that is federally certified as an intermediate care facility serving adult mentally ill persons on the effective date of the section shall not be denied a program license on the basis of any rule that requires physical plant specifications regarding the alteration of a certain number of beds and a certain number or size of living areas per treatment unit which would require the facility to alter its total number of beds. [Emphasis supplied]

The above-quoted statute does not require the deletion of certain beds in order to become operative. Rather, it talks about the alteration of a certain number of beds, which could mean the relocation of beds in order to meet the living unit requirements of proposed Rule 36. See Exhibit A, pages 3-4. The Hearing Examiner erroneously rejected this argument, interpreting the above statute to mean a facility would not be excluded from licensure unless it was forced to alter its total number of beds. Report of the Hearing Examiner, page 7.

ICF's should also be excluded from licensure under Rule 36 because DPW has chosen to exempt other types of facilities from the application of the Rule at Section A.2. Based on the record there is at least as much, if not more, justification for exempting ICF's from proposed Rule 36 requirements as there is justification for exempting the enumerated types of facilities presently appearing at proposed Rule 36 Section A.2. Hoikka House already better serves mentally ill residents than does the average nursing home, which is geared much more to the provision of straight medical care. See Exhibit B. Because Hoikka House already exceeds standards in Rule 36 for care of the mentally ill, and because it is already certified as an ICF and subject to ICF physical plant standards, it should be excluded from licen-

sure under Rule 36. Because Rule 36 does not exclude Hoikka House or other ICF's, it is unreasonable.

II.

RULE 36 MUST BE DISAPPROVED BECAUSE IT HAS NO REASONABLE RELATIONSHIP TO STATUTORY PURPOSE

The Attorney General must disapprove a rule if it has no reasonable relationship to statutory purpose. 1 MCAR §1.206 D.4. For the following reasons, Rule 36 has no reasonable relationship to statutory purpose, and must be disapproved.

Rule 36 has no reasonable relationship to the statutory purposes enabling its promulgation. In its Statement, at page 5, DPW cites Minn. Stat. §§245.781 to 245.812 as the general authority for the Commissioner to promulgate rules concerning the licensure of residential facilities who serve the mentally ill. Of these various statutes the law which describes this authority most clearly, is Minn. Stat. §245.802. It states:

> Subdivision 1. The commissioner shall develop and promulgate rules and regulations . . . for the operation and maintenance of day care and residential facilities and agencies, and for granting, suspending, revoking, and making licenses probationary.

Even though this statute offers the best indication of statutory purpose, it still does not provide a sufficiently clear statement of the purpose to which any rules promulgated thereunder can be compared. Instead, the purpose of the Rule 36 Enabling Law must be gleaned from the Statement.

Page 3 of the Statement said:

> Minimum standards designed to insure quality of service and accountability are imperative to a system of residential programs. Flexibility, however, is an important aspect of this design in that it allows for the variety of mental health needs. The revised

> Rule 36 effectively incorporates this flexibility within parameters of minimum standards.

This purpose of providing minimum standards of quality of service is further explained on page 6 of the Statement:

> It is acknowledged that the rule sets forth minimum standards, that the adult mentally ill are entitled to protection of the human rights and services must be provided in relation to individual needs. <u>These purposes that are consistent with current social policies are found in statute as well as commonly held views of appropriate treatment practice</u>.

With these purposes in mind, we respectfully direct your attention to our comments in Exhibit B regarding the existing role of Hoikka House in the treatment of mentally ill adults. There is ample evidence contained in Exhibit B showing that the programs at Hoikka House already meet the purposes of DPW in promulgating Rule 36. Therefore, additional requirements in Rule 36 that impose hardships on Hoikka House, and cause a reduction in quality of care, are not reasonably related to its statutory purpose.

The living unit and capacity requirements at Section P.1. of Rule 36, as applied to Hoikka House are clearly not related to statutory purpose. These physical plant requirements will not improve the already high level of treatment offered by Hoikka House. As discussed at length in Section I of this letter, there is no evidence in the record to suggest these capacity restrictions will have any positive impact on the care of the residents at Hoikka House. Further, these requirements will do nothing to increase the protection of the residents' "human rights". In fact, as applied to Hoikka House, these requirements will only serve to lower the quality of care at Hoikka House. This is clearly <u>not</u> one of the statutory purposes of Rule 36.

Rule 36 will adversely affect residents of Hoikka House and the community. As discussed in Section I of this letter, funding is not available to Hoikka House for the required renovation and construction. If Hoikka House cannot comply with

the 25-bed living unit requirement, then it must reduce its total capacity to 40 beds or less. This means at least 77 residents will be forced to relocate. This could mean the return of many residents to the State institutions - which is the exact opposite of the goal of DPW to provide small community-based treatment facilities. It does not take long to realize that application of Rule 36 to Hoikka House will have serious detrimental effects to mentally ill adults - exactly the class DPW seeks to protect.

Rule 36 is also not reasonably related to statutory purpose because it fails to "grandfather-in" facilities which already exceed the minimum programming standards of Rule 36, but do not meet the physical plant standards. As already noted many times above, the physical plant capacity requirements of Rule 36 do not have any relationship to quality of care. On the other hand, the education and experience of staff do have a relationship to quality of care. Even though Hearing Examiner Luis recognized the need for having qualified staff, he also realized the impossibility of immediate compliance by most facilities. Therefore, at page 19 of his report, he "grandfathered-in" existing staff. At the same time, he refused to "grandfather-in" existing facilities who cannot meet the physical plant requirements, which requirements do not even affect quality of care. The closing of facilities which have an excellent reputation and exceed the standards of Rule 36, yet due to funding cannot meet the physical plant requirements, cannot possibly be related, reasonably or otherwise, to the statutory purpose of Rule 36. Thus, Rule 36 must be disapproved.

III.

CONCLUSION

For the reasons set forth above, we respectfully urge you to disapprove Rule 36 in its present form as being unreasonable and not reasonably related to statutory purpose.

Very truly yours,

BROEKER, HARTFELDT, HEDGES & GRANT

By Terri A. Hagemeyer
Terri A. Hagemeyer

TAH:kll
cc: Rhoda Miller
Curt Hoikka
DPW

3638

BROEKER, HARTFELDT, HEDGES & GRANT
ATTORNEYS AT LAW
2850 METRO DRIVE - SUITE 800
MINNEAPOLIS (BLOOMINGTON) MINNESOTA 55420
TEL. (612) 854-5263

JOHN M. BROEKER
WILL HARTFELDT
STEVEN R. HEDGES
DAVID A. GRANT
STEVE M. MIHALCHICK
BARBARA J. BLUMER
WILLIAM J. WERNZ
BECKY A. COMSTOCK
EILEEN M. ROBERTS
TERRI A. HAGEMEYER

October 21, 1981

Mr. Richard C. Luis
Hearing Examiner
Office of Administrative Hearings
1745 University Avenue
Room 300
St. Paul, Minnesota 55104

Re: In the Matter of the Proposed Adoption of the Department of Public Welfare Rule Governing Residential Programs for Adult Mentally Ill Persons (12 MCAR §2.036) - Docket No. 82-004-RL - General Comments

Dear Mr. Luis:

These comments in regard to the above-referenced matter are being submitted on behalf of our client, Hoikka House, 238 Pleasant Avenue, St. Paul, Minnesota 55102, a facility providing care and residential services to mentally ill adults. Hoikka House has serviced mentally ill adults since the 1960's. Under separate cover we are transmitting to you a more complete description of the types of services and programs which are presently offered by Hoikka House.

This letter is intended to contain certain general comments on behalf of Hoikka House in regard to the above-referenced matter. The comments contained herein supplement other written comments which have been submitted by or on behalf of Hoikka House and confirm testimony given by the undersigned at the time of the public hearing on October 1, 1981.

For purposes of simplicity the following terminology will be used throughout this letter:

TERM	DEFINITION
DPW	Minnesota Department of Public Welfare

Exhibit A

Rule 36	Department of Public Welfare proposed Rule 36 (12 MCAR §2.036)
Statement	Statement of Need and Reasonableness filed by DPW in support of Rule 36
Enabling Law	Minnesota Statutes §§245.781 - 245.812
Funding Law	Laws 1981, Chapter 360
P.B. 81-69	DPW Policy Bulletin No. 81-69, dated September 7, 1981, with attachments (including DPW Temporary Rule No. 1)

While Hoikka House joins in many of the general concerns expressed about Rule 36 and its general proposed application, the purpose of this letter is to explore and comment on the application of Rule 36 to Hoikka House. It should be noted that Hoikka House shares many of the general concerns expressed at the time of hearing by oth in regard to the impossibility of compliance with Rule 36 from either a programmatic or practical standpoint in light of present funding and other limitations.

As noted at the time of the public hearing, Hoikka House conceptually recognizes the need for something like Rule 36 and the underlying purposes of providing for the health, safety and programing for mentally ill adult residents. In fact, Hoikka House has shared this concern for a number of years. However, Hoikka House is very concerned about its inability to change its physical plant, the cost of implementing Rule 36 and the implementation of certain program standards which appear to be clearly unnecessary. As constituted, Rule 36 may well cause facilities like Hoikka House to no longer be able to provide services for mentally ill adults even though the benefit of the type of services rendered by Hoikka House have been universally recognized as beneficial for mentally ill residents. If Hoikka House and facilities like Hoikka House are not able for any reason to continue to provide services to mentally ill adults, it is not Hoikka House which will ultimately suffer but, rather, it is the residents of Hoikka House who will be displaced from their present environment who will suffer, particularly if alternative Rule 36 facilities are not available. It is with these concepts in mind that Hoikka House earnestly urges the Hearing Examiner and the Commissioner of DPW to consider

the comments contained in this letter. For the best interest of all parties concerned, Hoikka House urges that Rule 36 not be adopted in its present form.

Specifically, Hoikka House notes the following in regard to Rule 36:

1. Rule 36 is unclear and ambiguous, arguably making it unreasonable as proposed. As pointed out at the time of the public hearing, there are apparent inconsistencies among the Enabling Law, the Funding Law, Rule 36, the Statement and P.B. 81-69. It is these inconsistencies which cause Hoikka House to be concerned about how Rule 36 may apply to it.

2. Under Section 15 of the Funding Law, which amends Minnesota Statutes §245.802, the basis exists for determining that Hoikka House, and facilities like it, should not be required to obtain a Rule 36 program license. That statute provides, in relevant part:

> "A residential facility that is federally certified as an intermediate care facility serving adult mentally ill persons on the effective date of this section shall not be denied a program license on the basis of any rule that requires physical plant specifications regarding the alteration of a certain number of beds and a certain number or size of living areas per treatment unit which would require the facility to alter its total number of beds." [Emphasis supplied.]

The above-quoted statute does not require the deletion of certain beds in order to become operative. Rather, it talks about the alteration of a certain number of beds, which could mean the relocation of beds in order to meet physical plant specifications under Rule 36. Rule 36 should be clarified to expressly incorporate the concepts of Section 15 of the Funding Law with DPW's interpretation of the word "alteration". Obviously the Legislature did not intend to jeopardize the operation of

intermediate care facilities, such as Hoikka House, probably in recognition of the fact that in any event such facilities must meet rather stringent physical plant requirements in order to be certified as intermediate care facilities. Facilities such as Hoikka House are not the type of facilities which simply provide living accommodations for mentally ill residents without some type of commensurate program and treatment. Section 15 of the Funding Law to Hoikka House would not exempt Hoikka House from program requirements of Rule 36, but would permit Hoikka House to operate within its existing physical plant. As discussed in our separate comments entitled "Relation of Facility Size to Effective Programming", permitting Hoikka House to operate within its present physical structure is totally consistent with the goals and purposes of Rule 36.

3. Based on testimony received at the time of the public hearing, primarily presented through the Minnesota Association of Health Care Facilities, there is ample justification for DPW to explicitly exempt intermediate care facilities from Rule 36 even without the Funding Law discussed in number 2, supra. DPW has already chosen to exempt certain types of facilities from the application of Rule 36 at Rule 36 A.2. Based on the record made at the time of this hearing there is at least as much, if not more, justification for exempting intermediate care facilities from Rule 36 requirements as there is justification for exempting the enumerated types of facilities presently appearing at Rule 36 A.2. Surely DPW must recognize that Hoikka House's present programs and physical plant better serve mentally ill residents than does the average nursing home which is geared much more to the provision of straight medical care.

4. DPW apparently has not contemplated the consequences for facilities which may have residents fitting into both the Category I and Category II programs, or residents who do not readily fit into either category. See Rule 36, B.3. and B.4. Hoikka House is such a facility. While presumably most residents in Hoikka House fall under Category I, to the extent

they can be categorized at all, others could fall into Category II in terms of program needs. While Rule 36 O. provides certain "living unit requirements" applying to both Category I and Category II programs, there are additional requirements for Category I programs at Rule 36 P. and additional requirements for Category II programs at Rule 36 Q. These additional requirements for Category I and Category II programs are not necessarily consistent. For example, Category II facilities existing as of July 1, 1980, are limited to a 25 bed capacity while facilities with a Category I program can have up to 40 beds. Compare Rule 36 P.1. and Rule 36 Q.1. Category I facilities must have a mental health therapist if mental health therapy is provided (see Rule 36 P.6.) while this type of individual is apparently not required for a Category II facility. The ratios of work hours required vary between Categories I and II. Compare Rule 36 P.9. with Rule 36 Q.8. Potential conflicts for facilities caring for both Category I and Category II residents are unanswered by Rule 36 and were not considered by DPW according to its own testimony at the time of the public hearing. The existence of such unanswered conflicts makes Rule 36 unenforceable and unreasonable and thus presumptively void.

5. DPW has attempted to identify the number of mentally ill residents which it projects will be affected by Rule 36. See the Fiscal Statement filed by DPW as part of Rule 36 and an October 6, 1981 Memorandum submitted for the hearing record entitled "Rule 36 Data" prepared by John Zakelji, Consultant, Management Support Division, DPW (hereinafter "Memorandum"). The Memorandum is intended to justify the figures contained in the Fiscal Statement. In both the Fiscal Statement and in the Memorandum, only 301 beds, including 117 at Hoikka House, are identified as falling within Category I. Hoikka House, and the undersigned, are aware of at least one facility, Andrew Care, in Hennepin County, which has over 200 residents, most of whom would presumably fall under Category I. DPW has not recognized Andrew Care or other facilities like it

within Category I. If DPW is not able to identify Category I facilities in making its fiscal projections, it is difficult to believe that DPW has any accurate concept whatsoever of how many residents fall within any given category for purposes of enforcement of Rule 36. Furthermore, it should be noted that the creation of two artifical categories is at variance with the concept of developing programs based on individual needs as set forth in the Statement. See for example, paragraph F at p. 11 of the Statement where it is noted "Because of the diversity of needs of the mentally ill, there must also be varied programs available." Also, as set out at item L. of the Statement, at p. 16 "No two residents are exactly alike and therefore no two programs should be exactly alike."

6. Throughout DPW's presentation at the time of hearing, a presumption was made that adequate funding exists to permit facilities to obtain necessary funding to implement Rule 36 programmatic and physical plant requirements. The Fiscal Statement, included as part of proposed Rule 36 and as part of the Statement, conveniently makes assumptions that permit DPW to come within the appropriations set forth in the Funding Law without containing any rational basis for reaching this conclusion. DPW has obtained a 4.9 million dollar appropriation for this biennium which provides a maximum of seventy-five percent of funding for implementing Rule 36 programmatic and physical plant standards. Counties are expected to pick up twenty-five percent of the Rule 36 costs, but nothing forces the counties to make matching payments if the counties determine not to do so. See Funding Law, Section 14, subdivision 2. The state share of funds cannot be used for anything other than programmatic costs and are not available for "[o]ther new costs, such as any required renovation, [which] must be paid from the local matching funds." See P.B. 81-69, p. 2. If Hoikka House is required to make physical renovations to comply with

Rule 36, Hoikka House has been advised that Ramsey County has no funding ability nor plans to provide funding to permit such physical renovations to be accomplished. Thus, per se, Hoikka House will not be able to comply with Rule 36. Hoikka House itself has no available funds for any physical renovation since the rate which it receives for care of mentally ill residents is basically set by the Ramsey County Board of Commissioners on a cost-related system. In spite of the fact that Hoikka House's cost increases exceeded twelve percent in the fiscal year ended June 30, 1981, the Ramsey County Board of Commissioners, pursuant to a recently adopted policy, limited the increase in the Hoikka House rate to nine percent. There is no feasible way that Hoikka House can comply with Rule 36, if required to do so, on the basis of the rate which it receives today for caring for mentally ill individuals.

DPW in its Fiscal Statement, and in the Memorandum, bases its cost projections on arbitrary conclusions, with no justification being set forth other than what DPW "feels" "is the best estimate available". DPW is relying on "informal contacts with a number of facilities and counties", but DPW does not state what the source of these contacts are or the validity of these contacts. See Memorandum. There was significant testimony at the time of the public hearing that the appropriations provided by the state and county under the new Funding Law are totally inadequate to fund the contemplated programmatic and physical plant requirements of Rule 36. In addition to what is an apparent attempt by DPW in its Fiscal Statement to fit fiscal requirements to existing appropriations, DPW makes arbitrary determinations that it will only fund a portion of the projected program need over four years of 1,100 beds. This clearly will not help those facilities already in existence which may well require a Rule 36 program license.

DPW makes the statement, in P.B. 81-69, that "the Department [DPW] has not enforced the rule [existing Rule 36] due to the lack of funds to pay for licensure requirements." This concept is reiterated in

the Statement. See, for example, Statement, p. 3. wherein it is stated:

> "In the past, the rule [existing Rule 36] has been viewed by facility operators as unrealistic because of the additional costs for staff and physical rehabilitation and the lack of stable public funding sources to reimburse expenses."

The evidence on the record herein clearly establishes that the same impediments to enforcement of Rule 36 which existed before still exist today. If a justification for not enforcing Rule 36 previously was lack of funding, the same justification exists today. If Rule 36 is to be enforced without adequate funding, it is unreasonable per se and as applied to individual facilities not able to obtain adequate funding.

7. Apparently DPW did nothing to determine whether or not Rule 36 physical plant requirements would vary from or be inconsistent with physical plant requirements for other licensure categories for facilities such as Hoikka House. It may well be that Rule 36 requirements may be inconsistent with requirements for other licensure standards.* Without having made this investigation, it is unreasonable for DPW to implement Rule 36. As referenced in number 3, supra, it is also possible that the intermediate care facility classification would meet the goals and purposes of Rule 36, even if a facility is not in literal compliance with Rule 36, under present physical plant standards.

---

* At p. 24 of the Statement it is admitted that "[t]here is a specific set of Health Department regulations that apply to Supervised Living Facilities that will create some difficulties for Rule 36 facilities . . .. For example, even though MI residential facilities have, as an objective, the movement of residents to a higher level of independent living, they would be required under literal application of the SLF standards to have commercial kitchen equipment and to restrict residents from its use." While DPW indicates that the Department of Health "has agreed to consider granting blanket waivers" [Statement, p. 25] for SLFs to comply with Rule 36 requirements, no assurances have been given that these waivers will be obtainable.

8. DPW did absolutely no investigation to determine whether or not facilities seeking to comply with physical structure requirements of Rule 36 would run afoul of state or federal Certificate of Need laws. The Minnesota Certificate of Need Act is codified at Minn. Stat. §145.832 et seq. That Act specifically applies to "any facility licensed under Sections 144.50 to 144.56." [That section of the statute under which boarding care facilities, such as Hoikka House, are licensed.] Minn. Stat. §145.833, subd. 2. A Certificate of Need is required under Minn. Stat. §145.834 for any construction or modification of a health care facility, with construction or modification being defined at Minn. Stat. §145.833, subd. 5 to include "a total capital expenditure in excess of $150,000, and which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance; . . .." In order to comply with Rule 36, Hoikka House would have to expend over $150,000 in making structural changes bringing the Certificate of Need Act into play. Presumably other affected facilities would have to do the same. Until or unless DPW addresses the Certificate of Need issue, requiring compliance with Rule 36 is unreasonable per se.

9. Rule 36 does provide for variances. See Rule 36 R. However, as Rule 36 is written, there are no assurances whatsoever that variances would be granted to facilities like Hoikka House which by definition cannot comply with Rule 36 in terms of physical structure. Furthermore, variances cannot exceed one year, meaning that Hoikka House or any other facility would never be assured of retaining any variance even if it was once granted. Apparently DPW is not intending to grant any permanent waivers. As written, the variance procedure of Rule 36 is almost meaningless.

10. As a general comment, not applicable to just Hoikka House, we do note that there is a general overlap of Rule 36 into areas of employee rights (wherein Rule 36 may well conflict with collective bargaining agreements), vulnerable adults,

discrimination and the patient Bill of Rights, and other unrelated areas. Clearly to the extent that Rule 36 addresses these subjects, Rule 36 goes beyond the enabling law. These subject areas are adequately covered in other statutes in any event and should not be repeated as part of Rule 36. See Minn. Stat. §15.0412, subd. 1. Any portion of the rule going beyond programmatic needs for residents of mentally ill facilities is beyond the scope of authority which DPW has under the Enabling Law.

11. At the time of public hearing it was noted that in the application of existing Rule 36 to Hoikka House and other facilities, it had caused the federal government to threaten to cut off certain Medical Assistance funds paid for the care of residents at facilities for the mentally ill. DPW suggested that this matter was no longer an issue since residents of facilities serving the mentally ill are no longer funded under Medical Assistance. This is not the case. Minimally, adult residents over the age of 65 may well qualify for Medical Assistance funding, which funding might be jeopardized by imposition of Rule 36. Hoikka House, for example, has a number of residents presently funded through Medical Assistance.

Some comment was made during the course of the public hearing that it may be premature for Hoikka House to be concerned about how Rule 36 would apply to it and to other facilities which might be appropriate for Rule 36 program licensure. Members of the DPW panel suggested that if problems should arise for Hoikka House or for other facilities under Rule 36, the appropriate time to raise such problems would be at the time of threatened enforcement rather than through these rulemaking procedures. However, we would respectfully suggest that if Rule 36 can be structured in such a way to avoid these potential problems such restructuring should be done now by recognizing the problems and by dealing with them at the present time. If Rule 36 is adequately drafted and adequately prepared, many of these potential problems can be anticipated and resolved to the benefit of DPW, residents of mentally ill facilities, and the facilities themselves.

If Hoikka House is faced with Rule 36 licensure, and if the problems in Rule 36 are not cleared up, Hoikka House is faced with some very undesirable alternatives. Hoikka House could elect to

proceed without Rule 36 licensure and risk a funding cutoff or criminal sanctions under Minnesota Statutes §245.803. That statute also provides for injunctive relief and provides that sanctions under the statute are cumulative and not restrictive of other available remedies, presumably including civil suits brought by residents or their families.

If Hoikka House makes a determination that it can no longer qualify under Rule 36 to care for mentally ill residents, and if it should determine that it does not wish to risk operation without obtaining a Rule 36 license, the ultimate losers will be the residents of Hoikka House who are admittedly receiving care appropriate for their needs. These residents presumably would be forced to return to state institutions, since it is difficult to contemplate the availability of 117 beds elsewhere to care for the 117 residents at Hoikka House, given the validity, arguendo, of DPW's own figures in P.B. 81-69 that only 301 Category I beds (including those at Hoikka House) exist in the state. The return of residents to state institutions would be tragic. Not only would this be more costly to the state and to the taxpayer (compare the current rate of approximately $30.00 per resident per day at Hoikka House with the $74.05 rate figure [Statement, p.2] at state hospitals), but this would run directly affront of the policy results which are desired through Rule 36. See for example p. 21 of the Statement wherein it is noted that allowing a phase-in period to implement Rule 36 "was viewed as a lesser evil than reinstitutionalization which would result from the closure of these facilities." We would urge upon the Hearing Examiner and DPW that a strict interpretation of Rule 36 to require physical structural changes at Hoikka House would, in fact, create the very real reinstitutionalization which is feared by the drafters of Rule 36. If the goal of Rule 36 is truely to provide better programmatic and living situations for mentally ill residents residing in certain unregulated facilities, we would note that placing Hoikka House and facilities like it strictly under Rule 36 would be counterproductive to the goals indicated by the DPW panel at the time of the public hearing.

In conclusion, we would urge that Rule 36 be clarified, corrected or otherwise changed to assure that Hoikka House and facilities like it could continue to operate as in the past, serving very real needs of its residents and of the community. If it is deemed that the changes necessary to bring about this interpretation are substantial within the meaning of the Minnesota Administrative Procedures Act, we urge that the public hearing be reconvened after appropriate notice is given to all affected parties. If this is not or cannot be done, we urge the

Hearing Examiner to make a recommendation that Rule 36, as proposed, is unreasonable for reasons cited in this letter, through other evidence presently on the record and through testimony given at the time of the public hearing. Thank you in advance for your consideration of these comments.

Very truly yours,

BROEKER, HARTFELDT, HEDGES & GRANT

By John M. Broeker
John M. Broeker

JMB:jlh

bcc: Rhoda Miller
Curt Hoikka
Rick Carter

BJB
JWI

BROEKER, HARTFELDT, HEDGES & GRANT
ATTORNEYS AT LAW

2850 METRO DRIVE - SUITE 800

MINNEAPOLIS (BLOOMINGTON) MINNESOTA 55420

TEL. (612) 854-5263

JOHN M. BROEKER
WILL HARTFELDT
STEVEN R. HEDGES
DAVID A. GRANT
STEVE M. MIHALCHICK
BARBARA J. BLUMER
WILLIAM J. WERNZ
BECKY A. COMSTOCK
EILEEN M. ROBERTS
TERRI A. HAGEMEYER

October 21, 1981

Mr. Richard C. Luis
Office of Administrative Hearings
Room 300
1745 University Avenue
St. Paul, Minnesota 55104

Re: In the Matter of the Proposed Adoption of the Department of Public Welfare Rule Governing Residential Programs for Adult Mentally Ill Persons (12 MCAR §2.036) - Docket No. 82-004-RL - Role of Hoikka House in Care and Treatment of Mentally Ill

Dear Mr. Luis:

Under separate cover we have today transmitted to you certain General Comments on behalf of our client, Hoikka House, as to the above-referenced matter. The purpose of this letter is to set out in greater detail the present program at Hoikka House in caring for mentally ill residents, which program justifies excluding Hoikka House from the purview of Rule 36. Hoikka House is clearly not the type of facility which simply cares for, but does not treat, mentally ill individuals. Imposition of Rule 36 as presently proposed to Hoikka House could effectively destroy the ability of Hoikka House to care for its residents to the detriment of those residents and their families, the state and the facility. This is more fully discussed in our General Comments submitted on behalf of Hoikka House.

Since the early 1960's, Hoikka House (hereinafter referred to as Hoikka) has provided expert and professional care to people with emotional and mental disabilities. The name "Hoikka" is well known throughout the state by social workers, physicians, families and clients. The original premise of Hoikka was that of providing a "boarding house" for the mentally ill. This premise developed during the early period when the Hoikka facility was

only a large residential house. Since then Hoikka has expanded in size, in resident population and in programming. Yet Hoikka has never failed to continue the expansion and improvements of its residential facility, rehabilitative programs and referral services, including its commitment to be in continual compliance with the various licensing agencies to which it is accountable.

Hoikka accepts residents from the age of 18 and older. Hoikka does a careful job of screening and interviewing potential residents. Hoikka carefully reviews the medical, social and emotional history of each of its potential residents. Referrals to Hoikka are made by a variety of sources including county social workers, state hospitals, private county hospitals, physicians and families. Most of the people referred to Hoikka, presently constituting the majority of its resident population, have a history of prolonged hospitalization or repeated hospitalizations. Most have chronic mental illness which requires long-term residential care and supervision, the type of residential care and supervision in which Hoikka specializes. Many of these residents have tried other living arrangements and have had no success.

To serve the various needs of the Hoikka residents, Hoikka utilizes a goal-directed, individualized program for each resident. This program uses information gathered from a variety of sources including referral forms, pre-admission interview, admission interview, medical information and resident and family input. Areas of need are identified and a program plan is developed specifying appropriate methods for meeting those areas so identified. These individual programs are then periodically re-evaluated and changed when the need arises. The development of such individual programs begins with a comprehensive admission policy which has been developed by the professional staff of Hoikka.

The admission policy of Hoikka, like its entire program for the mentally ill, already meets or exceeds the expectations of proposed Rule 36. Hoikka requires upon admission, a complete social and medical history of the potential resident and requires each new resident to have a complete physical shortly prior to or immediately after admission. See Exhibit 2, A, Pre-admission, 2 and 4. Each potential resident is required to visit Hoikka for the purpose of being interviewed by its staff and to get an opportunity to examine the facility and ask any questions he may have. See Exhibit 2, A, Pre-admission, 5. Prior to admission, the Hoikka staff and the staff of the referring agency communicate extensively so as to fully educate the Hoikka staff as to the needs, prognosis and recommended treatment avenues for the potential resident.

After admission, the new resident is introduced to a fellow resident who becomes his "special friend" for the day. This special friend will see to it that the new resident is introduced to other residents, and is familiarized with the facility and the surrounding neighborhood. See Exhibit 2, Admissions Procedures, F.

The resident is also interviewed very extensively by each department head and the staff begins to establish a structured schedule based upon his perceived and recommended needs. See Exhibit 2, Admissions Procedures, G and H. Hoikka's social services staff has a member present seven days a week. These counselors carefully monitor the progress of each resident and are responsible for seeing that the resident's overall program is being followed and is effective. They are also responsible for each resident's eventual placement in the community on a full or part-time basis depending on his progress.

Hoikka, besides referring many residents to community rehabilitative services, also has an in-house work and training program. See Exhibit 4. For some residents this service provides a stepping stone for getting community placement, for others it is a program which provides some positive input to improve their self-esteem. The residents have a monthly town meeting, at which concerns and desires can be expressed. Social and cultural activities of the residents are coordinated by an Activities Director.

Hoikka presently provides 24 hour per day nursing services. This continual nursing care is important for the many residents who are being actively treated or maintained on medications. Proper and controlled medication regulation is an important part of the care of the mentally ill, yet it should be pointed out that regulation of such medication is not addressed at all in proposed Rule 36. This point is further discussed below.

Exhibit 1 lists the great number of trained professionals presently employed by Hoikka. Exhibit 1 also enumerates some of the services and programs that Hoikka is presently offering. This staff composition and comprehensive provision of services meet and exceed any level of care that could be provided under the proposed Rule 36.

Another important factor in the success of Hoikka is the overall satisfaction that has been expressed privately and publically by the relatives and friends of their residents, and the agencies which often refer patients to Hoikka. See Exhibits 5 and 6. Further information about Hoikka and its program is contained in Exhibit 3. We respectfully refer you to that exhibit.

Hoikka agrees with the premise of proposed Rule 36 that smaller and/or more compartmentalized facilities can often be effective for treating certain mentally ill individuals, especially for those who have the potential to live independent lives in the community and need a transition facility which proposed Rule 36 facilities would provide. But such an independence-oriented program can be counterproductive to the type of residents such as those at Hoikka who need constant professional assistance, especially with the many types of medications which must be taken by these residents. Hoikka has established and maintains a careful and complete medication system to handle day to day resident observation. The majority of the residents at Hoikka are of that segment of the mentally ill population whose ability to even survive requires constant assistance in the tasks of everyday living. For these residents even the establishment and maintenance of stability in their lives is an ongoing goal and represents a great deal of progress for someone who has had a history of 20 to 25 previous hospitalizations.

Many residents would not function productively or properly if placed in a smaller, less structured or halfway house type of facility, yet proposed Rule 36 operates partly on the assumption that placement of all mentally ill patients in such facilities should be actively sought and achieved. However, such placement is not suitable for many chronically mentally ill individuals, and it is for these types of residents that facilities like Hoikka must exist, not as the standard nor the anamoly in mental health care, but as a needed option to provide for those residents for whom smaller, proposed Rule 36 facilities would prove to be inappropriate.

Hoikka does have its successes in terms of rehabilitation and does work to foster and develop the independence of those residents who are appropriate for community placement. Neither the size nor the staffing or program at Hoikka stands in the way of such independence. In fact, it is through Hoikka's comprehensive evaluation and individual programming that such independent living ability is detected and developed. Three former residents are presently employed full-time and are living independently. Much of their ability to function so well independently is a result of the ongoing assistance and support they continue to receive from caring staff members. Just as all mentally ill residents are not appropriate for state hospitalization, neither are all mentally ill residents appropriate for the smaller and/or compartmentalized treatment which is contemplated by proposed Rule 36.

Hoikka is fully aware of the benefit smaller unit treatment can sometimes provide, but Hoikka still has a long waiting list and

continues to receive referrals each day for the type of services it renders. Mentally ill persons may have no place to go should Hoikka be required to limit or curtail its present operating structure due to proposed Rule 36. At the present, the overall program opportunities provided by Hoikka either meet or exceed all important aspects and goals of the type contemplated by Rule 36. On a spectrum of available mentally ill treatment facilities, Hoikka would fit comfortably and effectively between state hospital facilities and programs and the smaller facilities and program types proposed by Rule 36. Such a variety of facility types would only serve to give more freedom of choice to mental health treatment consumers.

Hoikka's program is a highly efficient and productive one; successful on many levels and greatly supported by those who have had contact with the facility. Hoikka's existence will not threaten the goals underlying proposed Rule 36, but will only provide the needed services to those individuals inappropriate for proposed Rule 36 facilities and programs, while providing a freedom of choice for the ultimate consumers of mental health care.

Overall, there is no hard evidence that only small facilities are effective in the battle against and treatment of mental illness. Hoikka cannot see how an increase in treatment options could possibly threaten the purposes and goals underlying proposed Rule 36. There is a place in the mentally ill treatment scheme for Hoikka as it exists today. For the above-stated reasons, Hoikka should not be subjected to the potentially disastrous consequences to its facility and programs should it be forced to comply with proposed Rule 36.

Very truly yours,

BROEKER, HARTFELDT, HEDGES & GRANT

By James Ingvason
James W. Ingvason

JWI:jlh
Enclosures

bcc: Rhoda Miller
Curt Hoikka
Rick Carter
BJB

Exhibits to Comments submitted by
Hoikka House on Proposed Rule 36

TABLE OF CONTENTS

Exhibit 1: A listing of the staff presently employed at Hoikka House and some of the services presently offered there.

Exhibit 2: The Policies and Procedures for Admission and Discharge of Hoikka House.

Exhibit 3: Informational Bulletin about Hoikka House entitled: "Things you should know about Hoikka House".

Exhibit 4: Hoikka House, Inc. Resident Work-In-Training Program.

Exhibit 5: Letters from the parents and guardians of past and current Hoikka House Residents about the Hoikka House program.

Exhibit 6: Letters from professionals in the field of mental health concerning Hoikka House.

EXHIBIT 1

The staff at Hoikka House at this time includes:

1 Full Time Administrator
1 Full Time Program Director
2 Full Time Social Workers
1 Full Time Vocational Rehabilitation Coordinator
1 Full Time R.N., Director of Nursing
3 Full Time LPN's
2 Full Time Psych. Techs.
1 Part Time LPN, Days
2 Part Time LPN's for Night Coverage
2 Full Time C.O.T.A.'s
1 Part Time Activity Consultant
1 Full Time Evening Counselor
1 Full Time Night Counselor
3 Full Time Night Janitors
2 Part Time Weekend Counselors
1 Full Time Medical Records Secretary, Receptionist
1 Full Time Bookkeeper
1 Part Time Payroll Person
1 Full Time Maintenance Man
4 Full Time Cooks
1 Part Time Dietitian Consultant
3 Full Time Housekeepers
1 Part Time Chaplain
1 Medical Director and Staff
2 Consulting Psychiatrists
1 Pharmacist Consultant

Services offered by Hoikka House include, but are not limited to:

Budgeting assisting.
Referrals to community program, e.g., Oneida, Appollo, D.V.R., Day Activity Centers, Chemical Dependency Groups; Hearing impaired groups at St. Paul Ramsey Hospital.
Contemporary Living Skills.
Transportation to and from doctor appointments.
Medication supervision.
Assistance with yearly redeterminations for social security, welfare, etc.
Psychiatric consults within and outside the facility.
On-going nursing assessments of residents health needs.
Special diets as needed.
Ongoing groups, e.g., resocialization, cooking, grooming, communication skills, etc.
Individual counseling.
Family contact and counseling.
Crisis intervention as needed.
Full-time activities program within the facility.

EXHIBIT 2

POLICIES AND PROCEDURES
FOR
ADMISSION AND DISCHARGE

ADMISSION POLICIES:

A. Pre-admission:

1. All referrals for private pay residents can be forwarded directly to Hoikka House. For any prospective resident who is a recipient of Ramsey County assistance, the referral must be directed to Ramsey County Welfare with the recommendation for placement at Hoikka House. For any out-of-county recipient of county assistance, the referral must be originally made to the home county, who in turn, would refer the prospective resident to Ramsey County for placement at Hoikka House.

2. The material included in the original referral received by Hoikka House must include a complete social and medical history.

3. The referring agency must be able to produce proof of the resident's ability to meet the financial obligations of living at Hoikka House. This would mean verification of MA certification, assurance of payment from personal resources, or a letter from the home county to Ramsey County Welfare Department (with a copy to Hoikka House), guarantying Hoikka House that they would accept full responsibility to assume the cost of the resident's maintenance until such time that other financial resources become available.

4. Each new resident is required to have a complete physical not more than five days prior to admission or within 72 hours after admission.

5. Each prospective resident is required to visit Hoikka House, prior to being admitted, for the purpose of being interviewed by the staff and to see the facility to which he is being referred. During this visit, he will be interviewed by the Social Services Director, Nursing Services Director and the Activities Director. He will also be given some literature on Hoikka House explaining house rules, etc., have an opportunity to see the living quarters in the house and have any and all questions answered regarding his possible future at Hoikka House.

6. Prior to admission, the Hoikka House staff and the staff of the referring agency will communicate extensively so as to fully educate the Hoikka House staff as to the needs, prognosis and recommended avenues of rehabilitation regarding the resident.

7. If the resident seems to be a suitable prospect as a resident of Hoikka House, his name will be placed on the waiting list in order as of the date of his visit here. The waiting list will be occasionally updated and each time, the prospective resident will be informed as to his position on the list.

B. All private pay residents' payments to Hoikka House must be in advance, payable on the first of each month.

C. All admissions to Hoikka House must be completed by noon on Thursday. No new admissions will be received after Thursday noon in order to assure the new resident of the support of a full staff during the crucial first few days of his adjustment to his new surroundings.

D. Hoikka House reserves the right to reject any referral if the staff feel that the prospective resident would not be a candidate who could likely benefit from our program or if he should possess one or more of the following characteristics:

1. A susceptibility to seizures that are not being medically controlled.

2. Has a diagnosis other than some facet of mental illness.

3. Is chemically dependent.

4. Is physically aggressive and assultive.

5. Has a physical problem requiring a level of care that Hoikka House is not prepared to give.

6. If he does not have the financial resources to be maintained at Hoikka House.

7. Is strongly resistant to coming and would resit the attempts of the staff to promote his rehabilitation.

8. Has a history of any sexual misbehavior.

9. Has a criminal record.

E. Hoikka House will not be responsible for resident's lost or stolen articles.

ADMISSION PROCEDURES:

A. Upon admission, the new resident is met by the Director of Social Services and is asked to cooperate in the filling out of the standard admission form including the following items: name, previous address, permanent address, Social Security number, sex, marital status, age, date, place of birth, occupation, date and hour of admission, nearest relative, who to notify in case of emergency, religion and financial guarantor. He is also asked to read and sign the Resident's Bill of Rights and the Hoikka Resident Rules.

B. The new resident is advised against keeping large sums of money in his personal possession. He is encouraged to deposit any large sums in his account at Hoikka House and keeping on his person only what he might need for miscellaneous spending.

C. All medications brought with the new resident are to be turned in to the nursing office.

D. The housekeeping staff will help the new resident unpack and make a record of all valuables kept in his possession.

E. The new resident will be assigned a locker and given a key.

F. The new resident is introduced to a fellow resident who has been assigned the responsibility of being his "special friend" for the day. His responsibility is to see to it that the new resident is introduced to other residents, is familiarized with the neighborhood, and is shown all those aspects of living the daily life as a resident of Hoikka House.

G. On his first day, the new resident will be interviewed more extensively by each of the department heads.

H. The staff will establish a structured schedule for the new resident, outlining for him the recommended means of keeping occupied for approximately one week.

DISCHARGE POLICIES:

A. Hoikka House requires a 30 day notice in the case where a resident is voluntarily moving, but does reserve the right (if need arises) to precipitate a move with no specific notice being defined.

B. Hoikka House will define the reason(s) precipitating the discharge. The reason may be any one or a combination of the following:

1. Displays of hostility which pose a threat to himself or some other residents of the House.

2. Some change in his psychological status that, according to a doctor's recommendation, warrants long term care of a nature which we are not geared to give.

3. Moving to a living situation where the level of care is more appropriate in view of his specific needs.

4. Moving into an independent living situation.

C. The Hoikka House staff will assess the quality and appropriateness of the prospective living situation and advise accordingly.

D. Any interested family contacts or County Welfare service workers will be notified if a discharge is eminent.

E. If the discharge should involve the resident's returning to a state hospital, the hospital will be notified far enough in advance so as to insure their being ready for his return.

F. The discharged resident, upon leaving, must leave with Hoikka House, the full forwarding address.

G. The resident will be discharged with all of his prescribed medications being sent with him.

H. Hoikka House requests payment through date of discharge.

I. The balance of his personal account will be forwarded to the discharged resident when Hoikka House closes their books for the month of his discharge.

J. Hoikka House will retain informal contact with all of the discharged residents living in facilities where supervision is non-existent. The ex-resident will be informed that our support is available to him if he should realize the need.

DISCHARGE PROCEDURES:

A. The Hoikka House staff will determine the feasibility of, or the need for, discharging a resident only after consulting

with the resident, the county caseworker involved, and the Hoikka House staff as a team.

B. The House staff will assist in the making of suitable living arrangements for the resident about to be discharged.

C. The housekeeping staff will check all storage lists to be certain that the resident will be leaving with all his belongings having been removed from storage.

D. The housekeeping staff will assist the individual in the packing of his clothing and personal belongings.

E. The Hoikka House staff will have the responsibility of informing the receiving agency (hospital, nursing home, etc.) of the current psychological and medical status of the resident being discharged.

F. Discharged residents shall leave with all of their prescribed medications being sent with them.

G. Each department head will record in the resident's file, all of the pertinent data regarding his discharge (i.e. date and time of discharge, the reason for the discharge, the forwarding address, discharge diagnosis, and a notation as to whether or not they would recommend ever taking that individual back as a resident of Hoikka House again).

H. Each department head will forward the dead file on the discharged resident to the office of the administrators.

I. Upon discharge, Hoikka House will send, to the receiving agency, a referral including all pertinent information regarding medications, physical and emotional health, etc.

EXHIBIT 3

THINGS YOU SHOULD KNOW ABOUT HOIKKA HOUSE

Hoikka House is a long term health care facility for adult mentally ill individuals. Although persons considered for admission to our facility must have a primary diagnosis of mental illness, we are open to considering persons with other secondary diagnoses.

Our program presently involves a wide spectrum of individuals with hospitalizations varying from 30 years of institutionalization in a state hospital to very brief periods in a state hospital or in an acute psychiatric unit.

Since the necessary element in the success of a program such as ours is the active cooperation of the individual resident, the intake procedure for persons wishing to become involved in the program revolves around determining the mutual appropriateness of the resident and the home. This decision is based not only on primary diagnostic considerations, but also on behavioral and attitudinal ones.

Experience indicates that the population for whom this type of program have been successful include:

1. The older person who probably will not have the opportunity to become competitively employed. For this group, the program is one of establishing a comfortable and maximal level of participation and maintaining this in accordance with his/her physical and mental state. For many of these people, this involves participation in a comparatively undemanding work activity. For others it may be involvement and participation in in-house and community activities. For still others, no organized involvement is appropriate and the effort of the staff is on the maintenance of personal care and of informal social contacts.

Hoikka House, Inc.
9/79

2. Persons with long histories of hospitalizations may be either in the form of a small number of long term hospitalizations or a pattern of chronic short admissions. The emphasis with this group is on breaking away from the hospital as part of their life style. The efforts of the staff with persons in this group are directed toward establishing and maintaining contacts both within and outside the home that will tend to anchor them in the community. The programs usually recommended for this group are those that are fairly slow moving in nature due to the need to overcome many insititutionalized patterns of behavior.

3. Individuals with a short hospitalization history. For these individuals, a much more active and directed effort is made to establish a vocational goal. This includes referring to an educational setting, a high level workshop or training program. Encouragement to be involved in both in-house and extramural recreational and social activities to help him/her to develop social skills.

4. Younger Individuals - The major focus of our program with this group is the establishment of identification figures on which they can model adult behaviors and the involvement in training facilities which will give them the needed education and skills in order to establish themselves. Our program is not structured to serve many of these persons because we are too dependent on verbalized behavior to deal effectively with those whose coping patterns involve a great deal of physical acting out as a means of communication.

Hoikka House, Inc.
9/79

5. Mildly to moderately retarded adults - Characteristic is the inability to function independently with respect to activities and daily living skills. For this group, the program is aimed at seeking their highest level of functioning in each area (personal, social and vocational). We seek to provide them with a stable and structured setting that gives them the security and support necessary for exercising their own best capacities.

To serve the varying needs of our residents, we utilize a goal-directed, individualized program for each. This program, using information gathered from referral forms, pre-admission interviews, admission interviews and resident and family (if appropriate) input assists in identifying areas of need, problems and potentials. The program plan is developed specifying appropriate methods for meeting or fulfilling those areas identified. The people involved in each Resident Program conference include the resident, Ramsey County Welfare Department social worker, attending physician, and Hoikka House staff (Resident Services Director, Social Worker, Director of Nursing Services, Director of Activities Services), and other resource persons from referring agencies, rehabilitation service agencies, etc.

Porgrams are reviewed at least quarterly, but more often if so indicated by the nature of the specific program goals.

Necessarily, with such a broad spectrum of individuals, the services offered must be varied also. While staff are considered and utilized as part of the therapeutic atmosphere, three segments of the staff are primarily responsible for providing needed services. are 1) Nursing, 2) Activities, and 3) Social Services.

Nursing Service is provided seven days a week by licensed personnel. Nursing is responsible for supervising all medications and treatments received by residents as per doctor's orders. They make the necessary referrals and appointments for all medical, physical, dental and psychiatric needs. They are primary educators for resident nutrition and dietary needs and motivators and educators in proper hygiene and grooming.

Activities Services offers scheduled activities seven days and evenings per week. Offerings vary from Communications Group to softball; from museum tours to cooking skills; from gardening to pottery. Each activity offered is selected and directed toward helping residents meet their needs or fulfill their potential. Residents are encouraged not only to participate in scheduled activities, but also to become involved independently in hobbies, community programs, educational opportunities, etc.

Social Services is staffed seven days per week. Counselors and social workers are responsible for the overall program of each resident.

Hoikka House, besides referring many residents to community rehabilitative services, also has in-house work and training as part of its program. Involving 25 residents who are primarily low functioning, this service provides a "stepping stone" for some to community placements, and for others, it is a low keyed work program which provides positive input to improve their self-esteem. The work program is "trainee" centered in that the task assigned is made to fit the individual instead of vice-versa, which is often the case elsewhere. We are certified as a training and evaluation center and sheltered workshop by the Federal Government Wage and Labor Department.

Hoikka House, Inc.
9/79

Residents are made aware of their rights as provided by Federal law and encouraged to exercise these rights. One channel for exercising these rights is the "Town Meeting." This monthly meeting with only two staff present, (Resident Services Director and secretary), is primarily a resident centered meeting, allowing for the presentation of problems, questions and grievances through an open format. The Resident Services Director acts as liaison between residents and staff administration, attempting to deal with all points raised.

QUESTIONS

1. How is a person referred to Hoikka House?

   Hoikka House accepts referrals from any private practitioner, hospital or social service agency. Referrals from families or private individuals must include consultation with one of the above. This is so we can assure back up service for the individual resident for either psychiatric or physical hospitalization.

2. Intake procedure.

   The first step in the intake procedure is accomplished during the referring call. At this time, the Resident Services Director or a social worker gather some basic information which allows us to do a preliminary screening with respect to appropriateness. Following this, an appointment is made for the prospective resident to come to Hoikka House to interview and be interviewed by the Resident Services Director, Nursing Director and Activities Director.

We feel that it is extremely important that a person coming to live here comes of his/her own choice and because he/she "likes what he/she sees, "since it is based on this that we later demand of him a continuing commitment to his own rehabilitation program. Following this interview, the Resident Services Director will discuss appropriateness with the Director of Nursing and Activities Director and will make the decision with respect to admission.

3. What can a resident expect during his/her first few days at Hoikka House?

On the day an individual moves in, he is introduced to his social worker who assists him in getting his belongings settled and becoming oriented to the physical layout of the building. Also, one of the residents will introduce him to such things as schedules of meals, activities going on and meeting his fellow residents. Within the first few days, the resident will be spending some time with the social worker, Activities Director, Nursing Director and the Financial Secretary.

4. How long do people stay at Hoikka House?

For some of our residents we are a transitional facility, and for others we are a long term permanent living arrangement.

5. What is the attitude of Hoikka House toward hospitalization?

This is an important philosophical question for anyone involved in psychiatric rehabilitation. The prevailing attitude at Hoikka House is that hospitalization is an intricate part of continuation

of service that should be made available to individuals when needed. Consequently, we give a lot of credence to an individual's request for hospitalization. We do this on the basis of past experience where when the individual's verbal request for hospitaliazation was ignored, they proceeded to give their message behaviorally to force the hand of whatever agency they were involved with. This does not mean that we hospitalize automatically just because a resident thinks he needs it. We attempt many types of primary intervention aimed at helping the person learn ways of coping with the situation outside of a hospital setting.

We operate under the philosophy that we believe individuals with mental illness can more easily be rehabilitated and/or resocialized if they are allowed to function in a homelike, non-institutional atmosphere, where staff-resident relations promote individual awareness in each resident through contact with professional staff.

We believe that our facility and program can provide an important function in the continuum of care for the mentally ill.

The goal of Hoikka House, Inc. is to assist each individual resident in developing to his/her fullest potential with the objective that many will be able to return as useful and contributing members of the community.

Hoikka House, Inc.
9/79

EXHIBIT 4

HOIKKA HOUSE, INC.
RESIDENT WORK-IN-TRAINING PROGRAM

A PROBLEM AND A PHILOSOPHY

When a person first enters a psychiatric hospital, he has a dysfunctional or a confused identity. This identity has developed through an accumulation of life experiences. Many of these experiences have been labeled as "failure" either by the person himself or by the society he comes out of. Hospitalization itself is more failure. The person feels rejected, unaccepted and unworthy. The hospital either becomes a facility of greater "failure" or it becomes a stronghold of security where the person can feel safe from the rejection he had experienced out in society. In either case, the individual, when he leaves the hospital and returns to his community, finds himself struggling with the fears and anxieties that he will not be accepted by the society that had once rejected him. Perhaps more important, he often finds himself saddled with the misconception that he is unacceptable and a real "failure".

Being saddled with these fears and anxieties along with continuing mental illness, a large percentage of patients return to the community not capable emotionally or physically of immediately stepping into the structured rigor and demand of gainful, productive employment. This is a well known and accepted fact as evidenced by the existence of such agencies as the Department of Vocational Rehabilitation (DVR), Occupational Training Center (OTC), Goodwill Industries and St. Paul Rehabilitation Center.

(D)

It is our experience and our contention that despite the excellent job these agencies are doing, there is a definite need for training that is geared to a clientele unacceptable to these facilities. This group of people would be at least in part those persons who (for various reasons), have been rejected in the screening process of these agencies, or who have been unable to perform at levels acceptable to the standards set by these various agencies and have thus been terminated or quit of their own accord because of the pressures brought upon them to conform to certain standards more quickly than they were able. In either case, they would once again have the "failure" identity reinforced and could possibly be lost as productive, functioning citizens if they are not given the special attention and assistance they need to once again be able to function in a manner acceptable to society and thus "grow" out of their prison of failure through planned, measured and reinforced successes.

All too often success is measured in terms of a person being able to fulfill certain criteria. In many job training settings, a person is screened or accepted on the basis of his ability to match the job requirements. In other words, the job is defined and the person declared a failure or a success on the grounds of his ability to bend into the mold of the job. All too often the person's patterns and life styles and "mis"-conceptions of himself make him too rigid to bend to fit the mold, and instead of neatly bending, he breaks. This, of course, is not always true as shown by the successes

of the above mentioned agencies. Unfortunately though, it does happen and it is because of this basic fact that we at Hoikka House deem it necessary to have a different kind of training program. That is, we have a program that starts out not with a job and a procedure of choosing a person to fit it, but with a person and a procedure of choosing a job to fit him, his needs, his potentials and his immediate self-concept.

The "normal" person can usually conform to the stipulations, requirements and rigidity of a new job or a first job. Thus, for them, training is merely describing a job, instructions on requirements and expected performance and then evaluating their progress. Unfortunately, for the mentally ill person, training can be an almost traumatic reminder of past experience and can become another negative experience - something the failure burdened individual does not need. For this very reason, we feel that a training program must first and foremost deal with the trainee and secondarily deal with the job. For this reason, our training program is structured in such a way so as to allow work hours, expectations and levels of functioning to be adjusted according to the present condition of the trainee. This allows us to deal with individuals who are not able to function in the programs of other agencies.

As stated above, our training program is "trainee" centered. That is not to say that the job is never done properly because the individual cannot function in a correct and full manner. But, rather, it means the job does get done correctly and completely because we

deal not only with skills and the ability to function physically, but we also deal, and in our estimate, more importantly with the attitudes and self-confidence of the trainee. An individual who has been a failure all his life must be taught success - both how to attain it and how to recognize it. Success breeds success and very often an individual can, after miniscual and almost unnoticeable successes, begin to attempt and succeed at tasks that were before an impossibility because of his fear of failure.

A trainee then becomes a person who is not only being taught job skills and performance standards, but is more importantly being taught proper attitudes and self-confidence. I say "more importantly" because the person who has no self-confidence and the wrong attitudes will fail again and again, whereas the individual who has gained the right attitudes and real self-confidence can, and will, succeed even if he was trained on the most menial task.

Thus our understanding of a "trainee" is that he is an individual who, in the process of his total rehabilitation and resocialization program, needs to be properly prepared to hold a future, permanent, purposeful and productive job. If we can accept this definition then the Hoikka House program must be declared a training program.

Our program is geared to preparing the trainee for a permanent job. It is not in itself a permanent job. In the past, trainees have been referred to other agencies after months of training here at Hoikka House and others have been referred directly to competitive

jobs. This means that we gave people who either failed to get into or failed at other agencies a chance to become successes, and they did. Much of this is due to the total involvement of our entire staff. We have trainees involved in the kitchen, dishwashing room, laundry and housekeeping. The regular staff of these departments are hired, along with the other qualifications, with the understanding that much of their time and energey will be spent supervising resident trainees. Every staff member becomes an instructor and a reinforcer.

Coordinating the training program is the responsibility of the social worker, but the actual supervision comes from the departmental personnel who are instructors, not only verbally, but through their actions. They work side by side with the trainees on many jobs and thus show the trainee proper procedure as well as giving the much needed encouragement and reinforcement of the success image. This shoulder to shoulder contact not only supplies the necessary skill training, it also enables the trainee to identify himself as a person. He begins to perceive himself as useful and gains confidence as he sees himself working successfully, hand to hand with staff members.

This shoulder to shoulder, hand to hand training program was no accident. It was specifically structured this way to meet the needs of people who could not succeed on training programs where there is less supportive contact. Our training program is thus structured to provide much supportive contact as well as professional staff supervision, implementing a specific program for each

individual, in an effort to make success possible for persons who have been labeled failures by other agencies.

IMPLEMENTATION

How does one go about implementing such a program? Again, the entire program is "trainee" centered.

The first step, surprisingly enough, is evaluation. This is done by the staff often prior to the individual actually being contacted about a training position. It necessarily involves evaluation of physical ability and mental stability. It need not, but often does, include an evaluation of motivation. This evaluation is a part of the overall "Resident Program". This Program is written originally on the information received from the referring institution and is reviewed quarterly. It includes a summary of observed behavior and the present status as well as spelling out the overall "goal" and more specific "objectives". Very often the "goal" will be future competitive job placement with one of the "objectives" being placement in a training program. Evaluation for the training position and the Resident Program is done by the Social Services department in coordination with the Nursing Services, the county Social Worker and, where deemed necessary, consulting medical and psychiatric personnel.

Only after the evaluation does the application and interview come. It is felt that this step is an important part of any job training program. Every potential job seeker must have the ability

and the poise necessary to succeed in securing his future job. For these trainees, this step is especially important. We must remember that they have been failures all their lives and to learn how to present themselves as successes is a real challenge. It is indicated to each applicant before the application is filled out that this is a step in their training and many of them have to be guided step by step through the entire procedure.

The application used is a standardized version and the trainee is asked to fill it out as completely as possible. This often requires assistance in reading or spelling, but the trainee has a real sense of accomplishment when he finishes filling it out.

Once the application is completed, the trainee is interviewed by the social worker. Though the evaluation has all ready been completed, the interview is made as real as possible and yet every effort is made to make it a positive experience for the trainee.

Part of the interview is used to outline expectation and responsibilities. These have been carefully chosen before hand on the grounds of the evaluation. Expectations and responsibilities vary greatly. For example, one person may work one hour per day, four days a week, while another will work three hours per day, five days a week. One may carry out empty boxes while another must operate the dishwashing machine. Training programs are as varied and individual as the trainees themselves.

The interview ends with the trainee being taken to the departmental personnel to inform them that the new trainee is in the

program. He is then shown his work area, his duties are explained and he is assigned a time to start.

At this point he becomes more conscious of time. When he reports to the training position, he is instructed on the use of the time clock. Motivating a trainee to be punctual is an integral part of the training program. A phase of this is having the trainee procure an alarm clock and then teaching him (if necessary) how to operate it. He must be motivated (or taught) to respond to the alarm when it is time to get up and to be on the job on time. Again, this entire process is carried out on a very individualized basis. Support and encouragement are very important as trainees slowly learn the necessity of punctuality.

As difficult as this may be, the complex task of instructing each trainee on correct procedure is even more difficult and exacting for the staff. Each resident must be confronted, encouraged, stimulated and reinforced in a measured way. Getting up, punching a time card, getting the dishes clean and sanitized are very tangible, measurable items in the training process. More difficult to assess are the motivations, expectations, attitudes and concerns of the trainees. To deal with these problems, an integral part of our training program is the group meetings. Hoikka House trainees are required to attend two meetings per week as a part of their training. One meeting is a combined "All Worker's Group" which includes both Hoikka House trainees and those residents in training programs of other agencies. This group exposes the Hoikka House trainees to some

of the problems they may not meet as they train in this facility. Problems such as transportation to and from work or the need to carry a bag lunch are discussed.

The second required meeting is for Hoikka House trainees only. The purpose of this meeting is twofold. First, as an opportunity to deal with the many facets of work and work training. These trainees have very poor work records or no records at all and it is very important to supply them with information about as many areas of work as possible. Topics include: hygiene and proper grooming, desirable work skills, desirable work characteristics and how to achieve those; motivation, monetary value, budgeting, expenditures, what can be expected of an employer, social security, income tax and future job possibilities. It is also a time set aside specifically for dealing with problems that have arisen. It is a time for trainee to encourage trainee and for problems to be solved.

Secondly, the meetings help to establish an elite group. For some, being a part of this group provides the additional motivation necessary to struggle through problems instead of ending in failure.

Perhaps the most important factor in the success of any individual program is the motivation present or instilled. A very meaningful part of the Hoikka House training program is providing a motivation in the guise of "Worker's Group" outings. These vary from a restaurant dinner to a movie, from bowling to a hayride. Activities are chosen by (1) trainee preference, (2) in terms of helping the trainees

understand that these occasions are possible because they are working. Such pleasurable leisure outings are a powerful motivator.

To assure that each training program is continually meeting the needs of the trainee, regular evaluations are carried on by the social worker with the cooperation of departmental personnel. The program, it's requirements, expectations and duties, are adjusted according to the status of the resident. To increase the program is the hope, but decreases are not uncommon. This again, because at Hoikka House a program is made to fit the trainee, not the trainee forced to fit the program.

7/-11-

Dell Rose
Social Worker.

Dear Dell Rose, I thought you would be interested in Mary's glowing account of Hotel Hruce. Highest praise for all the staff - so kind to her. Said Mrs Miller very friendly also Mr. & Mrs. Hokka - said she knew I would like Mrs. Hokka - so "commonplace." Praised the food - very good and plenty. Said most residents are very friendly - enjoy - Bingo Bar co, cards etc. Brought home programs & brochures from places of interest - was so

impressed with God's plan.
in fact tells everyone about the
trips and cultural places she
has been at.

These three weeks have gone
so fast. she has been just
wonderful. most helpful.
Walks to church daily. eleven
blocks. Fluids then bring her
home. Even needs after to me.
Just had one sick day - terrific
headache - vomiting and
diarrhea gone her true typical
that was all. I was wondering
if her stiffness in hands
and also enlargement of
joints could be side effect
of medication or E.C.T. treatments

I wrote Lt. Bentley but no reply - wondered just how long she would have treatments, would so appreciate an evaluation of her; to see progress of talent such a personality change seems her old self. Tells a great deal about, and very accurate; of happening in the past. But about four years since 1976 - a total blank. We are to have a new director at Mental Health Center, a splendid person, as possible will have more contact

Thank you for your interest

in Mary. Sincerely yours,

Lorena Yates

June 28, 1994

Dear Mr Beyer, (Re: Vinson Schaffer)

I was so pleased to receive your letter and certainly found it helpful and [illegible] and will look forward to hearing from you again.

Vinson has made so much progress in the time that he has lived at Haddon, that it's simply incredible. He is happy there, and has made a place for himself. It's the first good beginning he has had in over 30 years.

I agree with your reasoning of why he said he should leave, he thought his time was running out, and he was no longer wanted. He really wants to live at Haddon, and with guidance, reassurance that he is wanted, he has potential to make even more progress than he has made in the past. I may

tell you that before he came to live there, his mind was really a blank, no awareness of people or of life going on around him. He was really a "vegetable". But now he is a person who is aware of life; but he has so many fears, and that's understandable. This is one of the reasons he has trouble making decisions. But he will improve there too as he gains confidence in himself, with your help.

Again I want to thank you, and the rest of the staff at Stubbs for all the interest and consideration given to Vernon. You are doing a great job with him. He's functioning now, and will, ever do better, as he has the ability and the desire to be an individual.

Am planning on visiting Vernon in the fall. So maybe we can meet.

Sincerely,
Rosalind Lloyd

Winona, Miss
5/1/81

Finance Dept:

Our Social Security Office notified me that Social Services welfare dept requested Mary's Social Security Check be sent direct to them. I called to find out the reason for change, was informed it's their policy with welfare cases. I called today when I didn't receive her check to be certain they had received check. They said they did and would take care of sending it to you. This explains why I'm not sending personal check due May 10th.

So my aged Mary must suffer such an improvement

She told everyone was
entire staff, even the cooks
are so kind to her. She
praised the food - also was
so happy, going to plays,
trips, shopping and as
many places of interest.
I haven't seen her so out
going and enjoying life in
the past five years.

Sincerely yours
Rosemary Yates

3/30/81

Del Rose
Social Service
Haikka House

Dear Mr. Rose,

Thank you for the letter about Betti's progress. It seems to me she is doing well and I am happy she has an opportunity for another program toward a future occupation.

She seems happier and sounds more cooperative toward what is being done for her than before.

I thank you and Haikka House for what they have done for Betti and what you are trying to do.

Sincerely -
Barbara Solo.

April 29, 1981
Anne M. Dolinar
325 9th St. N.E.
Chisholm, Minnesota 55719

Dear Mr. Rose,

Thank you very much for your letter of April 24th. As always, I am happy to hear an objective evaluation of Tom's problems. I have talked on the phone with him several times and he did mention that his hours were being cut and he was a little upset because he thought he needed the money, however he did not mention about being unruly and agrumentative. When I hear this I tend to worry because I think he might have a relapse, especially when he refuses to take his medications. I know that he will be watched carefully that he takes all the medications prescribed.

His personal hygiene has been one of the most aggravating problems between Tom and I. It would take a miracle for him to improve and I know how frustrating it can be. Did he get his false teeth fixed? He wasn't wearing them when I saw him last in March, and he told me that they were being fixed, but sometimes I don't know whether to believe him or not. I hope he isn't refusing to wear them.

I certainly am happy with Tom's progress , and he has come a long way at Hoikka House and I do hope that Tom will continue to cooperate and that his present problem will be resolved soon.

If there is anything I can do please let me know. I am sure that you have my work number and home number if you need to call me.

Thank you again for your kind letter and I especially thank you for your concer of Tom. He speaks very highly of you and has great confidence in you.

Sincerely yours,

Anne Dolinar

Eveleth Minn
Feb 25, 1979

Haikka House Inc
238-Pleasant Ave
St. Paul Minn.

Dear Mr. Lueck:

Thank you for the letter of Feb 23rd.
We are always very interested in our daughter Louise's welfare.
We know you are doing your best, as she has been much happier since moving to the Haikka House.
Before her illness she was a very neat person always taking plenty of baths, brushing her teeth after meals and keeping herself well groomed and dressed.
In her long stay at the State Hosp she seemed to lose all self interest.
She was always a rather quiet girl but doing her best at whatever she started doing, done very well in school till her illness.
It was after the start of her illness she went to beauty school, done very well there too. worked for a while at different jobs, but they all proved too much for her as her illness progressed.

She had many very nice girls friends while in skool, who still are concerned about her. She never seemed to want to socialize very much, which gave me some concern even when she was quite young.
On her last visit home she really had taken more interest in her appearance then usual for her. We told her how nice she looked.
She always seems happy about her work there when she talks about it with us.

Her father has been ill with cancer since last spring, and is bedridden now.

I called Louise on the 14th after the doctor visited here, and I write to her and keep her informed of his condition. She doesn't seem to feel comfortable coming home alone on the bus, but when my sister from Golden Valley comes down they always bring her along. Thank you All for the good care Louise is getting.

Sincerely Mrs Charles Ufnis

Sept 1, '81

Dear Mrs. Tierney.

We were pleased with Dan's optimistic outlook on life & report of the "friendly people at Webb's Dude" during his week at home.

We will be away for a week Sept 2-9 visiting our daughter in Lincoln, N.E. In case of emergency we can be reached at this address.

Bonnie Burgeson
2138 N. 65th St.
Lincoln, N.E 68505
Phone 402-466-3396

EXHIBIT 6

VETERANS ADMINISTRATION
OUTPATIENT CLINIC
FORT SNELLING
ST. PAUL, MINNESOTA 55111

August 26, 1976

IN REPLY REFER TO: 618 (122A)

Mrs. Rhoda Miller, Assistant Director
Hoikka House
238 Pleasant Avenue
St. Paul, Minnesota 55102

Dear Mrs. Miller:

We have received word of your annual open house in September. It also served as a reminder of the many years of cooperation we have enjoyed with the staff of Hoikka House.

We have been almost continuously searching the Twin City area for resources for the placement of mentally ill veterans. I can safely say we have found none which have exceeded your facility and very few which have even approached it.

As you know, the Veterans Administration Hospital, St. Cloud, has a family care program in their community. This has generally meant that we have received most of their heavy care referrals--veterans with long histories of repeated episodes of disabling psychosis. I would like to take this opportunity to thank you and your staff for the careful consideration you have given in the management of these difficult patients and their complex regimen of psychotropic drugs. We have long been convinced that this type of patient could not live outside of an institution without the well structured program of a home like yours.

We are looking forward to continuing the excellent relationship we have had with your home.

Sincerely yours,

Noel G. McLane

NOEL G. MC LANE
Supervisor, General Program
Social Work Service

Show veteran's full name, VA file number, and social security number on all correspondence.

EXHIBIT 6

UNIVERSITY OF MINNESOTA
TWIN CITIES

Department of Psychiatry
Medical School
Box 393 Mayo Memorial Building
Minneapolis, Minnesota 55455

July 7, 1977

Miss Marguerite Tierney, Supervisor
Social Services
Hoikka House
238 Pleasant Avenue
St. Paul, Minnesota 55102

Dear Miss Tierney:

I appreciated the opportunity of meeting again with you and your staff on June 30th, and learning more about your specialized treatment program for mentally ill adults which is vocationally oriented and focused on reintegrating them into the community. Also, I was impressed with the variety of social-recreational activities provided. Staff of the Adult Psychiatry Department have been pleased with its association with Hoikka House through the years, and with the prompt consideration that has been given to referrals of our patients. Also, we appreciate the follow-up information that has been supplied about them.

Thank you for the material on policies and procedures, and the attractive newsletter describing your many activities. I am sharing the information with our staff.

Sincerely yours,

Gertrude Shiely

(Miss) Gertrude Shiely
Principal Psychiatric Social Worker

csn

3836

BROEKER, HARTFELDT, HEDGES & GRANT
ATTORNEYS AT LAW

2850 METRO DRIVE - SUITE 800

MINNEAPOLIS (BLOOMINGTON) MINNESOTA 55420

TEL. (612) 854-5263

JOHN M. BROEKER
WILL HARTFELDT
STEVEN R. HEDGES
DAVID A. GRANT
STEVE M. MIHALCHICK
BARBARA J. BLUMER
WILLIAM J. WERNZ
BECKY A. COMSTOCK
EILEEN M. ROBERTS
TERRI A. HAGEMEYER

October 21, 1981

Mr. Richard Luis
Hearing Examiner
Office of Administrative Hearings
Room 300
1745 University Avenue
St. Paul, Minnesota 55104

Re: In the Matter of the Proposed Adoption of the Department of Public Welfare Rule Governing Residential Programs for Adult Mentally Ill Persons (12 MCAR §2.036) Docket No. 82-004-RL Relationship of Facility Size to Effective Programing

Dear Mr. Luis:

On behalf of our client Hoikka House, we wish to submit comments on the above subject matter for the hearing record as a follow up to comments made at the public hearing conducted October 1, 1981. Such comments should be read in conjunction with two other letters which we have submitted on behalf of Hoikka House for the hearing record, which letters contain general comments and commentary on the role of Hoikka House in the care and treatment of the mentally ill.

The following comments are directed toward the portions of proposed Rule 36, and the other materials submitted in support of these portions, concerning the living unit requirements, found at Part O; and the capacity provisions found at Parts P and Q of the proposed rule. These comments are especially directed at the facility, or treatment units within a facility, bed capacity limits as enumerated at Part P.1. and Q.1. of the proposed rule.

The Statement of Need and Reasonableness filed by the Commissioner of the Department of Public Welfare (DPW) states that the policy of DPW toward the mentally ill is to provide treatment in the least restrictive manner. Following that trend, DPW went on to state that it would also implement the concept of "normalization". In keeping with the spirit of normalization, treatment is to be provided in surroundings which are as culturally normalitive as possible, so

Exhibit C

that residents can establish and/or maintain personal behaviors and characteristics which are as culturally normalitive as possible. To meet these objectives, DPW has proposed that limiting the size of these facilities would promote a "normal" environment and thus upgrade the quality of care.

Hoikka House's concern of this limitation is two-fold: (1) There is no evidence to support a proposition that facility size is a significant factor in the quality of care provided by a facility and (2) There is no "optimal size" for these facilities, and the proposed Rule 36 capacity provisions are arbitrary and unreasonable.

I.

FACILITY SIZE IS NOT A SUBSTANTIAL FACTOR IN QUALITY OF CARE

Size, per se, is not a measure of quality in facilities for mentally ill persons. Even when size is considered, experts cannot agree on whether large or small facilities offer the best care. The only fact the experts do agree on is that there is very little data on the correlation of facility size to quality of care.

There are two primary sources available on this subject. The first, and most recent, is a study prepared by Landesman-Dwyer and Sackett in 1980,[1] in which comparisons were made of separate group homes for the mentally retarded ranging from six to twenty residents. The second is an article by David A. Balla written in 1976[2], in which Balla analyzed all the empirical data which had been compiled on the relationship between facility size and quality of care in homes for the mentally retarded.

DPW has cited the Landesman-Dwyer and Sackett study for its position that small facilities for the mentally ill are better than larger facilities. This reliance is misplaced for two reasons: (1) the Landesman study compared facilities which cared for the mentally retarded, not the mentally ill; and (2) even if the study were comparable, it does not support the theory that "small is necessarily better."

---

1 Landesman-Dwyer, Sharon and Sackett, Gene P. "Relationship of Size to Resident and Staff Behavior in Small Community Residences", American Journal of Mental Deficiency, 1980, vol. 85, No. 1, 6-17.

2 Balla, David A., "Relationship of Institution Size to Quality of Care: A Review of the Literature," American Journal of Mental Deficiency, 1976, vol. 81, No. 2, 117-124.

There are significant distinctions that can and should be drawn between the mentally retarded and the mentally ill. For purposes of this discussion, it is enough to assume that at the very minimum, the mentally retarded require more intense and individualized care. For that reason, the Landesman study asserts there may be some benefits correlated with smaller facilities. However, even the Landesman study concludes that there are benefits associated with larger facilities.

The Landesman study, among others, does not support the theory that"small is necessarily better". Like the Landesman study, the other studies discussed herein involve the treatment of the mentally retarded. The studies do not specify the degree of retardation involved, so it is difficult to apply the findings from those studies to this State's facilities for the mentally ill. However, to the extent that they are applicable, the studies show larger facilities can be beneficial, even for treatment of the mentally retarded.

Landesman-Dwyer and Sackett concluded that it was impossible to evaluate whether institutional size per se is a critical factor influencing the quality of care for retarded residents. Balla's research showed that there is very little evidence to suggest that the behavioral functioning of residents is different in institutions of different size. Balla concluded that if there are differences in the quality of care between smaller and larger homes, it is because of the type of the institution, not the size. Since Balla's conclusions were based on all data published on this topic prior to 1976 and the Landesman-Dwyer study was prepared as recently as 1980, it is easily shown that size alone in not a major factor in determining level of care.

While size is not a measure of quality of care, many other factors are relevant. For example, the effectiveness of residential treatment is assumed to be closely linked to the quality of their staff. According to Robinson and Robinson (1976)[3], the role of the attendant is the key to improvement of care. Baker (1977)[4] also concluded from a national survey of community residential alternatives that the quality of staff is the most important determinant of success in residential programing.

This is just one example of an area that has a direct impact on resident care. Resident/staff ratios effect all institutions,

---

[3] Robinson, N.M., and Robinson, N.B., The Mentally Retarded Child: A Psychological Approach, (2nd ed.). New York: McGraw-Hill, 1976.

[4] Baker, B.L., Seltzer, G.B., and Seltzer, M.M. As Close as Possible: Community Residences for Retarded Adults. Boston: Little, Brown, 1977.

small or large, and cutting the size of the facility would not provide an increased level of care.

Other factors which influence quality of care are facility layout, programs offered, geographical location of the facility, employee turnover rate, cost per patient day, and the philosophy of management. Again, there is no correlation between size and these other factors. There is no assurance that smaller institutions will be more "home-like" or "normal". It is true, however, that Hoikka House, at its present size, does offer a home-like and normal atmosphere.

Thus, facility size is irrelevant in determining quality of care. The bed capacity limitations in proposed Rule 36 is therefore arbitrary and unreasonable.

II.

THERE IS NO "OPTIMAL SIZE" FOR THESE FACILITIES AND THE CAPACITY LIMITATIONS IN THE PROPOSED RULE ARE ARBITRARY AND UNREASONABLE.

Not only is the effect of size and quality of care in dispute, but experts are also in disagreement as to whether small or large facilities have more advantages for the residents. Many of the studies found benefits to be gained from larger homes. For example, Landesman-Dwyer and Sackett concluded that residents in larger facilities tended to be more social, interacted more with peers, were more likely to have a "best friend" and to spend more time with their best friends than did residents in smaller homes. This study went on to say that the smaller group homes simply do not afford adequate opportunity for peer social interaction or for finding a close friend. The chances of two individuals being mutually attracted and developing a good relationship is less when the number of individuals is small. Clearly, the smaller facilities do not foster better interpersonal relationships than do larger facilities, contrary to what some professionals and advocates have claimed.

Other studies have shown that residents in a larger facility are more independent. Campbell (1971)[5] conducted a study of the extent of personal independence in individuals living in a mental deficiency hospital and in a group home. The group of individuals living in a group home had been transferred from a hospital for the mentally deficient. One year after the transfer, the large institution

---

[5] Campbell, A.C., "Aspects of Personal Independence of Mentally Subnormal and Severely Subnormal Adults in Hospital and in Local Authority Hostels," International Journal of Social Psychiatry, 1971, 17(4), 305-310.

residents showed significant gains in personal independence while subjects in the group homes did not. Thus, Campbell offers some evidence that resident care practices in group homes are not inevitably superior to those in larger facilities. Additional evidence on this point is provided by Edgerton (1975)[6] in a study of family care homes with six or fewer residents and group homes in California. Edgerton stated "for most mentally retarded people in this system, . . . the little institutions where they now reside appear to be no better than the large ones from which they came, and some are manifestly worse." pp. 130-131.

The purpose of these comments is not to debate whether large or small facilities are better, rather the purpose is to point out that there is very little empirical data available regarding the correlation between the size of the facility and the quality of care it provides. Even where data is available, experts disagree as to whether small or large facilities are better.

Therefore, the bed capacity provisions do nothing more than passify the newest whim of the social advocates. As such, they are arbitrary and unreasonable.

III.

SUMMARY

Hoikka House has a history of offering high-quality services and care to its residents. Imposing a maximum bed limitation upon Hoikka House, or forcing it to subdivide its residents into small living units would be contrary to recent research findings. In addition, it would impose excessive hardship upon Hoikka House and most importantly, its residents.

It is impossible for DPW, or any sociologist or psychologist, to determine that limiting the size of residential treatment homes for mentally ill adults would have a positive effect on the residents. Quality of care depends on quality of staff, parental, and community involvement. These are factors that cannot be dictated by the size of a facility. The assumption that the quality of care for individuals is superior in smaller institutions than in larger institutions is no longer true. Futhermore, that assumption has never been supported by more than a mere smattering of empirical data.

For the above reasons, the Hearing Examiner should find the Department of Public Welfare's proposal to adopt capacity limitations

---

6 Edgerton, R.B. "Issues Relating to the Quality of Life Among Mentally Retarded Persons." In M.J. Begab and S.A. Richardson (Eds.), The Mentally Retarded and Society: A Social Science Perspective. Baltimore: University Park Press, 1975.

for residential facilities for the adult mentally ill unreasonable. In the alternative, if proposed Rule 36 is found reasonable and enacted in its present form, then Hoikka House should be deemed exempt from its application for the reasons stated above, and as contained in other, separately filed, comments.

Very truly yours,

BROEKER, HARTFELDT, HEDGES & GRANT

By_____
Terri A. Hagemeyer

TAH:bew

bcc: Rhoda Miller
Curt Hoikka
Rick Carter

BJB
JWI

STATE OF MINNESOTA)
(ss.
COUNTY OF RAMSEY)

AFFIDAVIT OF SERVICE

Eileen A. Gaiovnik, being first duly sworn, deposes and says that on the 15th day of December, 198 , at the City of St. Paul, County of Ramsey, State of Minnesota, she served the attached Report of the Hearing Examiner DPW-82-004-RL upon The Commissioner of Public Welfare by handing to and leaving the same with JOhn Sauer, Welfare Specialist, Mental Health.

Eileen A. Gaiovnik

Subscribed and sworn to before me
this 15th day of December, 198 .

Susan C. Wojcik

SUSAN C. WOJCIK
NOTARY PUBLIC-MINNESOTA
RAMSEY COUNTY
My Commission Expires April 26, 1986

DPW-82-004-RL

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF PUBLIC WELFARE

In the Matter of the Proposed Adoption of the Department of Public Welfare Rule Governing the Licensure of Residential Facilities for Adult Mentally Ill Persons, 12 MCAR § 2.036.

REPORT OF THE CHIEF HEARING EXAMINER

The above-entitled matter came on for review by the Chief Hearing Examiner pursuant to the provisions of Minn. Stat. § 15.0412, subd. 4d (1980) which provides in part:

> If the [hearing examiner's] report contains a finding that the proposed rule is substantially different from that which was proposed at the public hearing, or that the agency has not met the requirements of section 15.0412, subdivisions 4 through 4f, it shall be submitted to the chief hearing examiner for approval. If the chief hearing examiner approves the finding of the hearing examiner, he shall advise the agency of actions which will correct the defects, and the agency shall not adopt the rule until the chief hearing examiner determines that the defects have been corrected. If the chief hearing examiner determines that the need for and reasonableness of the rule has not been established pursuant to subdivision 4, clause (c), and if the agency does not elect to follow the suggested actions of the hearing examiner to correct that defect, then the agency shall submit the proposed rule to the legislative commission to review administrative rules for the commission's advice and comment. The agency shall not proceed to adopt the rule until it has received and considered the advice of the commission; provided, that the agency is not required to delay adoption longer than 30 days after the commission's receipt of the agency's submission.

Based upon a review of the record in this proceeding, the Chief Hearing Examiner hereby approves the Report of the Hearing Examiner in all respects and specifically as to any finding of substantial change or of failure to comply with Minn. Stat. § 15.0412, subd. 4-4f (1980) or of failure to establish need for and reasonableness of the proposed rule.

In order to correct the defects enumerated by the Hearing Examiner, the agency shall either take the action recommended by the Hearing Examiner or reconvene the rule hearing if appropriate. If the agency chooses to reconvene the rule hearing, it shall do so as if it is initiating a new rule hearing, complying with all substantive and procedural requirements imposed on the agency by law or rule.

If the agency chooses to take the action recommended by the Hearing Examiner, it shall, prior to submitting the rules to the Attorney General for review, submit to the Chief Hearing Examiner a copy of the rules as initially published in the State Register, a copy of the rules as proposed for final adoption in the form required by the State Register for final publication, and a copy of the agency's Findings of Fact and Order Adopting Rules. The Chief Hearing Examiner will then make a determination as to whether the defect in regard to substantial change and the requirements of Minn. Stat. § 15.0412, subd. 4-4f (1980) have been corrected.

Should the agency make changes in the rules other than those recommended by the Hearing Examiner, it shall also, prior to submitting the rule to the Attorney General, submit the complete record to the Chief Hearing Examiner for a review in regard to substantial changes.

Dated: December 15, 1981.

DUANE R. HARVES
Chief Hearing Examiner

DPW-82-004-RL

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF PUBLIC WELFARE

In the Matter of the Proposed Adoption of the Department of Public Welfare Rule Governing the Licensure of Residential Facilities for Adult Mentally Ill Persons, 12 MCAR § 2.036.

REPORT OF THE HEARING EXAMINER

Pursuant to an Order for Hearing issued July 31, 1981 by the Commissioner of the Department of Public Welfare, Arthur E. Noot, the above-entitled matter came on for hearing before Richard C. Luis, duly appointed Hearing Examiner, at 9:30 a.m. on October 1, 1981 in Room 83 of the State Office Building, Wabasha Street (between Aurora and Fuller), St. Paul, Minnesota. This Report is part of a rulemaking proceeding conducted pursuant to Minn. Stat. Ch. 15 to determine whether the Department of Public Welfare (hereinafter the "Department") has authority to adopt proposed 12 MCAR § 2.036, which would govern the licensure of residential facilities for adult mentally ill persons. The current 12 MCAR § 2.036, which has been in effect since February 4, 1974, is proposed for repeal.

Ellen Dubuque, Special Assistant Attorney General, appeared as counsel for the Department. Members of the agency panel included: Jay Bambery, Assistant Director of the Mental Health Program Division; John Sauer, Mental Health Program Consultant, Mental Health Division; Tom Eberhart, Director of the Management Support Division, Bureau of Mental Health; Terry Sarazin, Director of the Mental Illness Program Division; John Buzzell, Director of the Division of Licensing, Bureau of Support Services; Rollin Peek, Director, Child Protection Office; Steven Bartay, Program Evaluation Specialist, Office of Policy Analysis; and John Zakelj, Consultant, Management Support Bureau. The Department personnel listed above were assisted in their presentations by the following persons: Representative John Brandl, co-author of the Rule 36 appropriation bill; Bill Conley, Director of Public Affairs, Minnesota Mental Health Association; Tish Halloran, Director, Mental Health Programs, Hennepin County Mental Health Services; Mila Hundley, Treatment Director, Sharing Life in the Community; Harriet Grinstead, Executive Director, Hope Transition Center; Bob Ryan, Administrator, Guild Hall; Marge Wherley, Residential Program Consultant, Hennepin County Mental Health Services; and Terry Ford, student at Inver Hills Community College and former mental health "consumer".

Seventy-three persons signed the hearing register. Sixteen members of the public spoke at the hearing. The Department submitted 16 exhibits at the hearing, and the public submitted 20.

The Commissioner of Public Welfare must wait at least five working days before taking any final action on the rules; during that period, this Report must be made available to all interested persons upon request.

Pursuant to the provisions of Minn. Stat. § 15.0412, subd. 4d (1980), this Report has been submitted to the Chief Hearing Examiner for his approval. If the Chief Hearing Examiner approves the findings of this Report, he will advise

the Commissioner of actions which will correct the defects and the Commissioner may not adopt the rule until the Chief Hearing Examiner determines that the defects have been corrected. However, in those instances where the Chief Hearing Examiner identifies defects which relate to the issues of need or reasonableness, the Commissioner may either adopt the Hearing Examiner's recommendations to cure the defects or, in the alternative, if the Commissioner does not elect to adopt the recommendations, he may submit the proposed rule to the Legislative Commission to Review Administrative Rules for the Commission's advice and comment. Provisions relating to this submission to the Commission may be found in Minn. Stat. § 15.0412, subd. 4d (1980).

If the Commissioner elects to adopt the recommendations of the Hearing Examiner and makes no other changes and the Chief Hearing Examiner determines that the defects have been corrected, then the Commissioner shall submit the rule to the Attorney General for review of form and legality. If the Commissioner makes changes in the rule other than those recommended by the Hearing Examiner, then he shall submit the rule, with the complete record, to the Chief Hearing Examiner for a review of the changes before adopting it and submitting it to the Attorney General. Procedures relating to this subsequent review by the Chief Hearing Examiner are set forth in Minn. Stat. § 15.0412, subd. 4e (1980).

When the Commissioner submits the rule to the Attorney General, he shall give notice on the day of submission to all persons who requested that they be informed of the submission to the Attorney General.

Based upon all the testimony, exhibits and written comments, the Hearing Examiner makes the following:

FINDINGS OF FACT

Procedural Requirements

1. On May 19, 1980, a Notice of Intent to Solicit Outside Opinion concerning the rule relating to the licensure and operation of residential programs for adult mentally ill persons was published at 4 State Register 1835.

2. On August 3, 4 and 5, 1981, the Department filed the following documents with the Chief Hearing Examiner:

(a) A copy of the proposed rules.
(b) The Order for Hearing.
(c) The Notice of Hearing proposed to be issued.
(d) A Statement of the number of persons expected to attend the hearing and estimated length of the Agency's presentation.
(e) The Statement of Expenditures estimated to be incurred by local public bodies for the next two fiscal years following adoption of the proposed rule.

3. On August 24, 1981, the Department mailed the Notice of Hearing to all persons and assocations who had registered their names with the Department for the purpose of receiving such notice, and to certain other individuals and associations, which included:

(a) Current and Potential Rule 36 Facilities;
(b) Minnesota's County Welfare Departments;
(c) Minnesota's Human Services Boards;
(d) Minnesota's State Hospitals;
(e) Members of the Rule 36 Task Force.

4. On August 31, 1981, a Notice of Hearing and a copy of the proposed rule were published at 6 State Register 249.

5. On September 4, 1981, the Department filed the following documents with the Hearing Examiner:

(a) The Notice of Hearing as mailed;
(b) The Department's certification that its mailing list was accurate and complete as of August 24, 1981.
(c) A copy of the Order for Hearing, dated July 31, 1981;
(d) The affidavit of mailing of Notice to all persons on the Department's list;
(e) An affidavit of additional mailing;
(f) The Statement of Need and Reasonableness;
(g) The names of Department personnel who would represent the Department at the hearing, together with the names of other persons solicited by the Department to appear on its behalf.
(h) A photocopy of 6 State Register 249-262, the pages on which the Notice of Hearing and proposed Rule were published.
(i) Materials received by the Department in response to its Notice of Intent to Solicit Outside Opinion.

These documents were available for inspection at the Office of Administrative Hearings from the date of filing to the date of the hearing.

9 MCAR § 2.105 I. requires an agency to submit at least 25 days prior to the hearing, a copy of the State Register in which the Notice of Hearing and proposed rule are published. The Department submitted only the photocopied pages on which the Notice of Hearing and proposed Rule actually appeared. The Hearing Examiner has checked the submission and finds that it matches the pages as published in the State Register on August 31, 1981, so it is specifically found that the violation of 9 MCAR § 2.105 I. is technical, not substantial in nature, and constitutes no bar to the adoption of the proposed rule.

6. The record remained open through October 21, 1981 for the receipt of written comments and statements, as ordered by the Hearing Examiner prior to the close of the hearing on October 1, 1981. Pursuant to Minn. Stat. § 15.0412, subd. 4d, the Chief Hearing Examiner granted an extension of the deadline for filing this Report beyond the 30-day statutory limit, to December 14, 1981.

7. On October 21, 1981, the law firm of Broeker, Hartfeldt, Heuges & Grant filed with the Hearing Examiner a copy of a letter sent to Arthur E. Noot, Commissioner of the Department of Public Welfare. In this letter, Mr. James Ingison of the firm stated that three facilities represented by the firm, which facilities might be affected by the adoption of proposed Rule 36, did not receive timely notice of the October 1, 1981 hearing. It was alleged that the rights of these potentially affected facilities have been violated by their not being given notice of the hearing and afforded an opportunity to participate. As a result, Mr. Ingison requested that the hearing process on proposed Rule 36 be reinstituted in order to allow all affected facilities an opportunity to participate. The facilities in question are: Helgeson Rest Home in Sauk Rapids; the South Side Care Center in Minneapolis, and the Willmar Health Care Center in Willmar.

The Ingison letter cites as authority for its position the first sentence of Minn. Stat. § 15.0412, subd. 4, which states:

> "No rule shall be adopted by any agency unless the agency first holds a public hearing thereon, affording all affected persons an opportunity to participate."

In this same subdivision of Minn. Stat. § 15.0412, the Legislature clearly set out just who is entitled to notice of an administrative rule hearing:

> . . . each agency shall maintain a list of all persons who have registered with the agency for the purpose of receiving notice of rule hearings . . . . The agency shall, at least 30 days prior to the date set for the hearing, give notice of its intention to hold a hearing by United States mail to all persons on its list, and by publication in the state register.

The facilities represented by Mr. Ingison's firm were not on the Department's mailing list. However, the Department compiled an additional list of 84 facilities that might be potentially affected by the adoption of proposed Rule 36, on which list the Helgeson, South Side and Willmar facilities were listed, in positions 2, 18 and 36, respectively. The Department was not required by statute or rule to mail notice of the hearing to any of the 84 facilities on this additional list, but did so on its own initiative. In addition, the Hearing Examiner believes that it is highly unlikely that these three facilities were not mailed notice when, presumably, all other facilities on the supplementary mailing list were mailed notice. The Hearing Examiner finds that the Department has complied with the notice provisions of Minn. Stat. § 15.0412, subd. 4, and that the hearing process should not be reinstituted for any violation thereof.

Statutory Authority

8. The specific statutory authority to adopt proposed Rule 36 is contained in Minn. Stat. §§ 245.781-812 and 252.28, subd. 2, the Public Welfare Licensing Act. Minn. Stat. § 245.802, subd. 1, provides in part:

> . . . The Commissioner shall develop and promulgate rules and regulations pursuant to chapter 15 for the operation and maintenance of daycare and residential facilities and agencies, and for granting, suspending, revoking, and making licenses probationary.

In Minn. Stat. § 245.782, subds. 2 and 6, the words "person" and "residential facility" are defined as follows:

> . . . "Person" means an adult who is handicapped by reason of mental retardation, mental illness, chemical dependency, or physical handicap and a child, whether handicapped or not.

> . . . "Residential facility" means any facility, public or private, which for gain or otherwise regularly provides one or more persons with a 24-hour per day substitute for care, food, lodging, training, education, supervision, habilitation, rehabilitation, and treatment they need, but which for any reason cannot be furnished in the person's own home. Residential facilities include, but are not limited to: State institutions under the control of the commissioner of public welfare, foster homes, residential treatment centers, maternity shelters, group homes, residential programs, or schools for handicapped children.

The Department also cites Minn. Stat. §§ 245.61-.70; 246.61.612-.614; Minn. Stat. Ch. 256E; and Minn. Laws (1981), ch. 360, Art. 2, sec. 14, subd. 1 as authority for the adoption of proposed 12 MCAR § 2.036.

The Hearing Examiner finds that the Department has general statutory authority to adopt proposed 12 MCAR § 2.036.

Discussion of Proposed 12 MCAR § 2.036.

9. For the sake of clarity, the Hearing Examiner points out that, in addition to the amendments to the proposed rule submitted by the Department at the public hearing, the Department filed with the Hearing Examiner a Memorandum on

the last day of the comment period. In this Memorandum, the Department responds to questions and comments raised at the hearing and thereafter and suggests further amendments to proposed Rule 12 MCAR § 2.036. The Hearing Examiner hopes to alleviate any confusion which might result when amendments to the proposed rule and other issues are discussed in the remainder of the body of this Report. The Hearing Examiner has chosen not to discuss many questions raised by the public which, in his opinion, the Department adequately responded to in its Memorandum. Nor will this Report dwell upon each and every new proposal advanced by the Department prior to the close of the record. Any changes not discussed are found by the Hearing Examiner to be either clarifying or editorial in nature, or corrections of grammatical, spelling and clerical errors, and are found not to constitute a substantial change from the Rule as originally published in the State Register. Each of these changes are specifically found by the Hearing Examiner to be necessary and reasonable. A copy of the Department's Memorandum has been retained by the Hearing Examiner and is available upon request from the Office of Administrative Hearings for the customary copying fee.

The proposed Rule is intended to replace the present Rule rather than only amend portions of it. Because of this, and because of the fact that the proposed Rule is being proposed for adoption pursuant to the Public Welfare Licensing Act which superseded the licensing law under which the present Rule 36 was adopted, the discussion which follows will proceed from the posture that the Department is proposing an entirely new Rule for adoption. For organizational purposes, effort has been made to discuss individual proposals in sequential order as they appear in the proposed new rule. Any provisions of the Rule as finally proposed which are not specifically discussed below are found to be necessary and reasonable, supported by an affirmative presentation of facts in the record.

A - Applicabilty.

10. The Department stated in its Statement of Need and Reasonableness that the purpose of § A was "to ensure that providers of care and treatment to adult mentally ill persons clearly understand who is or is not required to meet provisions of this rule." Several requests were made by the public to explain the language in A.1. and A.2. so as to clarify just who falls within the provisions of the proposed Rule and to discuss the authority for the inclusions and exclusions set out therein. This general problem is explored in detail below.

11. Minn. Stat. § 245.791 lists certain types of facilities which are not included within the provisions of the Public Welfare Licensing Act. Included within these exclusions are the following:

> . . . (2) Day care or residential care provided for a cumulative total of less than 30 days in any 12-month period;
> . . . (7) A day care or residential facility serving fewer than five physically or mentally handicapped adults.

These exclusions account for the language in Section A.1. that proposed Rule 36 "applies to all providers offering residential care . . . to five or more adult mentally ill persons at one time for more than 30 days in any 12-month period. . .".

12. The authority to license mental health residential programs for adult mentally ill persons in state hospitals is found in Minn. Stat. § 245.782,

subd. 6, which defines residential facility as including, "state institutions under the control of the commissioner of public welfare". Minn. Stat. § 246.01 states, in part:

> "(The commissioner) is hereby charged with and shall have the exclusive power of administration and management of all of the following state institutions: . . . state hospitals for the mentally ill.".

13. The Hearing Examiner also notes that the definition of "residential facility" in Minn. Stat. § 245.782, subd. 6, also includes "foster homes". Proposed Rule 36 includes within its scope, "adult foster care homes". The Hearing Examiner recommends that this language be amended to read "adult foster homes" to more accurately reflect the definition of "residential facility" set out in the statute. The rule as amended is found to be necessary and reasonable and the amendment constitutes a clarification, not a substantial change.

14. In response to a question raised by the Hearing Examiner as to the meaning of the words, "safe house", the Department has amended § A.1. by excluding all reference to "safe houses". The Hearing Examiner agrees with the Department that the deletion is not a substantial change because the reference to safe houses is redundant, and the applicability of the Rule is already well defined. In addition, there is no statutory definition for safe houses. The Hearing Examiner finds that this deletion is necessary and reasonable and that it does not constitute a substantial change in the Rule as proposed.

15. The Department has also amended § A.1. in the following respects. In the first sentence, the word "treatment" has been deleted and replaced with the words "program services". In the second sentence, the phrase "treatment facilities" has been deleted and replaced with the word "program". These amendments were made in order to clarify any confusion which might result from the use of the word "treatment". The Hearing Examiner finds these amendments are needed and reasonable and do not constitute a substantial change in the Rule as originally proposed, and that the subsection as finally proposed is needed and reasonable.

16. In an attempt to clarify the language in subsection A.2., the Department amended this subsection to read:

> 2. Rule 12 MCAR § 2.036 does not apply to programs located within a licensed hospital, except state institutions under the control of the commissioner; nor does it apply to programs located within a licensed nursing home.

Minn. Stat. § 245.791 states, in part:

> Sections 245.781 to 245.813 shall not apply to: . . .
> (5) A licensed hospital whose psychiatric or chemical dependency program is located within the hospital; and
> (6) A nursing home, hospital, or boarding care home, licensed by the state board of health, except that an identifiable unit of such a facility which regularly provides care for more than five handicapped persons must be licensed under §§ 245.781 to 245.813; . . ."

The Department has excluded all nursing homes from the provisions of proposed Rule 36, primarily because of the demands that will be placed upon already scarce funds if such facilities are included. The appropriations for funding Rule 36 programs are based upon the presumption that nursing homes will not be covered. Minn. Stat. § 245.791 specifically states that nursing homes with "identifiable units" of a certain type must be licensed, but the proposed Rule specifically excludes them.

Similarly, the proposed Rule only partially complies with Minn. Stat. § 245.802, subd. 1, in that no provisions are proposed for suspending, revoking or making probationary the licenses to be issued. The Hearing Examiner finds that the Department's administrative decisions not to cover nursing homes and not to propose disciplinary rules during this rule proceeding are within its discretion and not a violation of law. Certainly, the Department has not exceeded its statutory authority. In fact, it has stopped short of regulating all which the Legislature has authorized to regulate. There is no current legal bar to making the proposed Rule applicable to nursing homes in a future rule-making procedure when the money to implement the rule, with respect to nursing homes, may be available. The Department also retains the statutory authority to set up licensing standards for nursing homes under another Rule. In addition, the Department can propose disciplinary rules at any time under the statute. Its decision to forego that power at this time is within its discretion.

The Hearing Examiner specifically finds that the Department's amendments proposed for § A. are necessary and reasonable, and do not constitute a substantial change in the rule as originally published. It is suggested that the word "Rule" at the beginning of subsections A.1. and A.2. be deleted because it is redundant.

p. 2 not deleted see F+F 2

17. Several members of the public, in particular the Minnesota Association of Health Care Facilities, suggested that licensed board and care facilities which are also certified as Intermediate Care Facilities pursuant to federal regulations, should be excluded from the provisions of proposed 12 MCAR § 2.036. Having reviewed all the evidence on the record, the Hearing Examiner finds:

(a) The Public Welfare Licensing Act is very specific as to what types of facilities are to be included and excluded from licensure by the Department of Public Welfare. It is clear that board and care/intermediate care facilities fall within the provisions of this Act and are to be included within the scope of proposed Rule 36.

(b) Minn. Laws (1981), Ch. 360, Art. II, sec. 15 (to be codified as Minn. Stat. § 245.802, subd. 3) states, in part:

> A residential facility that is federally certified as an intermediate care facility serving adult mentally ill persons on the effective date of this section shall not be denied a program license on the basis of any rule that requires physical plant specifications regarding the alteration of a certain number of beds and a certain number or size of living areas per treatment unit which would require the facility to alter its total number of beds.

The Hearing Examiner finds that this statute is not applicable to 12 MCAR § 2.036 licensure considerations because Rule 36 does not mandate a change in the total number of beds.

(c) The Hearing Examiner also finds, with respect to the comparison made by the Department between standards established by proposed Rule 36 and those required by Intermediate Care Facility Requirements; All Facilities, 42 C.F.R §§ 442.250-442.254 (1980) and Standards for Intermediate Care Facilities Other Than Facilities for the Mentally Retarded, 42 C.F.R §§ 442.300-442.346 (1980) that there simply is not enough required of an intermediate care facility relating specifically to mental health programming, either by definition, focus, job descriptions, staffing patterns, or ratios to suggest comparability. Intermediate Care

Facility licensure, and board and care licensure from the Minnesota Department of Health, focus upon health care standards as opposed to mental health programs.

For the specific reasons found above, the proposal to exclude from 12 MCAR § 2.036 coverage any program in a facility which has been licensed as a board and care facility and also certified as an intermediate care facility should not be adopted. The Department's inclusion of such facilities among those required to obtain Rule 36 licensure is reasonable and consistent with the enabling legislation.

16. With respect to the language ". . . and based in part, on Minn. Stat. § 245.782, subds. 6 and 9.", in subsection A.1., the definitions of "residential facility" and "'regularly' or 'on a regular basis'" are set out in those statutes. If the Department wishes to include the definitions in its rule, this should be done in the definitions section. Such additions would be clarifying and not substantial in nature, and the Hearing Examiner finds them to be necessary and reasonable. In addition, these definitions, if adopted, are found to be essential to the reader's understanding of the rule even though they repeat statutory language.

not included see FoF 3

The Hearing Examiner further suggests that the final word of subsection A.1. be changed from "facilities" to "program" in order to conform with the definitions in subsections D.3. and D.4. In the alternative, the subsection should be amended to end with "II". Either alternative is found to be a necessary and reasonable clarification and not a substantial change. It should be noted that the Public Welfare Licensing Act refers throughout to the licensure of facilities, not programs. The use of the word "programs" throughout proposed 12 MCAR § 2.036 is a recognition of the fact that not all providers of care for adult mentally ill persons will be exclusively engaged in caring for these people. For example, many facilities do and will have residents who are not mentally ill adults, and the requirements of 12 MCAR § 036 are not intended to apply to the care of such people. The purpose of licensing each "program", then, is to assure that the specific needs of mentally ill residents are met. The authority to license "programs" is implied in Minn. Stat. § 245.791(6), which requires the licensure of "identifiable units" regularly providing care for more than five handicapped persons within facilities that serve non-handicapped persons and persons who are not mentally ill. The Hearing Examiner suggests that "programs" be defined in Section B for the purpose of clarifying the entire Rule. Such an addition would be clarifying, not substantial in nature, and is found to be necessary and reasonable.

so ended p. 1

defined see B.15 p. 3

B. - Definitions

19. In addition to the amendment of the definition of "mentally ill person" proposed by the Department at the public hearing, and discussed below, the Department has proposed for amendment several other definitions in § B. It is found by the Hearing Examiner that these other amendments do not change the meaning of the definitions as originally proposed, but merely clarify those meanings through the use of additional language making them more flexible and responsive to public comment. The Hearing Examiner finds that these other amendments do not constitute substantial revisions of Rule 36 as proposed and are needed and reasonable.

20. The Department proposed a new definition of "mentally ill person" at the public hearing, which definition reads as follows:

> "Mentally ill person" means a person who has been diagnosed by a physician, a licensed psychologist, or a licensed consulting psychologist as having a condition which results in an inability to interpret the environment realistically, and in impaired functioning in primary aspects of daily living such as personal relations, living arrangements, work and recreation; or which is listed in the International Classification of Diseases (ICD-9-CM), code range 290, 293-302.9 or 306-314.9, or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III), I, III or III.

The Hearing Examiner finds that the final proposed definition of "mentally ill person" is necessary and reasonable and does not constitute a substantial change from the definition as originally published in the State Register. The public was notified in the Notice of Hearing that the rules, as proposed, could change as a result of the hearing process. The basic difference between the originally proposed definition and the final proposal is that the final proposal includes certain organic brain syndromes. This is not considered to be a substantial change by the Hearing Examiner because not all persons suffering from organic brain disorders are residents of nursing homes or licensed hospitals. Indeed, many of these persons reside or will be residing in facilities whose programs will be proposed for licensure under 12 MCAR § 2.036. In addition, the proposed new definition of "mentally ill person" is found to be necessary and reasonable.

C. - Licensing Process.

21. The Public Welfare Licensing Act sets out in great detail just what is required of the Department with respect to the licensing process and rules which are to be adopted to implement this process. Section C. of the proposed rule complies generally with this mandate.

Questions were raised at the public hearing regarding a transitional phase-in period for facilities required to be licensed. Concerns were raised about possible sanctions for non-compliance upon the effective date of the rule and whether the Department had the licensing capacity to adequately respond to licensing requests. The Hearing Examiner finds that the variance provision of the proposed rule, Section R., and the Department's amendment of subsection P.1. adequately respond to these concerns. Facilities can request variances pursuant to Section R. dealing with any provision of the proposed rule. Subsection P.1., as amended, responds to the difficulties of physical plant compliance by allowing a three-year grace period within which to alter the physical lay-out of any facility to the living unit requirements of the proposed rule. See, Discussion of Sections O. and P. for further analysis.

22. At the hearing, the Department amended subsection C.3. by deleting the words "a completed" from the first sentence and inserting the word "an" in place thereof. The Hearing Examiner finds that this amendment is needed and reasonable based on the reasons given by Mr. John Buzzell at the hearing that a completed application is not necessary at the time an initial application is made. This amendment is not a substantial change of the rule as proposed and is needed and reasonable. p. 6

23. The Department also proposes to amend subsection C.4.c. to read "Interviews with staff and a sample of residents". The Hearing Examiner finds that this amendment merely clarifies the language of the subsection, and is ✓ amended p. 6

needed and reasonable and does not constitute a substantial revision of the rule as proposed.

D. - License Changes; Report.

24. At the hearing, there were requests to clarify the meaning of the phrase "Major changes in programming", which constituted the text of originally proposed subsection D.5. In response to this request, the Department amended the subsection by adding the following language:

> Major changes in programming include such areas as a change in the target population or shifting from the internal provision of services to the external provision of services through a purchase of service contract. Changes in programming which do not have to be reported include such changes as the addition of staff, reassignment of staff, and establishing new groups.

added p.7

The Hearing Examiner finds that the amended subsection is not a substantial change in the rule as proposed and is needed and reasonable in order to clarify the difference between major and minor changes in programming.

E. - Program Policies and Procedures Manual.

25. This Section requires every mental health residential program to develop a written policy and procedures manual, which manual shall contain all materials required by §§ F. through M. (to be discussed below). This requirement is based on sound management practice, in that it establishes a baseline for accountability and provides the Department's licensing staff with a central resource for review and analysis. The Hearing Examiner finds this section to be necessary and reasonable.

F. Statement of Purpose and Policies.

26. At the hearing, the Department amended Section F. by changing the letters "a", "b", and "c" to the numbers "1", "2" and "3", respectively. In addition, the Department has amended the language of subsection F.2. to read "The design and methodology of program services". The Hearing Examiner finds that these amendments are needed and reasonable and do not constitute substantial changes in the rule as proposed. The amendment of subsection F.2. clarifies Department intent with respect to this Section and constitutes a more consistent and less ambiguous use of language.

amended p.7

G. - Program Organization and Administration.

27. In response to suggestions made at the hearing, the Department has amended subsection G.1., by deleting the words "reasonably broad" from the first sentence, and by adding the following language to the end of the last sentence: ". . . who are members at the time of submitting an application or renewal of a license under 12 MCAR § 2.036.". The Hearing Examiner agrees with the Department's contention that the amendments are clarifying in nature, are necessary and reasonable, and do not constitute a substantial change in the subsection as originally proposed.

deleted p.7
added p.8

28. Several questions were raised concerning whether advisory committees should be mandatory or optional in the case of non-profit facilities or when the governing body of a facility determines that an advisory committee is not needed. The Hearing Examiner agrees with the Department that advisory committees are needed to promote accountability and responsiveness on the part of programs to the communities in which they are located and to the residents they serve. It should be noted that the Department has stated that it was its

intention to create flexibility within the framework of a program's administrative bodies so that advisory committes can be tailored to the particular facility. Under the scheme proposed, if representation on the governing body meets advisory committee requirements, the governing body can be designated as the advisory committee as well.

H. - Required Documentation and Reports.

29. The Department presented amendments to various provisions of Section H. at the hearing and has proposed several other amendments in response to suggestions made at the hearing and during the comment period. Any portions of this Section not discussed below (that is, which were not amended) are found to be necessary and reasonable.

The Department amended subsection H.2. by adding the words "or otherwise appropriately insured" after the word "bonded". This amendment creates flexibility for providers in the requirement to provide financial protection for residents.

The second sentence of subsection H.3. has been amended by the deletion of the word "assurance" and insertion of the words "a plan" in place thereof. This amendment reflects both the realities of tight funding and adequate assurance of financial responsibility.

Subsection H.5. has been amended by the deletion of the word "treatment" and insertion of the phrase "the provision of program services" in place thereof. In addition, the word "religion" has replaced the word "relation". The first amendment reflects a more consistent use of language, and the second amendment corrects a clerical error. In response to a suggestion that a subsection be added to Section H. that would require documentation of compliance with the provisions of Minn. Stat. § 626.557 (also known as the Vulnerable Adults Act), the Department added a subsection after H.5. which reads,

> "6. Each applicant shall document compliance with provisions of the Vulnerable Adults Act, Minn. Stat. § 626.557."

The Hearing Examiner agrees with the Department that the addition of this subsection helps assure that facilities are aware of the requirements which are essential to the protection of resident rights and assurance of a minimum level of care. It is noted that the addition of this subsection necessitates the renumbering of the following subsections to numbers 7, 8 and 9, respectively. The Hearing Examiner suggests deletion of the clause "Vulnerable Adults Act" from the subsection because that title is not part of the referenced statute.

Subsection H.8. (formerly H.7.) was amended in its first sentence by adding a comma after the word "body", by deletion of the word "and", and by adding the phrase "and to the host county" after the word "committee". H.8.a. was amended by deleting the word "category" and inserting the phrase "job class" in place thereof. The Hearing Examiner finds that these amendments merely clarify the language of this subsection.

H.9.a. was amended by deleting the second sentence thereof. The following sentence was added to the end of section H.9.a.:

> In a format developed by the Commissioner, the data and documentation required by b., c. and d. shall be submitted to the Commissioner on an annual, aggregate basis for state-wide summaries and for planning the use of state resources.

This amendment clarifies the process of program evaluation.

In subsection H.9.b., the last sentence was deleted by the Department in its final proposal in order to avoid redundancy, because this same language was added to the end of subsection H.9.a.

With respect to subsection H.9.d., the Department added the word "available" after the word "with" and has proposed the insertion of the word "document" in place of "demonstrate". The first amendment reflects the reality that some counties might not have the technical assistance staff to allow providers to comply with the mandatory requirement of collaboration, but still retains the Department's intent to require such collaboration if possible. The second amendment merely clarifies how results are demonstrated.

The Hearing Examiner finds that all of the above amendments are necessary and reasonable and that the amendments proposed do not constitute substantial changes in the rule as proposed.

I. - Personnel Policies and Procedures.

30. The Department has amended Section 1. in several respects in response to suggestions made at the hearing and during the comment period. In subsection 1.4., the comma after the word "promotion" has been deleted and replaced with the word "and". Additionally, everything after the word "suspension" on line 7 has been deleted. This amendment was prompted by a comment at the hearing that including language referring to staff stress in I.4. might be tantamount to an admission that staff stress is a condition of employment and exists in all facilities as part of the job. The Department has deleted this reference to staff stress in I.4. and added a category "i" under 1.9., which reads, "i. Staff stress or burnout; and". By including staff stress or burnout as an area about which staff are to be educated , the Department has acknowledged the need for staff to confront and deal with this potential problem. These amendments are found to be necessary and reasonable and do not constitute substantial changes.

31. Subsection I.9. has been further amended by the deletion of the phrase "inservice or outside training," in the first sentence and the substitution of "continuing education" in place thereof. The word "developed" in the next sentence has been replaced by the word "reviewed". The phrase "in-service training, or training through community resources, or both" has been deleted and replaced with the words "continuing education" in the third sentence. Subsection I.9.a. has been changed to read simply "a. First-aid training", and because of the addition of category "i" (staff stress or burnout), the category beginning with the words "Other topics" has been relabelled "j". These amendments clarify the original intent of the Department with a more consistent and less ambiguous use of language. The change in I.9.a. merely recognizes that there are other types of first-aid training besides Red Cross and that, since the training requirements are approached on an annual basis, the reference to "every three years" was inappropriate. The amendments to subsection I.9. are found to be needed and reasonable and do not constitute substantial changes from the original proposal.

32. The Hearing Examiner finds that Section I. is not too detailed or stringent in its provisions and adequately reflects the Department's intent to clarify staff responsibility, to ensure the protection of employee rights, and to promote the effective management of residential mental health programs. As such, the Section is found to be necessary and reasonable.

However, the Hearing Examiner believes that the suggestion made at the hearing to include training for persons not referenced in the rule should be implemented. Rick Carter of the Minnesota Association of Health Care Facilities has suggested the following language:

> Personnel of the program not reference in this rule shall receive continuing education as appropriate to their role and function within the program.

The Hearing Examiner believes that including a provision in the Rule dealing with the education and training of people not referenced in the Rule would not be a substantial change in the Rule as proposed. Furthermore, such an inclusion would be justified for the same reasons given by the Department to justify the continuing education of staff personnel. Non-direct care staff will undoubtedly have some contact with the residents in a facility and must be appropriately educated in areas such as the problems and needs of the mentally ill and, perhaps, basic first aid. The Hearing Examiner finds that the addition of such a requirement to Section I. would be necessary and reasonable.

J. - Personnel Files.

33. In subsection J.2., the Department has added the following sentence after the sentence ending with the word "review":

> Each employee shall be able to review their personnel file, subject to the provisions of the Minnesota Government Data Practices Act.

added but still a question as to correctness of cite - p. 13

Although the Department's amendment did not give the statutory reference to this Act (Minn. Stat. §§ 15.1611 et seq.), the Hearing Examiner suggests that such a reference is appropriate and would not be a substantial change. The addition of the statutory citation is found to be necessary and reasonable.

34. At subsection J.2.a., after the word "application", the Department added the words "or a resume". Although the Hearing Examiner agrees with this addition, it is suggested that the words "or a resume" be inserted after the word "employment" rather than after the word "application". This adjustment would be a clarifying grammatical change only. The addition of a resume as an alternative to an application form reflects realistic, sound management practices. p. 13

35. The Hearing Examiner further suggests that the language in subsection J.1. be amended to reflect the changes made in Section I. Specifically, the sentence beginning after the phrase "Central training file" should be amended to read "The orientation and continuing education required by I. shall be documented by each program in a central training file.". None of the above amendments or suggestions, if adopted, would constitute a substantial change in the rule, as proposed, and all are needed and reasonable. Any other portions of proposed Section J. not discussed herein are found to be necessary and reasonable. amended p. 12

K. - Admission, Discharge and Transfer Policies.

36. In subsection K.1., the Department has proposed the deletion of the words "and responsibility". At subsection K.2.a., the Department proposes addition of the words "if possible" after the word "resident". The Hearing Examiner finds that these proposed amendments do not constitute a substantial change in the rule, as proposed, and are needed and reasonable to eliminate redundancy in the first instance, and, in the second, in order to reflect the reality that there will be times when a resident's request cannot be honored due to cost reasons or the occasional refusal of individuals to comply. p. 13

37. In response to a suggestion that all reference to the word "transfer" be deleted from Section K., the Hearing Examiner cannot agree with its adoption because the language is clear as it stands and transfer policies are necessary to ensure an adequate level of treatment for the residents consistent with the concept of a continuum of care. It is found that the application of the Section, as proposed, to transfers as well as to admissions and discharges, is necessary and reasonable.

L. - Program Services.

38. The Department has amended Section L. by changing the first clause to read: "The following services shall be offered either by the program or through working agreement with other community resources." In substituting the word "by" for "within" and the word "program" for "facility", the Department has clarified its original intent that an applicant for licensure or a licensee could provide some program services outside the physical plant in which the residents reside. The substitution of "working agreement" for "contract" in the same clause was needed to clarify Departmental intent that a signed contract was not necessary between programs and different community resources.

In subsection L.3., the word "services" has been replaced with "skills training" to clarify the original Departmental intent to emphasize the requirement to provide training in areas of independent living skills. In addition, subsections a.-k. have been re-designated as 1-11.

The Hearing Examiner finds that the amendments discussed above do not constitute substantial changes in the rule as proposed and are necessary and reasonable.

M. - Policies and Procedures Guaranteeing Resident Rights.

39. In response to a suggestion that the language "and to his or her responsible party within 30 days", be deleted from subsection M.1., the Department chose to delete the words "within 30 days of" in the subsection's third sentence and insert the phrase ", if the resident has a legal guardian" after the word "party". In addition, the Department added the word "on" before "admission" at the end of the third sentence. This final proposal is consistent with the notion that program requirements of 12 MCAR § 2.036 are designed for persons who are capable of living in a residential facility as opposed to persons who need total care and treatment, while still acknowledging that some residents may have a legal guardian. This amendment also ensures that there is not an undue delay in residents being informed of their rights and responsibilities. It is specifically found that subsection M.1., as amended, is necessary and reasonable, and that the amendments proposed therefor do not constitute substantial changes from the original proposal.

40. Subsection M.2. has been amended by the deletion of the words "Within 30 days" and the insertion of the word "upon" at the beginning thereof. This amendment also ensures that there is no undue delay in residents being informed of their rights. At subsection M.2.a., the word "facility" has been deleted and replaced with the words "program staff". This amendment merely clarifies the language of the provision. The Hearing Examiner finds that the above-mentioned amendments are necessary and reasonable and do not constitute substantial changes in the rule as proposed.

41. The first two sentences of original subsection H.4. have been amended to a single sentence, which reads:

> Staff will not supervise the use of residents' personal funds or property unless policies governing the supervision have been written and unless the resident has signed a consent form prior to the exercise of supervision indicating an awareness of and consent to procedures governing the program's use of the resident's personal funds.

This amendment clarifies that supervision of funds will not occur in the absence of written policies governing their supervision and that the resident must have agreed to any such supervision. This amendment is found to be necessary and reasonable and is not a substantial change in this provision.

42. Subsection H.5. has been proposed for amendment, to finally read:

> 5. Resident compensation. A resident who performs labor other than that of a housekeeping nature shall be compensated appropriately and in compliance with applicable state and federal labor laws, including minimum wage and minimum wage reduction provisions. Labor of a housekeeping nature shall be limited to household chores which a person living in his own residence in the community would normally perform.

Although the Hearing Examiner believes that subsection H.5., as finally proposed, is still somewhat confusing with respect to what actually are "household chores which a person living in his own residence in the community would normally perform", beyond the responsibility to clean one's personal living area, the amendment is an acceptable compromise which is consistent with the desire to create a normal living situation and is responsive to residents' rights. It would be counter-productive, in this instance, to attempt to specifically list work that is not compensable. The Hearing Examiner finds that the proposed subsection is needed and reasonable and does not constitute a substantial change from the original proposal.

43. Subsection H.6. has been amended by the deletion of the words "a private" and insertion of the words "his or her" in place thereof. This amendment is merely clarifying in nature and is necessary and reasonable. It does not constitute a substantial change of this provision.

44. Subsection H.7. has been amended and now reads:

> 7. Photographs of residents. Photographs shall only be taken for public uses with the resident's written consent. Photographs may be taken and used for the resident's personal and social purposes unless the resident has indicated his or her objection.

The Hearing Examiner finds the language of the proposed amendment to be vague because "public uses" are not defined, and the second sentence is internally inconsistent. Therefore, the proposed amendment cannot be adopted because it violates substantive provisions of law. See Minn. Stat. § 15.0411, subd. 3 (1980), which defines "rule", in part, as "<u>every</u> agency statement . . . made to implement or make <u>specitic</u> the law enforced or administered. . . ." (Emphasis supplied). It is suggested that it is simpler and equally effective to say that a resident shall not have his or her photograph taken for any purpose beyond identification unless he or she consents. A provision so drafted would not constitute a substantial change and is found to be necessary and reasonable. In the alternative, the subsection, as originally published in the State Register, is found to be necessary and reasonable.

45. The phrase "within the facility" has been inserted after the word "access" in the first and second sentences of subsection N.8. The Hearing Examiner finds that this subsection, as amended, clarifies the Department's intent and is, therefore, necessary and reasonable and not a substantial change.

46. In response to a suggestion that a provision dealing with visitors be added to this section, the Department has proposed the addition of subsection N.11., which reads as follows:

> N.11. Visitors. Residents shall be allowed to receive visitors at reasonable times, and shall be allowed to receive visits at any time from their personal physician, religious advisor, and attorney. The right to receive visitors other than those specified above may be subject to reasonable written visiting rules and hours established by the head of the facility for all residents. The head of the facility may impose limitations on visits to an individual resident only if he/she finds the limitations are necessary for the medical welfare of the resident and if the limitation and reasons are fully documented in the resident's individual treatment plan.

The Hearing Examiner finds that the addition of this subsection is needed and reasonable and is not a substantial change from the rule as proposed.

N. - Resident Records

47. In response to concern that 30 days was too long to wait to write an Individual Program Plan and, on the other hand, to respond to the argument that an Individual Program Plan cannot be developed until a sufficient amount of time has passed to allow for proper evaluation of the resident's needs, the Department finally proposed to replace the first sentence of subsection N.1. with the following sentences:

> 1. Individual program plan development. The mental health residential program staff shall, within ten days after admission, write short-term goals with each resident in order to address their immediate needs. The program staff shall, within 30 days of admission, write an individual program plan which contains the components specified in 2.

The Hearing Examiner finds that subsection N.1., as amended, is necessary and reasonable and is not substantially different from the originally proposed version of this provision. The Department maintains that it has always been their policy that the programming process should begin as soon as possible. In addition, the amendment does not place any greater burden upon facilities to comply with the provisions of this subsection. The Hearing Examiner further finds the remainder of Section N. to be necessary and reasonable.

O. - Living Unit Requirements.

48. In response to requests that the Department clarify the term "home-like", the Department proposed two amendments. The Department has added a definition of "living unit" to Section B., which definition reads as follows:

> 13. Living unit. "Living unit" means a set of rooms which are physically self-contained, which have the defining walls extending from floor to ceiling, and which include bedrooms, livingrooms or lounge areas, bathrooms and connecting areas.

The second amendment was to subsection O.1., which the Department proposes to amend as follows:

> 1. Furnishings. Each living unit shall include furnishings appropriate to the psychological, emotional, and developmental needs of each resident.

The above amendments do not include the term "home-like". The Hearing Examiner agrees that this term was confusing and its deletion is necessary and reasonable. The above amendments are found to be necessary and reasonable in order to clarify the concept of "living unit", and not a substantial change. Use of the word "appropriate" in this context does not violate the requirement that Rules be specific because what is "appropriate" will obviously vary with each situation and must be determined by the programs and the Department on a case-by-case basis.

49. The Department amended subsection O.2. to read:

> 2. Ratios. For existing facilities, there shall be one living room or lounge area per living unit for up to 25 residents. For new facilities, there shall be one living room or lounge area per living unit for up to 16 residents.

Questions were raised concerning the criteria used to determine the specific ratios set out in O.2. This issue will be discussed below. Initially, the Hearing Examiner is unable to understand why the figure of 16 residents is referred to in the last part O.2. No rationale has been presented for this figure and the use of this figure seems inconsistent with the concept of living unit, which is designed around a 25-resident capacity. It is found that the Department has failed to demonstrate the need for and reasonableness of the second sentence in subsection O.2. by an affirmative presentation of facts on the record. It cannot be adopted as proposed in this rule proceeding. This defect can be corrected by deletion of the last sentence of the subsection, or deleted p.19 by changing "16" to "25" in the same sentence, or by inserting the words "each program" after "for" and before "there" in the first sentence in addition to deleting the second sentence. While the Department has demonstrated that a need exists to set a ratio of 25 residents per living room or lounge area in order to emphasize leisure-time activities and provide, as far as possible, a "home-like" atmosphere for residents, it has not demonstrated that some programs should provide these amenities for every 16 residents while others are not so required. To justify the determination on the basis of a current non-availability of funds is a failure to address the basic thrust of the subsection, which is a reasonable provision of amenities. If an application of the Department's expertise results in a determination that 25 people per living unit/lounge area is appropriate to a "home-like" setting, then that ratio should hold for all programs.

In other respects, subsection O.2., as amended, is found to be needed and reasonable and its amendment does not constitute a substantial revision of the rule, as proposed. It is suggested, however, that the word "programs" be substituted for "facilities" in order to better clarify the subsection's meaning.

P. - Additional Requirements for Category I Programs.

50. In response to public comment, the Department completely amended subsection P.1. P.1., as amended, now reads:

> P.1. Capacity. Applicants with facilities existing as of July 1, 1980, with a capacity exceeding 25 beds, shall have a three-year grace period from the effective date of 12 MCAR § 2.036 to reduce capacity to 40 beds or less, or to divide the facility into living units which do not exceed 25 beds. Applicants with facilities existing as of July 1, 1980 with a capacity

so amended p.20

exceeding 25 beds per living unit shall not increase the total capacity of the facility. New facilities shall not exceed a maximum capacity of 25 beds.

Questions were raised at the hearing and during the comment period as to just what capacity larger facilities would have to scale down to and what sort of transition period would be allowed in order to accommodate any physical plant alterations. Subsection P.1., as amended, responds to these concerns. Larger facilities are not required to scale down to a 40-bed limit within three years, but are required to meet the 25-bed per living unit requirement within this time frame. The amendment to subsection P.1. clarifies the original intent of the Department as to capacity requirements and represents a reasonable compromise that accommodates the needs of existing facilities and also the Department's desire to adopt a rule which will eventually allow for uniformity of licensure and operation of all residential facilities. The Hearing Examiner finds subsection P.1., as finally proposed, to be needed and reasonable and not a substantial change from the originally-published rule.

A great deal of comment was also generated about the capacity limits set out in subsection P.1. and the criteria used to determine these limits. The Department has presented very little concrete evidence to suggest that capacity figures selected by it are any more reasonable than higher or lower figures. However, the Hearing Examiner believes that the Department has established the need for and reasonableness of the capacity numbers set out in P.1. Relying primarily upon years of experience, the task force arrived at a figure that is reasonable, both programmatically and from a practical standpoint. The figures in subsection P.1. are not inconsistent with the concept of normalization and the type of environment which is conducive to growth and development. Furthermore, compliance with living unit requirements or the 40-bed maximum will not place an undue burden upon the facilities, given the three-year grace period to allow existing facilities to make adjustments, the variance provisions of the proposed rule, and the fact that legislative appropriations might alleviate some of the funding problems.

51. The Department has proposed to amend subsection P.2. to read: "The facility shall be licensed as a supervised living facility, a board and care home, or a hospital." The Hearing Examiner finds that this re-writing of subsection P.2. is necessary and reasonable. The reference to hospital was inadvertently left out of this subsection as originally proposed. Use of the word "facility" is appropriate here because the reference is to Department of Health licensure and not to Department of Public Welfare licensure.

so amended p.20

52. In connection with the Minnesota Department of Health standard requirements of subsection P.2., many comments were received regarding problems created by application of all current Supervised Living Facilities requirements to Rule 36 facilities. The Department is aware of these problems and has requested the Minnesota Department of Health to grant waivers. In response to a misunderstanding as to whether or not blanket waivers would be granted, Clarice Seufert of the Department of Health, sent a letter to the Hearing Examiner stating unequivocally that blanket waivers would not be granted and that individual evaluation would have to take place. However, the Department of Public Welfare has reached an informal agreement with the Department of Health that such waiver requests would be processed as quickly as possible.

53. The education and experience requirements of subsection P.4. through subsection P.8. generated a great deal of comment. In an effort to respond to some of the questions raised, the Department has proposed several amendments. First, the Department has placed the section dealing with the qualifications of the Administrator before the section dealing with the qualifications of the Program Director. The Hearing Examiner agrees that this is a more logical order for these sections to be and finds the re-arrangement to be necessary and reasonable and not a substantial change.

Under Program Director, the words "at least" have been inserted after the word "meet". The words "at least" have also been inserted in subsection P.6., after the word "in". Subsection P.6.a. has also been amended by deletion of everything originally published after the word "degree". In addition, subsection P.7.a. has been amended by the addition of the words "or an R.N. degree or an A.A. degree if the experience requirement of b. is extended to three years." The above amendments were all made to clarify the educational and experience requirements of subsections P.4. through P.8. and also constitute partial concessions to requests by members of the public to ease the requirements. The Hearing Examiner finds that the amendments proposed for subsections P.4. through P.8. are needed and reasonable and do not constitute substantial changes from the rule as proposed, subject to Finding of Fact 54.

54. The educational and experience requirements of Section P. are highly controversial. Among the criticisms are that they are not responsive to the needs of current staff, that they do not allow for entry level positions, and are also arbitrary. With respect to their arbitrariness, the Department has demonstrated to the Hearing Examiner's satisfaction the importance of having educated and experienced staff and that such education and experience is an important factor in determining the success of residential facilities for the mentally ill. However, the Hearing Examiner finds that the Department has not presented any facts which clearly explain how the specific requirements in these sections were arrived at other than from task force deliberations. While the Hearing Examiner did give a great deal of deference to task force expertise in determining capacity limits for living units, this was done because the Hearing Examiner believes that the capacity requirements will only affect a relatively small number of facilities, primarily large existing facilities. In addition, that is a building, materials and construction problem, not a human one. The educational and experience requirements, however, affect all personnel and all programs in all facilities. The Hearing Examiner cannot accept the Department's contentions that summer jobs and other part-time employment, combined with the variance provisions of the proposed Rule 36 and the allegation that employees will probably have the experience by the time their facilities are licensed, adequately address the problems that will be faced by existing staff and incoming personnel.

It is specifically found that the Department has failed to demonstrate the need for and reasonableness of Section P.'s educational and experience requirements by an affirmative presentation of facts, in the following specifics:

(a) Even if the Department has demonstrated the need for and reasonableness of requirements that program directors, mental health therapists, mental health counsellors, and mental health workers meet certain specific standards of education, experience and training, the Department has not demonstrated the need for

effecting the termination of employment by rule of persons currently in place within the affected programs. Its argument is essentially no more than a bald allegation that many persons currently in the affected positions are incompetent. However no evidence has been offered to show that the incompetent are uneducated or inexperienced, or to show that education or experience will automatically produce competence to perform the specific functions. This defect can be cured by allowing the "grandfathering" of persons currently employed in the affected positions.

(b) The qualifications proposed do not allow for entry-level professional employment in the positions affected. All of the affected positions require "experience" in one form or another before a job applicant can be hired, but the only way to get that experience in most instances is on the job for which the applicant is applying. This anomaly makes the qualifications standards unreasonable per se with respect to mental health therapists, mental health counsellors, and mental health workers.

Therefore, subsections P.6.c., P.7.b. and c., and P.8. cannot be adopted at this time. In order to cure the defects listed above, the Department should allow "grandfathering" of persons currently serving in the affected positions and strike the experience requirements found at proposed subsections P.6.c., P.7.b. and c. and P.8. This leaves the educational requirements in place to affect future hirings. The Hearing Examiner has not recommended that the qualifications for program directorship be changed because he finds that the Department has demonstrated the need for and reasonableness of such qualifications for this key position by an affirmative presentation of facts.

55. Amendments were made to subsection P.9. by the Department, both at the public hearing and during the comment period. The first three sentences of the subsections, as finally proposed, read:

9. Staffing ratios. The facility shall have sufficient staff to provide the required program services and implement the individual program plans. Staffing patterns shall be developed to ensure 24-hour coverage within the mental health residential program and to reflect the need for more staff per number of residents during hours of concentrated programming. The hours of the day devoted to concentrated programming shall be identified.

Subsection P.9.a. has been amended in the following manner. All the language after the word "of" in the first sentence has been deleted and replaced with:

. . . 40 hours per week to 40 residents. With this ratio, applicants shall be allowed to use one program director to direct more than one program and shall be allowed to use one full-time program director for programs with less than 40-bed resident capacity. With this ratio, applicants shall not be required to have more than full-time program director for programs with more than one a 40-bed resident capacity. However, applicants or programs with more than a 40-bed capacity shall describe whatever additional assistance they intend to provide for the program director function.

Subsection P.9.b. has been amended by the addition of the following language, which is to be placed after "1:5 F.T.E." and within the parentheses: ", averaged weekly". Subsection P.9.c. has been deleted completely. The above-discussed amendments are intended to clarify just how staffing ratios are to be applied. The Hearing Examiner finds that the above amendments are needed and reasonable for that purpose and do not constitute a substantial revision of the rules as proposed. In addition, the Hearing Examiner finds that the Department has established that the staffing ratios are not arbitrary and are necessary and reasonable.

Q. - Additional Requirements for Category II Programs.

56. Section Q. deals with programs where the mental health services will not be as intense within the program structure itself. In fact, it is noted that a mental health therapist is not contemplated as part of the program's required staff. If such therapy is to be administered, it will presumably will be done outside the program or by a therapist retained on contract. It is suggested, however, that if a category II program employs a therapist on staff, that he/she be subject to the same requirements and qualifications as are found in subsection P.6. An additional subsection under Section Q. to that effect would not constitute a substantial change and is found by the Hearing Examiner to be necessary and reasonable.

The Department has amended Section Q. in several respects. Subsection Q.2. has been amended by the deletion of the words "each program" and the insertion of the words "The facility" in place thereof. In addition, the phrase "from the Minnesota Department of Health or its equivalent from a local health department" has been inserted after "license" and before "or".

Subsection Q.4. has been amended by the addition of the words "with a board and lodging license" after the word "program" in the first sentence thereof.

The beginning of subsection Q.8. has been amended to read:

> 8. Staffing ratios. The facility shall have sufficient staff to provide the required program services and implement the individual program plans. Staffing patterns will be developed to ensure 24-hour coverage within the mental health residential program and to reflect the need for more staff per number of residents during hours of concentrated programming. The hours of the day devoted to concentrated programming shall be identified. . . .

Subsection Q.8.a. has been amended by deleting the words "one to 40 (1:40 F.T.). No more than one program director per program is required.", and the addition of the same language that was added to section P.9.a. (See Finding of Fact 55)

Subsection Q.8.b. has been amended by the addition of the following language, which is to be placed after "F.T.E." and within the parentheses: ", averaged weekly".

The Hearing Examiner finds that the above amendments are necessary and reasonable for clarification of Section Q. and for the purpose of consistency with Section P, and that the above amendments do not constitute a substantial change in the rule as proposed. However, the Hearing Examiner finds that the Department has failed to demonstrate the need for and reasonableness of the experience requirements of subsection Q.7. by an affirmative presentation of facts for the same reasons he so found with respect to subsections P.6.c., P.7.b. and c., and P.8. at Finding of Fact 54. They cannot be adopted at this time for the same reasons as stated in that Finding, and the methodology suggested above for curing the defect applies to these subsections as well.

R. - Variances.

57. The Hearing Examiner finds that the need for and reasonableness of the variance section (R.) of 12 MCAR § 2.306 has been adequately demonstrated by an affirmative presentation of facts by the Department in its Statement of Need and Reasonableness.

S. - Appeals.

56. This section acknowledges the statutory right of applicants and licensed programs to appeal decisions made by the licensing authority and refers to the mechanism established for pursuing such appeals. The Hearing Examiner finds Section S. to be necessary and reasonable.

Based upon the foregoing Findings of Fact, the Hearing Examiner makes the following:

CONCLUSIONS

1. That the Department of Public Welfare gave proper notice of the hearing in this matter.

2. That the Department has fulfilled the procedural requirements of Minn. Stat. § 15.0412, subd. 4-4f (1980) and all other procedural requirements of law or rule, except as noted at Finding 5; that the procedural irregularity noted at that Finding was technical in nature and no corrective action is needed in the absence of prejudice to any interested parties .

3. That the Department has demonstrated its statutory authority to adopt the proposed rules and has fulfilled all other substantive requirements of law or rule within the meaning of Minn. Stat. §§ 15.0412, subd. 4e and 15.052, subd. 3(4)(i) and (ii) (1980), except as noted at Finding 44.

4. That the Department has documented the need for and reasonableness of its proposed rules with an affirmative presentation of facts in the record within the meaning of Minn. Stat. § 15.0412, subd. 4c (1980), except as noted at Findings 49, 54 and 56.

5. That the amendments and additions to the proposed rules which were suggested by the Department after publication of the proposed rules in the State Register do not result in rules which are substantially different from the proposed rules as published in the State Register within the meaning of Minn. Stat. § 15.0412, subd. 4d (1980) and 9 MCAR §§ 2.110 A. and 2.111 (1980 Ed.).

6. That the Hearing Examiner has suggested action to correct the defects cited in Conclusions 3 and 4 as noted at Findings 44, 49, 54, and 56.

7. That due to Conclusions 3, 4 and 6, this Report has been submitted to the Chief Hearing Examiner for his approval pursuant to Minn. Stat. § 15.0412, subd. 4d (1980).

8. That any Findings which might properly be termed Conclusions and any Conclusions which might properly be termed Findings are hereby adopted as such.

9. That a finding or conclusion of need and reasonableness in regard to any particular rule subsection does not preclude and should not discourage the Department of Public Welfare from further modification of the proposed rules based upon an examination of the public comments, provided that no substantial change is made from the proposed rules as originally published, and provided that the rule finally adopted is based upon facts appearing in this rule hearing record.

Based upon the foregoing Conclusions, the Hearing Examiner makes the following:

RECOMMENDATION

It is hereby recommended that the proposed rules be adopted except where specifically otherwise noted above.

Dated this 11th day of December, 1981.

RICHARD C. LUIS
Hearing Examiner

M E M O R A N D U M

Significant issues were raised during the hearing and comment period which deserve mention, even though they go beyond an analysis of the specific proposals for Rule 36.

Minn. Laws 1981, Ch. 360, Art. 1, § 14, reads:

> For the biennium ending June 30, 1983, the commissioner of public welfare, the commissioner of economic security, the commissioner of corrections, the commissioner of health and the various health-related boards shall not promulgate nor implement any rules which will increase state expenditures by more than $50,000 during the biennium without the review by, and approval of the governor, after consultation with the legislative advisory committee."

Concern was raised at the hearing and prior to the close of the record as to whether the Department complied with the above-quoted statute. The Hearing Examiner does not share that concern. As was pointed out by Commissioner Noot in his Memorandum dated August 12, 1981 and appended to the Department's Memorandum submitted prior to the close of the record, ". . .we will not formally submit the rule to the Legislative Advisory Committee unless the rule actually increases state expenditures beyond those authorized by the Legislature." Since proposed 12 MCAR § 2.036 was not published in the State Register until after the legislature had appropriated, and the governor had approved, $4,928,300 in increased funding for "Rule 36 mentally ill services" (see p. D01117 of the Department's 1982-83 biennial budget appended to the Department's Memorandum), the above-quoted statute will not apply, if ever, until the Department attempts to over-spend its current appropriation by more than $50,000 in the course of implementing the Rule.

Another major concern was the effect of the application of the proposed Rule on a provider's compliance (or non-compliance) with the Minnesota Certificate of Need Act, Minn. Stat. § 145.832-145.845. Specifically, Minn. Stat. § 145.834 provides, in part:

> No construction or modification or predevelopment activities by a health care facility, whether public, non-profit, or proprietary, shall be commenced or offered unless a certificate of need has been issued therefor in accordance with sections 145.832 to 145.845 . . . The commissioner of health shall promulgate rules to define the commencement of the construction or modification or predevelopment activities and other rules necessary to implement, enforce and administer sections 145.832 to 145.845 . . . ."

The concern is that many of the facilities housing Rule 36 programs are, or in order to qualify under proposed subsection P.2., must be licensed by the Department of Health in such a way as to come under the Certificate of Need Act's

definition of "health care facility". The Hearing Examiner does not consider this to be a major problem. It should be pointed out that Minn. Stat. § 145.835, subd. 4, provides a process whereby the requirement to obtain a Certificate of Need can be waived, and the Department's argument to the effect that waivers should be granted in most cases because of the fact that the facilities may not be undergoing changes that are costly enough to require a full Certificate of Need procedure, or that Certificate of Need compliance costs are not related to direct patient care services, is persuasive. (See Department Memorandum, p. 26). In addition, 12 MCAR § 2.001 (Temporary), also known as "Temporary rule 1", which is the rule providing for grants for services to adult mentally ill persons in Rule 36 facilities, is flexible enough in its provision to allow the granting of costs attendant to the Certificate of Need process (see Temporary 12 MCAR § 2.001 F.6.). The Department alleges that one of the intentions of subsection F.6. of the Temporary Rule is to grant funds for qualifying facilities that may need to qualify under the Certificate of Need Act as a result of having to comply with Rule 36.

The proposed Rule was also criticized as being unreasonable "per se" because the presumptions used in arriving at the amount of money appropriated for its implementation are flawed. This is an issue of great concern but is beyond the scope of this Report. If there is no money to implement the Rule, the Department will either not implement it or go to the Legislature for more funds. Such considerations do not bear on the legal questions of the Department's authority to make the Rule or whether the Department has demonstrated rational bases underlying the need for and reasonableness of the Rule's provisions.

R.C.L.

OFFICE OF THE REVISOR OF STATUTES
PROPOSED RULES

Agency Department of Public Welfare

Division Mental Health Bureau - Mental Illness Program Division

Agency Contact John Sauer
Janet Bisbee

Phone Number 296-3923
296-1858

Title: Proposed Rules Governing Licensure of Residential Facilities for Adult Mentally Ill Persons

Type of Rules: Permanent X Temporary ____

Incorporations by References:

Rule Number	Material Incorporated Author Title Place Publisher Date Cost Places Available
H.8.e.	"all applicable federal rules or laws"
M.5.	"applicable state and federal labor laws..."

See Additional references on back Yes ___ No X

Duplication of Statutory Language None

Rule Number	Statutory Section Duplicated

The attached rules are approved as to form.

Steven C. Cross
Revisor of Statutes

Name: Theresa M. Lauterbach

Title: Assistant Revisor

Phone: 296-0956

RECEIVED
AUG 8 1991
ADMINISTRATIVE HEARINGS

Notice of Intent to Solicit Outside Opinion Concerning Pre-admission Screening for Nursing Home Care

Notice is hereby given that the Minnesota Department of Public Welfare is drafting a temporary rule, 12 MCAR § 2.065 (DPW Rule 65), and, subsequently, a permanent rule, 12 MCAR § 2.065, governing pre-admission screening for nursing home care. This notice is to request comments and opinions for the permanent rule. A separate notice will be published in the *State Register* requesting comments when the proposed temporary rule is published.

Authority for the rule is contained in Laws of Minnesota, ch. 575 (1980), codified as Minn. Stat. § 256B.091.

The rule will govern the establishment of local nursing home pre-admission screening teams, prescribe the duties of the teams and the Commissioner of Public Welfare, and provide for a sliding fee scale for interested persons desiring screening who are not Medical Assistance recipients or who would be eligible for Medical Assistance within 90 days of admission. This rule will affect admission of Medical Assistance recipients, those who would be eligible for Medical Assistance within 90 days, or those desiring the screening service only if the admission is not from an acute care facility or a transfer from another nursing home.

All interested or affected persons or groups are requested to participate. Statements of information and comment may be made orally or in writing. Written statements of information and comment may be addressed to:

Charlene Seavey, Supervisor
Utilization Control Unit
444 Lafayette Road, Box 43208
St. Paul, Minnesota 55101

Oral statements of information and comment will be received during regular business hours over the telephone at (612) 296-6963.

All statements and comment must be received by June 20, 1980. Any written material received by the department shall become part of the hearing record.

Department of Public Welfare
Mental Health Bureau

Notice of Intent to Solicit Outside Opinion Concerning Rule Relating to the Licensure and Operation of Residential Programs for Adult Mentally Ill Persons

Notice is hereby given that the Minnesota Department of Public Welfare is considering draft amendments to 12 MCAR § 2.036 (DPW 36). This rule governs licensure and operation of all residential programs for adult mentally ill persons.

The proposed changes are to 1.) refine the levels of care so that each level accurately describes the standard of care and treatment needed by each client category. 2.) develop a funding proposal for each level according to the services needed to adequately provide the appropriate standard of care and treatment.

All interested or affected persons or groups are requested to participate. Statements of information and comment may be made orally or in writing. Written statements of information and comment may be addressed to: Jay Bambery, Minnesota Department of Public Welfare, Mental Health Program Division, 4th Floor Centennial Building, St. Paul, MN 55155.

Oral statements of information and comment will be received during regular business hours over the telephone at (612) 296-3923. All statements of information and comment must be received by July 1, 1980.

Any written material received by the department shall become part of the hearing record.

Secretary of State

Notice of Vacancies in Multi-Member State Agencies

Notice is hereby given to the public that vacancies have occurred in multi-member state agencies, pursuant to Minn. Stat. § 15.0597, subd. 4. Application forms may be obtained at the Office of Secretary of State, 180 State Office Building, St. Paul 55155; (612) 296-2805. **Application deadline is Tuesday, June 10, 1980.**

Council on the Economic Status of Women has 11 vacancies open June 30, 1980. Council studies the economic status of women and makes recommendations to the governor and the legislature; monthly meetings; members are appointed by the governor and receive $35 per diem plus expenses. For specific information, call or write Council on the Economic Status of Women, 400 S.W. State Office Building, St. Paul, MN 55155; (612) 296-8590.

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

RECEIVED
AUG 5 1981
ADMINISTRATIVE HEARINGS

In the Matter of the Proposed Adoption of the Department of Public Welfare Rule Governing Residential Programs for Adult Mentally Ill Persons (12 MCAR 2.036)

ORDER FOR HEARING

IT IS ORDERED this 31 day of July, 1981, that a public hearing on the proposed rules captioned above be held in Room 83 at the State Office Building, Wabasha Street (between Aurora and Fuller), St. Paul Minnesota 55155, on October 1, 1981, commencing at 9:00 a.m., and continuing until all representatives of associations or other interested groups or persons have had an opportunity to be heard.

IT IS FURTHER ORDERED that notice of said hearing be given to all persons who have registered their names with the Department of Public Welfare for that purpose and be published in the State Register.

STATE OF MINNESOTA

Commissioner of Public Welfare

RC

RECEIVED
AUG 25 1981
ADMINISTRATIVE HEARINGS

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

IN THE MATTER OF THE PROPOSED ADOPTION OF THE DEPARTMENT OF PUBLIC WELFARE RULE GOVERNING RESIDENTIAL PROGRAMS FOR ADULT MENTALLY ILL PERSONS (12 MCAR §2.036)

NOTICE OF HEARING

A public hearing concerning the above entitled matter will be held in Room 83 at the State Office Building, Wabasha Street (between Aurora and Fuller), St. Paul, Minnesota 55155, on October 1, 1981 commencing at 9:00 a.m. and continuing until all interested persons have an opportunity to be heard. The proposed rule may be modified as a result of the hearing process. Therefore, if you are affected in any manner by the proposed rule, you are urged to participate in the rule hearing process.

Following the agency's presentation at the hearing, all interested or affected persons will have an opportunity to ask questions and make comments. Statements may be made orally and written material may be submitted. In addition, whether or not an appearance is made at the hearing, written statements or material may be submitted to Richard C. Luis, Hearing Examiner, Office of Administrative Hearings, 1745 University Avenue, Room 300, St. Paul, Minnesota 55104, (612)296-8114, either before the hearing or within five working days after the public hearing ends. The hearing examiner may, at the hearing, order that the record be kept open for a longer period not to exceed 20 calendar days. The rule hearing procedure is governed by Minn. Stat. §§15.0411-15.0417 and 15.052, and by 9 MCAR §§2.101-2.112 (Minnesota Code of Agency Rules). If you have any questions about the procedure, call or write the hearing examiner.

Notice is hereby given that 25 days prior to the hearing, a Statement of Need and Reasonableness will be available for review at the agency and at the Office of Administrative Hearings. This Statement of Need and Reasonableness will include a summary of all the evidence and argument which the agency anticipates presenting at the hearing justifying both the need for and the reasonableness of the proposed rule or rules. Copies of the Statement of Need and Reasonableness may be obtained from the Office of Administrative Hearings at a minimal charge.

The purpose of 12 MCAR §2.036 is to establish standards for the development, operation and maintenance of residential programs for five or more adult mentally ill persons. This rule is intended both as a means to ensure the human rights of adult mentally ill persons through enforcement of these provisions and as a way to ensure that mental health residential programs organize services consistent with the needs of residents.

The provisions of 12 MCAR §2.036 are described in the following Sections A-S:

Section A identifies to whom the rule applies and which entities are excluded from coverage.

Section B contains the definition of terms used in the rule.

Section C describes the various steps in the process of obtaining a license.

Section D establishes certain restrictions for maintaining a license or provisional license after it has been issued.

Section E requires that each program develop a policy and procedure manual.

Section F identifies the requirement for a complete statement of program philosophy and goals.

Section G establishes provisions for the organization and administration of a program.

Section H outlines required documentation and reports to be completed by programs.

Sections I and J describe personnel policies and procedures and requirements for maintenance of personnel files.

Section K describes provisions for admission, discharge and transfer policies.

Section L identifies the services which a program is required to offer.

Section M outlines the requirements for policies and procedures guaranteeing resident rights.

Section N describes requirements for programs developing and maintaining resident records.

Section O establishes provisions regarding living units for the residents.

Section P describes additional requirements for Category I programs including such areas as maximum resident capacity, Department of Health standards, intake information, the types and qualifications of staff and staffing levels.

Section Q identifies additional requirements for Category II programs and includes the same type of information as that contained in Section Q.

Section R describes the process and provisions for the granting of variances of specific provisions of 12 MCAR §2.036.

Section S identifies what actions by the Licensing Division may be appealed and the process to be followed.

The previous Rule 36 (12 MCAR §2.036) effective February 4, 1974, will be repealed in its entirety with the adoption of this rule.

The agency's authority to adopt the proposed rule is contained in Minn. Stat. §§245.781-245.812 and Minn. Stat. §256E.05. 4

See Attachment A which contains an estimate of the cost to local public bodies of implementing this rule for the two years immediately following its adoption within the meaning of Minn. Stat. §15.0412, Subd. 7. 10

Copies of the proposed rule are now available and at least one free copy may be obtained by writing to Jay Bambery, Mental Illness Program Division, Mental Health Bureau, Department of Public Welfare, Centennial Building, St. Paul, Minnesota 55155, telephone (612) 296-3923. Additional copies will be available at the hearing. If you have any questions on the content of the proposed rule contact Jay Bambery. 36

Any person may request notification of the date on which the hearing examiner's report will be available, after which date the agency may not take any final action on the rules for a period of five working days. Any person may request notification of the date on which the hearing record has been submitted or resubmitted to the Attorney General by the agency. If you desire to be so notified, you may so indicate at the hearing. After the hearing, you may request notification by sending a written request to the hearing examiner, in the case of the hearing examiner's report, or to the agency, in the case of the agency's submission or resubmission to the Attorney General. 8

Minn. Stat. ch. 10A requires each lobbyist to register with the State Ethical Practices Board within five days after he or she commences lobbying. A lobbyist is defined in Minn. Stat. §10A.01, subd. 11, as any individual:

(a) Engaged for pay or other consideration, or authorized by another individual or association to spend money, who spends more than five hours in any month or more than $250, not including his own travel expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials; or 6

(b) Who spends more than $250, not including his own traveling expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials.

The statute provides certain exceptions. Questions should be directed to the Ethical Practices Board, 41 State Office Building, St. Paul, Minnesota 55155, telephone (612)296-5615.

Dated: 8-5-81

Arthur E. Noot
Commissioner

KT/dba

ATTACHMENT A

FISCAL STATEMENT

Rule 36-Residential Facilities for Adult MI

Methodology used to arrive at dollar projections for this bill:

There are currently 301 beds in community residential facilities which would come under Rule 36 Category I (intensive treatment/rehabilitation services) and 1996 beds which would come under Rule 36 Category II (semi-independent living). It is estimated that projected reductions in hospitalization and provision of residential services to mentally ill persons who are now in the community but not receiving the residential care they need will require 1100 Category I beds and 3800 Category II beds by 1985.

Since the Department has decided not to require licensure of facilities in the nursing care category under Rule 36, this budget does not include approximately 14,500 mentally ill persons residing in nursing care facilities; it also excludes certain other categories of MI residential care, e.g. psychiatric hospitals, which would not come under Rule 36.

MI residential care in State Hospitals will be covered by Rule 36, but is not included in these statistics because the state hospital budget is presented elsewhere in the Department's budget.

Category I

Projected program need over four years is1100 beds. There presently exists 301 beds. For the purpose of this cost projection, upgrading the existing 301 beds will cost the same as establishing new beds.

Since the following figures are based on phasing in these beds over a 4 year period, bed days will be calculated by halving the total bed days being funded for the initial phase-in year.

1100 beds are needed over 4 years, 1100 ÷ 4 or 275 are the number of beds needed each year. In the first year of the biennium, the per diem rate applied is $8.21. In the second year of the biennium, the per diem rate applied is $9.44. Below are the calculations:

1st Year
275 beds x 365 days = 100,375 bed days
100,375 x ½ (phase-in calculation) = 50,188 bed days
50,188 x $8.21 (per diem) = $412,039
$412,039 + 20% fringe of $82,408 = $494,447 (Total 1st Year Costs)

2nd Year
275 beds x 365 days = 100,375 bed days (carried over from 1st year)
100,375 x 1 (phase-in complete by beginning of 2nd year) = 100,375 bed days
100,375 x 9.44 (2nd year per diem) = $947,540
947,540 + 20% fringe = $1,137,048
275 beds x 365 days = 100,375 bed days
100,375 x ½ (phase-in of 2nd 275 beds calculation) = 50,188 bed days
50,188 x 9.44 (2nd year per diem) = $473,770
$473,770 + 20% fringe of $94,754 = $568,524
Total 2nd Year Costs = 1,137,048 + 568,524 = $1,705,572

Category II

Projected program need over four years is 3800 beds. Since 3800 beds are needed over 4 years, 3800 ÷ 4 (or 950) are the number of beds needed each year. In the first year of the biennium, the per diem rate applied is 4.72. In the second year the per diem rate applied is 5.43. Below are the calculations:

1st Year
950 beds x 365 days = 346,750 bed days
346,750 x ½ (phase-in calculation) = 173,375 bed days
173,375 x 4.72 = $818,330
$818,330 + 20% fringe = $981,996 (Total 1st Year Costs)

2nd Year
950 beds x 365 days = 346,750 bed days (carried over from 1st year)
346,750 x 1(Phase-in of 1st 950 beds complete by beginning of 2nd yr)=346,750 bed days
346,750 x 5.43 (2nd year per diem) = $1,882,853
1,882,853 + 20% fringe = $2,259,424
950 beds x 365 days = 346,750 bed days
346,750 x ½ (phase-in of 2nd 950 beds calculation) = 173,375 bed days
173,375 x 5.43 (2nd year per diem) = $941,426
941,426 + 20% fringe = $1,129,711
Total 2nd Year Costs = 2,259,424 + 1,129,711 = $3,389,135

Summary

	First Year	Second Year
Category I	494,447	1,705,572
Category II	981,996	3,389,135
Total Year Cost	1,476,443	5,094,707
Total Biennium Cost	$6,571,150	

	First Year	Second Year
Local Share (25%)	369,111	1,273,677
State Share (75%)	1,107,332	3,821,030
Total State $ for 1981-83 biennium	$4,928,362	

Summary of Rule 36 Funding Projections Over Five Years
(Figures do not include an inflation factor after year 2)

	Category I	Category II	Total	State Share (75%)	Local Share (25%)
1st Year	494,447	981,996	1,476,443	1,107,332	369,110
2nd Year	1,705,572	3,389,135	5,094,707	3,821,030	1,273,676
3rd Year	2,842,620	5,648,559	8,491,179	6,386,385	2,122,794
4th Year	3,979,668	7,907,983	11,887,651	8,915,738	2,971,912
5th Year	4,548,192	9,037,694	13,585,886	10,189,414	3,396,471

RECEIVED
SEP 4 1981
ADMINISTRATIVE HEARINGS

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

In the Matter of the Proposed Adoption of the Department of Public Welfare Rule Governing Residential Programs for Adult Mentall Ill Persons (12 MCAR 2.036)

AFFIDAVIT OF MAILING

John Sauer, being first duly sworn, deposes and says:

That on the 24th day of August, 1981, at the City of St. Paul, County of Ramsey, State of Minnesota, he served the attached Notice of Hearing by depositing in the State of Minnesota Central Mail System for first class mailing (or) in the United States mail at said City of St. Paul, a copy thereof, properly enveloped, with postage prepaid, on all persons and associations who have requested that their names be placed on file with the Department of Public Welfare for the purpose of receiving notice of the proposed adoption of rules by this Department.

John Sauer

Subscribed and sworn to before me

this 31st day of August, 1981.

Margaret Holt

KTH/ddg

MARGARET HOLT
NOTARY PUBLIC-MINNESOTA
RAMSEY COUNTY
My Comm. Expires Sept. 22, 1984

RECEIVED
SEP 4 1981
ADMINISTRATIVE
HEARINGS

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

In the Matter of the Proposed Adoption of the Department of Public Welfare Rule Governing Residential Programs for Adult Mentally Ill Persons (12 MCAR 2.036)

AFFIDAVIT OF ADDITIONAL MAILING

John Sauer, being first duly sworn, deposes and says:

That on the 24th day of August, 1981, at the City of St. Paul, County of Ramsey, State of Minnesota, in addition to serving the attached Notice of Hearing to all persons and associations who have requested that their names be placed on file for the purpose of receiving notice of the proposed adoption of rules by this Department, he also served the attached Notice by depositing in the State of Minnesota Central Mail System for first class mailing (or) in the United States mail at said City of St. Paul, a copy thereof, properly enveloped, with postage prepaid to the following agencies and individuals:

Current and Potential Rule 36 Facilities
Minnesota's County Welfare Departments
Minnesota's Human Service Boards
Minnesota's State Hospitals
Members of the Rule 36 Task Force

John Sauer

Subscribed and sworn to before me

this 31st day of August, 1981.

Margaret Holt

KTH/ddb

MARGARET HOLT
NOTARY PUBLIC-MINNESOTA
RAMSEY COUNTY
My Comm. Expires Sept. 22, 1984

RECEIVED
SEP 4 1981
ADMINISTRATIVE
HEARINGS

STATE OF MINNESOTA

DEPARTMENT OF PUBLIC WELFARE

In the Matter of the Proposed Adoption of the Department of Public Welfare Rule Governing Residential Programs for Adult Mentally Ill Persons (12 MCAR 2.036)

CERTIFICATE

I hereby certify that the list of persons, associations, and other interested groups who have requested, pursuant to Minn. Stat. ¢15.0412, subd. 4, that their names be placed on file with and maintained by the Department of Public Welfare for the purpose of receiving notice of the proposed adoption of rules by this Department is accurate and complete as of 9:00, A.M., this 24th day of August, 1981.

Robert J. Hanger

KTH/ddc

12 MCAR § 2.036 (proposed) 249
12 MCAR § 2.079 (proposed) 13

Part 3 Housing Finance Agency
12 MCAR §§ 3.002, 3.133 (proposed temporary) 69
12 MCAR §§ 3.002, 3.133 (proposed temporary, notice of correction) 159
12 MCAR § 3.002 (proposed) 213
12 MCAR § 3.133 (proposed) 214
12 MCAR § 3.053, 3.054 (proposed) 216

TITLE 14 TRANSPORTATION

Part 1 Transportation Department
14 MCAR § 1.5050 (withdrawn) 38

RECEIVED
SEP 4 1981
ADMINISTRATIVE HEARINGS

PROPOSED RULES

Pursuant to Minn. Laws of 1980, § 15.0412, subd. 4h, an agency may propose to adopt, amend, suspend or repeal rules without first holding a public hearing, as long as the agency determines that the rules will be noncontroversial in nature. The agency must first publish a notice of intent to adopt rules without a public hearing, together with the proposed rules, in the *State Register*. The notice must advise the public:

1. that they have 30 days in which to submit comment on the proposed rules;
2. that no public hearing will be held unless seven or more persons make a written request for a hearing within the 30-day comment period;
3. of the manner in which persons shall request a hearing on the proposed rules;

and

4. that the rule may be modified if modifications are supported by the data and views submitted.

If, during the 30-day comment period, seven or more persons submit to the agency a written request for a hearing of the proposed rules, the agency must proceed under the provisions of § 15.0412, subds. 4 through 4g, which state that if an agency decides to hold a public hearing, it must publish in the *State Register* a notice of its intent to do so. This notice must appear at least 30 days prior to the date set for the hearing, along with the full text of the proposed rules. (If the agency has followed the provisions of subd. 4h and has already published the proposed rules, a citation to the prior publication may be substituted for republication.)

Pursuant to Minn. Stat. § 15.0412, subd. 5, when a statute, federal law or court order to adopt, suspend or repeal a rule does not allow time for the usual rulemaking process, temporary rules may be proposed. Proposed temporary rules are published in the *State Register*, and for at least 30 days thereafter, interested persons may submit data and views in writing to the proposing agency.

Department of Public Welfare

Proposed Rule Governing Residential Programs for Adult Mentally Ill Persons (12 MCAR § 2.036)

Notice of Hearing

A public hearing concerning the above entitled matter will be held in Room 83 at the State Office Building, Wabasha Street (between Aurora and Fuller), St. Paul, Minnesota 55155, on October 1, 1981 commencing at 9:00 a.m. and continuing until all interested persons have an opportunity to be heard. The proposed rule may be modified as a result of the hearing process. Therefore, if you are affected in any manner by the proposed rule, you are urged to participate in the rule hearing process.

Following the agency's presentation at the hearing, all interested or affected persons will have an opportunity to ask questions and make comments. Statements may be made orally and written material may be submitted. In addition, whether or not an appearance is made at the hearing, written statements or material may be submitted to Richard C. Luis, Hearing Examiner, Office of Administrative Hearings, 1745 University Avenue, Room 300, St. Paul, MN 55104, (612) 296-8814, either before the hearing or within five working days after the public hearing ends. The hearing examiner may, at the hearing, order that the record be kept open for a longer period not to exceed 20 calendar days. The rule hearing procedure is governed by Minn. Stat. §§ 15.0411-15.0417 and 15.052, and by 9 MCAR §§ 2.101-2.112 (Minnesota Code of Agency Rules). If you have any questions about the procedure, call or write the hearing examiner.

Notice is hereby given that 25 days prior to the hearing, a statement of need and reasonableness will be available for review at the agency and at the Office of Administrative Hearings. This statement of need and reasonableness will include a summary of

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." ADOPTED RULES SECTION — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

all the evidence and argument which the agency anticipates presenting at the hearing justifying both the need for and the reasonableness of the proposed rule or rules. Copies of the statement of need and reasonableness may be obtained from the Office of Administrative Hearings at a minimal charge.

The purpose of 12 MCAR § 2.036 is to establish standards for the development, operation and maintenance of residential programs for five or more adult mentally ill persons. This rule is intended both as a means to ensure the human rights of adult mentally ill persons through enforcement of these provisions and as a way to ensure that mental health residential programs organize services consistent with the needs of residents.

The provisions of 12 MCAR § 2.036 are described in the following Sections A-S:

Section A identifies to whom the rule applies and which entities are excluded from coverage.

Section B contains the definition of terms used in the rule.

Section C describes the various steps in the process of obtaining a license.

Section D establishes certain restrictions for maintaining a license or provisional license after it has been issued.

Section E requires that each program develop a policy and procedure manual.

Section F identifies the requirement for a complete statement of program philosophy and goals.

Section G establishes provisions for the organization and administration of a program.

Section H outlines required documentation and reports to be completed by programs.

Sections I and J describe personnel policies and procedures and requirements for maintenance of personnel files.

Section K describes provisions for admission, discharge and transfer policies.

Section L identifies the services which a program is required to offer.

Section M outlines the requirements for policies and procedures guaranteeing resident rights.

Section N describes requirements for programs developing and maintaining resident records.

Section O establishes provisions regarding living units for the residents.

Section P describes additional requirements for Category I programs including such areas as maximum resident capacity, Department of Health standards, intake information, the types and qualifications of staff and staffing levels.

Section Q identifies additional requirements for Category II programs and includes the same type of information as that contained in Section Q.

Section R describes the process and provisions for the granting of variances of specific provisions of 12 MCAR § 2.036.

Section S identifies what actions by the Licensing Division may be appealed and the process to be followed.

The previous Rule 36 (12 MCAR § 2.036) effective February 4, 1974, will be repealed in its entirety with the adoption of this rule.

The agency's authority to adopt the proposed rule is contained in Minn. Stat. §§ 245.781-245.812 and Minn. Stat. § 256E.05.

See Attachment A which contains an estimate of the cost to local public bodies of implementing this rule for the two years immediately following its adoption within the meaning of Minn. Stat. § 15.0412, Subd. 7.

Copies of the proposed rule are now available and at least one free copy may be obtained by writing to Jay Bambery, Mental Illness Program Division, Mental Health Bureau, Department of Public Welfare, Centennial Building, St. Paul, Minnesota 55155, telephone (612) 296-3923. Additional copies will be available at the hearing. If you have any questions on the content of the proposed rule contact Jay Bambery.

Any person may request notification of the date on which the hearing examiner's report will be available, after which date the agency may not take any final action on the rules for a period of five working days. Any person may request notification of the date on which the hearing record has been submitted or resubmitted to the Attorney General by the agency. If you desire to be so notified, you may so indicate at the hearing. After the hearing, you may request notification by sending a written request to the hearing examiner, in the case of the hearing examiner's report, or to the agency, in the case of the agency's submission or resubmission to the Attorney General.

Minn. Stat. ch. 10A requires each lobbyist to register with the State Ethical Practices Board within five days after he or she commences lobbying. A lobbyist is defined in Minn. Stat. § 10A.01, subd. 11, as any individual:

(a) Engaged for pay or other consideration, or authorized by another individual or association to spend money, who spends more than five hours in any month or more than $250, not including *his own* travel expenses and membership dues, in any year,

for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials; or

(b) Who spends more than $250 not including *his own* traveling expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials.

The statute provides certain exceptions. Questions should be directed to the Ethical Practices Board, 41 State Office Building, St. Paul, Minnesota 55155, telephone (612) 296-5615.

July 30, 1981

Arthur E. Noot, Commissioner
Department of Public Welfare

ATTACHMENT A

FISCAL STATEMENT

Rule 36-Residential Facilities for Adult MI

Methodology used to arrive at dollar projections for this bill:

There are currently 301 beds in community residential facilities which would come under Rule 36 Category I (intensive treatment/rehabilitation services) and 1996 beds which would come under Rule 36 Category II (semi-independent living). It is estimated that projected in hospitalization and provision of residential services to mentally ill persons who are now in the community but not receiving the residential care they need will require 1100 Category I beds and 3800 Category II beds by 1985.

Since the department has decided not to require licensure of facilities in the nursing care category under Rule 36, this budget does not include approximately 14,500 mentally ill persons residing in nursing care facilities; it also excludes certain other categories of MI residential care, e.g. psychiatric hospitals, which would not come under Rule 36.

MI residential care in State Hospitals will be covered by Rule 36, but is not included in these statistics because the state hospital budget is presented elsewhere in the Department's budget.

Category I

Projected **program** need over four years is 1100 beds. There presently exists 301 beds. For the purpose of this cost projection, upgrading the existing 301 beds will cost the same as establishing new beds.

Since the following figures are based on phasing in these beds over a 4 year period, bed days will be calculated by halving the total bed days being funded for the initial phase-in year.

1100 beds are needed over 4 years, 1100 ÷ 4 or 275 are the number of beds needed each year. In the first year of the biennium, the per diem rate applied is $8.21. In the second year of the biennium, the per diem rate applied is $9.44. Below are the calculations:

1st Year 275 beds × 365 days = 10,375 bed days
100,375 × ½ (phase-in calculation) = 50,188 bed days
50,188 × $8.21 (per diem) = $412,039
$412,039 + 20% fringe of $82,408 = $494,447 (Total 1st Year Costs)

2nd Year 275 beds × 365 days = 100,375 bed days (carried over from 1st year)
100,375 × 1 (phase-in complete by beginning of 2nd year) = 100,375 bed days
100,375 × 9.44 (2nd year per diem) = $947,540
947,540 + 20% fringe = $1,137,048
275 beds × 365 days = 100,375 bed days
100,375 × ½ (phase-in of 2nd 275 beds calculation) = 50,188 bed days
50,188 × 9.44 (2nd year per diem) = $473,770
$473,770 + 20% fringe of $94,754 = $568,524
Total 2nd Year Costs = 1,137,048 + 568,524 = $1,705,572

Category II

Projected **program** need over four years is 3800 beds. Since 3800 beds are needed over 4 years, 3800 ÷ 4 (or 950) are the

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." ADOPTED RULES SECTION — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

number of beds needed each year. In the first year of the biennium, the per diem rate applied is 4.72. In the second year the per diem rate applied is 5.43. Below are the calculations:

1st Year 950 beds × 365 days = 346,750 bed days
346,750 × ½ (phase-in calculation) = 173,375 bed days
173,375 × 4.72 = $818,330
$818,330 + 20% fringe = $981,996 (Total 1st Year Costs)

2nd Year 950 beds × 365 days = 346,750 bed days (carried over from 1st year)
346,750 × 1 (Phase-in of 1st 950 beds complete by beginning of 2nd yr) = 346,750 bed days
346,750 × 5.43 (2nd year per diem) = $1,882,853
1,882,853 + 20% fringe = $2,259,424
950 beds × 365 days = 346,750 bed days
346,750 × ½ (phase-in of 2nd 950 beds calculation) = 173,375 bed days
173,375 × 5.43 (2nd year per diem) = $941,426
941,426 + 20% fringe = $1,129,711
Total 2nd Year Costs = 2,259,424 + 1,129,711 = $3,389,135

	Summary First Year	Summary Second Year
Category I	494,447	1,705,572
Category II	981,996	3,389,135
Total Year Cost	1,476,443	5,094,707
Total Biennium Cost		$6,571,150

	First Year	Second Year
Local Share (25%)	369,111	1,273,677
State Share (75%)	1,107,332	3,821,030
Total State $ for 1981-83 biennium		$4,928,362

Summary of Rule 36 Funding Projections Over Five Years
(Figures do not include an inflation factor after year 2)

	Category I	Category II	Total	State Share (75%)	Local Share (25%)
1st Year	494,447	981,996	1,476,443	1,107,332	369,110
2nd Year	1,705,572	3,389,135	5,094,707	3,821,030	1,273,676
3rd Year	2,842,620	5,648,559	8,491,179	6,386,385	2,122,794
4th Year	3,979,668	7,907,983	11,887,651	8,915,738	2,971,912
5th Year	4,548,192	9,037,694	13,585,886	10,189,414	3,396,471

Rule as Proposed (all new material)

12 MCAR § 2.036 Licensing of residential facilities for adult mentally ill persons.

A. Applicability.

1. Rule 12 MCAR § 2.036 applies to all providers offering residential care and treatment to five or more adult mentally ill persons at one time for more than 30 days in any 12-month period and is based, in part, on Minn. Stat. § 245.782, subds. 6 and 9. This rule applies to mental health residential treatment facilities which are Category I programs as defined in B.3. and semi-independent or supportive group living facilities which are Category II programs as defined in B.4. This rule applies to mental health residential programs for the adult mentally ill within state hospitals, and adult foster care homes or safe houses with five or more adult residents who are mentally ill. These entities must be licensed as either Category I or Category II facilities.

2. Rule 12 MCAR § 2.036 does not apply to a licensed private hospital which has a psychiatric or chemical dependency program located within the hospital or to a mental health residential program located within a nursing home.

B. Definitions. As used in 12 MCAR § 2.036, the following terms have the meanings given them.

1. Applicant. "Applicant" means an individual, organization, association, partnership, corporation or unit of a state institution which submits an application for licensure under 12 MCAR § 2.036 to provide care and treatment for five or more adult mentally ill persons in a mental health residential program.

2. Case management services. "Case management services" means the arranging and coordinating of direct services for a resident with the involvement of the resident. These direct services include, but are not limited to: assuring a diagnosis

when needed, assessing the resident's strengths and weaknesses in order to determine the resident's needs, developing an individual treatment plan, and evaluating the plan's effectiveness.

3. Category I program. "Category I program" means a mental health residential program which provides intensive treatment for persons who are mentally ill and in which there is an emphasis on services being offered on a regular basis within the facility with the use of community resources being encouraged and practiced.

4. Category II program. "Category II program" means a mental health residential program which provides either a transitional semi-independent living arrangement or a supervised group supportive living arrangement for mentally ill persons. This type of program offers a combination of in-house and community resource services with emphasis on securing community resources for most daily programming and employment.

5. Commissioner. "Commissioner" means the Commissioner of the Department of Public Welfare or a duly authorized representative.

6. Community representative. "Community representative" means an individual who represents a broad base of citizen interest and who is neither an employee or board member, nor has any other official affiliation with the mental health residential program.

7. Crisis services. "Crisis services" means a set of activities designed to respond to medical, situational, and psychiatric emergencies.

8. Department. "Department" means the Department of Public Welfare.

9. Full-time. "Full-time" means work time equalling at least 37½ hours per week.

10. Independent living services. "Independent living services" means services which both emphasize development of an individual's skills required to perform increasingly independent daily living functions and which are appropriate to the needs of the individual.

11. Individual program plan. "Individual program plan" or "individual treatment plan" means a written plan of intervention and treatment developed on the basis of assessment results and modified at frequent intervals. The plan specifies goals and objectives and a means for their accomplishment, and also identifies responsible staff persons.

12 License. "License" has the meaning given it in Minn. Stat. § 245.782, subd. 11.

13. Mental health counselor. "Mental health counselor" means an individual who, under the supervision of a mental health therapist or program director, provides treatment for mentally ill residents in a mental health residential program and who meets the requirements of P.7.

14. Mental health residential program. "Mental health residential program" means a planned combination of living conditions, services and resources for the treatment and rehabilitation of five or more mentally ill adults on a 24-hour per day basis.

15. Mental health therapist. "Mental health therapist" means an individual skilled in providing mental health therapy in a mental health residential program and who meets the requirements of P.6.

16. Mental health therapy. "Mental health therapy" means various treatment modalities which may reasonably be expected to improve the resident's condition.

17. Mental health worker. "Mental health worker" means an individual who, under the supervision of a mental health counselor, mental health therapist, or program director, provides care, support, or assistance to mentally ill residents in a mental health residential program and who meets the requirements of P.8. Possible job titles for this staff position are resident manager, human services technician, independent living skills worker and licensed practical nurse.

18. Mentally ill person. "Mentally ill person" means a person with a functional, nonorganic, emotional disorder which has been diagnosed by a physician or a licensed consulting psychologist, and who has demonstrated by his or her behavior an inability to interpret realistically the environment, cope with independent daily living or form meaningful relationships.

19. Motivation and remotivation services. "Motivation and remotivation services" means a set of activities which encourages the development of positive attitudes and self-concept, and which encourages the resident to develop goals and to use available community resources.

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." ADOPTED RULES SECTION — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

20. Program director. "Program director" means a person who is responsible for the development and implementation of the mental health residential program and who meets the requirements of P.4.

21. Provisional license. "Provisional license" has the meaning given it in Minn. Stat. § 245.782, subd. 12.

22. Recreation and leisure time services. "Recreation and leisure time services" means a set of activities designed both to meet a resident's personal and therapeutic needs of self-expression, social interaction, and entertainment, and to develop skills and interests that lead to enjoyable and satisfying use of leisure time. A major objective of those services is the integration of residents into the recreational mainstream of the community.

23. Restraint. "Restraint" means any physical device that limits the free and normal movement of body and limbs.

24. Seclusion. "Seclusion" mean involuntary removal into a separate room whhich prevents social contact with other persons.

25. Socialization services. "Socialization services" means a set of activities in which residents learn interpersonal relationship and communication skills.

26. Social services. "Social services" includes psychosocial evaluation; counseling based on social work problem-solving methods; activities designed to assist residents in dealing with tasks of daily living; utilization of community resources; psychotherapy for individuals, families and groups; and education, planning, and advocacy for the social needs of residents.

27. Support group services. "Support group services" means a forum designed for residents to participate with other individuals in a group process of sharing feelings, experiences, and constructive feedback.

28. Vocational services. "Vocational services" means a set of activities emphasizing development of skills required to perform work functions in a competitive or quasi-competitive setting.

C. Licensing process.

1. License required. No mental health residential program shall operate in Minnesota unless it has a current and valid license or provisional license as required by Minn. Stat. §§ 245.781-245.812.

2. Information furnished. Upon written request, each individual, organization or agency shall be furnished with a copy of 12 MCAR § 2.036 and other pertinent materials such as an application form and instructions for obtaining a license.

3. Application. Persons interested in obtaining licensure under 12 MCAR § 2.036 shall submit to the commissioner a completed application on forms supplied by the department. The applicant shall either document compliance with all applicable building codes, fire and safety codes, health rules, zoning ordinances, and other applicable rules and regulations or submit documentation that appropriate variances have been granted.

4. Decision. The commissioner shall make a decision on licensure after completion of the following steps:

a. A review of the application;

b. A visit to the program site; and

c. Interviews with a random sample of residents and staff, in the case of existing facilities.

5. Fee. Each applicant shall pay to the commissioner a nonrefundable fee not to exceed $150 for the costs of processing the license application. Information regarding the specific amount and the timing of the payment shall be made available to the applicant.

6. Renewals. Application for renewal of a license shall be made on forms furnished by the department at least 30 days prior to the date of expiration of the license.

D. License changes; report. Any changes in the following areas shall be reported in writing to the department at least 20 days prior to the change:

1. A change in licensed capacity;

2. The location of the program;

3. A change in program director;

4. A change in ownership; or

5. Major changes in programming.

E. Program policy and procedures manual. Each mental health residential program shall develop a written policy and procedures manual. The manual shall contain all materials required by F.-M. The manual shall be available for inspection by the department.

F. Statement of purpose and policies. The manual shall contain a complete statement describing the mental health residential program's philosophy and goals. This statement shall include, but not be limited to a description of:

a. The geographical area to be served;

b. The treatment design and methodology; and

c. The scope of services offered.

G. Program organization and administration.

1. Advisory committee. Each program shall have an advisory committee which provides for reasonably broad community representation and public participation in its operation. The advisory committee shall have a core group which comprises a quorum. The core group shall include at least one program resident, the facility's administrator, and a community representative. The advisory committee shall document the procedure whereby residents are assured access to the advisory committee. The committee shall meet at least quarterly. Minutes of the meetings shall be recorded and kept on file at the facility. Each program shall provide to the department a list of names and titles of the members of the advisory committee.

2. Governing body. All programs shall have a governing body which is accountable for, and has authority over, the policies and activities of the program. In the case of a program owned by a proprietor or partnership, the proprietor or partners shall be regarded as the governing body for the purpose of this part. Each program shall provide to the department a list of names and titles of the members of its governing body.

3. Designated authority. A program operating within Minnesota with headquarters outside of the state shall have a duly authorized representative with decision-making responsibility designated within this state.

H. Required documentation and reports.

1. Insurance coverage. Each program shall have written documentation of insurance coverage in an amount sufficient to protect the interests of residents and staff. Each program must document the specific types and amounts of coverage and the carrier or carriers.

2. Bonding. Each program shall have written documentation that all employees are bonded if they have access to or responsibility for handling money.

3. Financial information. Each program shall make available to the commissioner an annual fee schedule. A new program shall document in writing assurance of funding sufficient to meet total projected program costs for a period of at least one year in addition to start-up costs.

4. Maintenance. Each program shall document that the maintenance and upkeep of the facility is being done by staff hired by the program or through a written working agreement with an outside person or firm.

5. Non-discrimination policy. Each program shall have a written policy which requires that no resident be discriminated against in admission, termination, or treatment on the basis of race, creed, color, national origin, relation, physical handicap, sexual preference, public assistance status or marital status.

6. Accident reports. Each program shall have a written policy regarding accidents and missing persons. Each program shall maintain in central files at the facility reports regarding accidents or missing persons if the reports pertain to facility residents.

7. Annual comprehensive report. Each program shall give a comprehensive annual report to its governing body and its advisory committee. The report shall also be available to the commissioner. The report shall include documentation in at least the following areas:

a. A current organizational chart listing the number of full-time equivalent positions in each category;

b. Training, staff development, and continuing education activities of staff;

c. Administrative policy and procedure changes;

d. Program evaluation as required in 8.; and

e. A financial report.

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." ADOPTED RULES SECTION — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

8. Program evaluation.

a. Process required. Each program shall institute an evaluation process to be conducted on an ongoing basis. An annual report of this evaluation shall be submitted to the program's governing body and advisory committee and to the host county. The evaluation process shall be outcome-based and consistent with the emphasis of 12 MCAR § 2.036 on individual treatment planning.

b. General data. Each program shall systematically collect data that includes, but need not be limited to: resident demographic data, program service data, and data on concurrent services. Each program shall submit the data to the host county for combination with follow-up data collected by county case workers. In a format developed by the commissioner, the data shall be submitted by each program to the commissioner on an annual, aggregate basis for statewide summaries and for planning the use of state resources.

c. Individual data. Each program shall also, for the purpose of examining the program's impact, assess the progress of each resident relative to the resident's individual treatment plan. Progress shall be assessed by rating each resident within 30 days of admission and thereafter at the time of quarterly review on uniform level of functioning scales determined by the commissioner.

d. County technical assistance. Each program shall collaborate with county technical assistance staff to examine the evaluation results, to assess the overall progress of residents in the program, and to demonstrate how the results are used in administrative and program development.

e. Data restrictions. Each program shall collect the statistical data described in 8. for the purpose of program evaluation. The categories of data shall be compatible with the evaluation requirement of the Community Social Services Act, Minn. Stat. ch. 256E, and shall not require duplicate data collection. Dissemination shall be in accordance with provisions of the Minnesota Government Data Practices Act, Minn. Stat. §§ 15.1611-15.1699, and all applicable federal rules or laws.

I. Personnel policies and procedures.

1. General requirements. Each program shall have a written personnel policy and shall make a copy of it available to each employee upon employment and to the department for review. Personnel policies shall be carried out in accordance with affirmative action policies and equal employment opportunity regulations.

2. Job description. The personnel policy shall contain job descriptions for each position specifying responsibilities, degree of authority to execute job responsibilities, standards of job performance, and qualifications.

3. Job evaluation. The personnel policy shall provide for job performance evaluations conducted on a regular and ongoing basis with a written annual review. As part of the annual performance review, each staff member shall have a growth and development plan. Each program shall develop a policy and establish procedures for resident input into staff evaluations.

4. Conditions of employment. The personnel policy shall describe the employees' conditions of employment, including their benefits, hours of work, methods of promotion, the general conditions which constitute grounds for dismissal and suspension, and the ways in which staff stress will be recognized and addressed.

5. Organizational chart. The personnel policy shall also include a chart or definition of organizational structure indicating lines of authority.

6. Grievance procedure. The personnel policy shall describe a grievance procedure for use by staff. This procedure shall allow the aggrieved party to bring the grievance to the highest level of authority in the operation of the facility. A list of other community resources, such as the Health Facilities Complaint Office in the Department of Health, the Licensing Division in the Department of Public Welfare, and the Department of Human Rights, shall be made available to staff by the facility.

7. Personnel data. Program employee personnel data shall be accessible to the department.

8. Staff orientation. The personnel policy shall include a program of orientation for all new staff and the orientation shall be based on a written plan. At a minimum, the plan of orientation shall provide for training related to the specific job functions for which the employee was hired, facility policies and procedures, and the needs of mentally ill persons.

9. Staff training. The program shall have a staff development plan, including in-service or outside training opportunities. The plan shall be developed annually. The plan shall be relevant to the facility's program and resident population. There shall be at least 15 hours of in-service training, or training through community resources, or both, annually for each staff person working directly with mentally ill persons. The training shall include, but need not be limited to, the following areas:

a. Red Cross certified first-aid training or equivalent, to be updated at least every three years;

b. Crisis intervention training for psychiatric emergencies;

c. Problems and needs of mentally ill persons and their families;

d. Community resources locally available to mentally ill adults;

e. Psychotropic medications and their side effects;

f. Resident rights;

g. Cultural awareness training;

h. Rules governing the operation of residential facilities for adult mentally ill persons; and

i. Other topics, such as case management, individualized goal planning, chemical use and abuse, health and nutrition, and services for multiple disability residents.

J. Personnel files.

1. Central training file. The orientation and in-service and training through community resources required by I. shall be documented by each program in a central training file. The file shall be available to the department for review. Documentation shall include, but need not be limited to: the date, the subject, the name of the person who conducted the training, the names of staff attending, and the number of hours attended.

2. Individual files. Each program shall maintain a separate personnel file for each employee. The files shall be available to the department for review. At a minimum, each file shall contain the following:

a. An application for employment;

b. Verification of employee's credentials;

c. An annual job performance evaluation;

d. An annual growth and development plan;

e. Documentation of orientation; and

f. A record of training and education activities during employment.

K. Admission, discharge, and transfer policies.

1. Admission criteria. Each program shall develop admission criteria delineating the types and characteristics of persons who can and cannot be served by the program. Intake policies and procedures shall be developed including the role and responsibility of community resources.

2. Discharge and transfer policies. Each program shall develop detailed discharge and transfer policies and procedures. The policies and procedures shall include:

a. A planned discharge or transfer conference with the resident, staff representatives, and others requested by the resident;

b. Identification of community resources which directly relate to the continuing needs of the resident;

c. A description of the process by which a discharged or transferred resident would or would not have access to the staff and other residents in order to facilitate readjustment in the community.

L. Program services. The following services shall be offered either within the facility or through a contract with other community resources:

a. Case management services;

b. Crisis services;

c. Independent living services;

d. Mental health therapy;

e. Motivation and remotivation services;

f. Recreation and leisure time services;

g. Socialization services;

h. Support group services;

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." ADOPTED RULES SECTION — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

i. Social services;

j. Vocational services; and

k. Other services if their need is indicated by the resident assessment.

M. Policies and procedures guaranteeing resident rights.

1. Explanation of rights. A written statement of residents' rights and responsibilities shall be developed encompassing 2.-10. Program staff shall explain to each resident the resident's rights and responsibilities. A written statement of residents' rights and responsibilities shall be given to each resident and to his or her responsible party within 30 days of admission. A list of residents' rights and responsibilities shall be posted in a place accessible to the residents and shall be available to the department for review.

2. Grievance procedure. Within 30 days of admission each resident shall be informed of grievance procedures available to the resident, and a copy of the procedures shall be posted in a place accessible to the resident. The grievance procedures shall include the following:

a. An offer of assistance by the facility in development and process of the grievance; and

b. A list of internal resources for use by the resident, such as the resident council or a grievance committee, and a list of community resources available to the resident, such as the health facilities complaint office in the Department of Health, the Licensing Division in the Department of Public Welfare, and the Department of Human Rights.

3. Resident council. Each program shall have a resident council through which residents have an opportunity to express their feelings and thoughts about the program and to affect policies and procedures of the program. Minutes of council meetings shall be recorded and made available to the program director.

4. Personal funds policy. If staff supervises the use of residents' personal funds or property, policies governing the supervision shall be written. The resident shall sign a consent form prior to the exercise of supervision indicating an awareness of and consent to procedures governing the program's use of the resident's personal funds. In order to encourage independent living skills, any restriction of a resident's personal funds must be documented in the individual treatment plan. Resident fund accounts shall be maintained separately from program fund accounts.

5. Resident compensation. A resident who performs labor which contributes to the operation and maintenance of the facility for which the facility would otherwise employ someone shall be compensated appropriately and in compliance with applicable state and federal labor laws, including minimum wage and minimum wage reduction provisions. This provision shall not apply to labor of a personal housekeeping nature, nor to labor performed as a condition of residence in a small group living arrangement.

6. Physician appointments. A resident shall be allowed to see a private physician at any reasonable time.

7. Photographs of residents. Photographs may be taken and used for personal or social purposes unless the resident has indicated his or her objection. Photographs may be taken for informational purposes only upon written consent of the resident.

8. Telephone use. Residents shall have access to a telephone for incoming, local outgoing, and emergency calls. They shall have access to a pay phone or its equivalent for outgoing long distance calls. Any restriction on resident access to telephones shall be documented in the individual treatment plan.

9. Mail. Residents shall be allowed to receive and send uncensored mail. Any restrictions shall be documented in the individual treatment plan.

10. Restraints. The facility shall have a written policy that defines the uses of restraint, seclusion, and crisis medications as a treatment mode; the staff members who may authorize its use; and a mechanism for monitoring and controlling its use. Physical restraint and seclusion shall be used only when absolutely necessary to protect the resident from injury to himself or to others. Restraint, seclusion, and medications shall not be used as punishment, for the convenience of staff, or as a substitute for a program.

N. Resident records.

1. Individual program plan development. Each mental health program shall develop and complete a written individual program plan for each resident within 30 days of admission. Medical, social, psychological, and psychiatric histories of the resident shall be used in the development of the plan. The plan shall be developed by an interdisciplinary team including the resident, the program staff, a representative of the referring agency and other appropriate resources, such as family, concerned others, and health care providers requested by the resident. Each resident shall be actively involved in developing his or her plan, unless contraindicated. The persons involved in the development of the individual program plan shall be noted on the plan. The extent of the resident's participation in developing the program plan shall also be noted on the plan. The plan and documentation related to it shall be kept in the facility where the mental health program is located.

2. Plan contents. An individual program plan shall contain at least the following components:

a. An assessment, including a strength and need list, of the resident in at least the following areas of life: social, medical, legal, family, leisure and recreation, spiritual or religious, psychological, financial, vocational and educational;

b. The specific problems to be resolved;

c. A list of goals in order of priority;

d. Specific, measurable, and time-limited objectives which relate directly to the goals;

e. Specific methods, strategies, and resources, including medications, to be used by the staff in assisting the resident to accomplish the goals and objectives;

f. The agency, program staff or other persons designated to assist the resident in implementing the various components of the plan; and

g. Notes indicating progress in achieving the goals and objectives.

3. Progress report. A quarterly review of the resident's response to the individual treatment plan and his or her involvement in the facility's overall program shall be written. Copies of this report shall be given to the resident and shall be sent to the representative of the referring agency and other persons deemed appropriate by the program director and resident. The resident's level of participation in the development and the review of the report shall be documented. The report shall be kept at the facility.

4. Discharge or transfer summary. A discharge or transfer summary shall be written for each person transferred or discharged. The summary shall include at least the following information:

a. A brief review of the resident's problems, strengths and needs while a resident of the program;

b. The response of the resident to his or her individual treatment plan and to the facility's overall program;

c. An aftercare plan which identifies the persons, including at least the resident, a program staff member, and a representative of the referring agency, who participated in the development of the aftercare plan; goals and objectives for the first three months after discharge or transfer; and individuals or agencies who will be working with the resident after discharge or transfer; and

d. A forwarding address and telephone number for follow-up contacts.

5. Accidents and missing persons. A copy of any report regarding accidents and missing persons must be documented in the individual's resident record if the resident is involved in the report.

6. Release of information. Private data regarding a resident shall not be used or released by the facility to any person or agency, except pursuant to the Minnesota Government Data Practices Act. The facility shall use written consent forms for any release of resident information or data.

O. Living unit requirements.

1. Structure. Each living unit of a mental health residential program shall be physically self-contained and shall include bedrooms, living rooms or lounge areas, bathrooms and connecting areas. Walls defining the living unit shall extend from floor to ceiling. These units shall be patterned after a home-like atmosphere, and shall include furnishings appropriate to the psychological, emotional, and developmental needs of each resident.

2. Ratios. For existing programs, there shall be one living room or lounge area for every 25 residents. For new programs there shall be one living room or lounge area for every 16 residents.

3. Program space. There shall be space available for program services as indicated in the individual treatment plans such as an area for learning recreation and leisure time skills, and an area for learning independent living skills, such as laundering and cooking.

4. Gender of residents. The unit or complex of units shall house both male and female residents insofar as this conforms to prevailing cultural norms, unless contraindicated by the facility's overall program plan. The unit shall provide for appropriate separation of male and female residents.

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." ADOPTED RULES SECTION — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

5. Privacy. The living unit shall allow for individual privacy and group socialization. Each resident shall have the opportunity for privacy during assessment, interviews, counseling sessions and visitations.

6. Storage space. Each facility shall provide to each resident storage space for clothing and other personal property, including a secure place for valuables. Each facility may exclude particular kinds of personal property from the facility for reasons of space limitations or safely. Any exclusions shall be documented and included in the policies and procedures manual of the facility.

P. Additional requirements for Category I programs. In addition to the requirements of A.-O., Category I programs shall meet the requirements of 1.-9.

1. Capacity. Facilities, or treatment units within facilities existing as of July 1, 1980, not exceeding a maximum capacity of 40 beds shall be permitted. Facilities or units having over 40 beds shall have a three year period from the effective date of 12 MCAR § 2.036 to reduce the capacity to 40 beds or less. New facilities shall not exceed a maximum capacity of 25 beds.

2. Department of health licensing standards. Each program shall be licensed either as a supervised living facility or as a boarding care facility.

3. Intake information. Each facility shall maintain in the facility documentation that:

a. A prospective resident has been diagnosed as being mentally ill and requires treatment;

b. The diagnoses are based on medical, social, psychological, and psychiatric information; and

c. Medical, social, psychological and psychiatric histories were obtained for each resident.

4. Program director. An individual shall be designated as the program director. The positions of program director and administrator may be filled by the same person. This individual shall meet the following qualifications:

a. A master's degree in the behavioral sciences or related field with at least two years of work experience providing services to mentally ill persons, or a bachelor's degree in the behavioral sciences or related field with a minimum of four years of work experience providing services to mentally ill persons; and

b. One year of experience or training in administration or supervision.

5. Administrator. An individual shall be designated as administrator of the mental health residential program. The administrator shall be responsible for continuous overall operation, including maintenance and upkeep of the facility. In the administrator's absence, a staff member who is familiar with operations of the organization shall be designated to assume the responsibilities of the administrator. An individual who is functioning as administrator but not as program director shall meet qualifications determined by the governing body which are consistent with the training and education needed to meet the stated goals of the facility.

6. Mental health therapist. If mental health therapy is provided within the mental health residential treatment facility, a mental health therapist shall be hired. The mental health therapist shall be qualified in the following ways:

a. A bachelor's degree in one of the behavioral sciences or related field;

b. A master's degree in the behavioral sciences or related field or two years of advanced level, certificate training in mental health therapy; and

c. One year of experience providing services to mentally ill persons.

7. Mental health counselors. If program services other than mental health therapy are provided within the mental health residential treatment facility, they shall be provided by mental health counselors or mental health workers, or both. Mental health counselors shall meet the following qualifications:

a. A bachelor's degree in one of the behavioral sciences or related field;

b. A minimum of one year's experience working with mentally ill persons; and

c. Supervision by a mental health therapist or the program director.

8. Mental health workers. Mental health workers shall qualify in one of the following ways:

a. One year of experience working with mentally ill persons;

b. One year as a resident of a mental health residential program with three months' training relevant to the job responsibilities of a mental health worker; or

c. Three months of on-the-job training with continued supervision by at least a mental health counselor.

9. Staffing ratios. Staffing patterns shall be developed to ensure 24-hour coverage within the mental health residential treatment facility. The hours of the day devoted to active treatment programming shall be identified. The following minimum

staff-to-resident ratios shall be maintained. The requirements of b. and c. represent full-time equivalencies and may be prorated based on licensed resident capacity.

a. The number of work hours performed by the program director shall be prorated based on resident capacity with a ratio of 1 to 40 (1:40 F.T.). No more than one program director per program is required.

b. The number of work hours performed by the mental health therapist and mental health counselor and mental health worker may be combined in different ways, depending on program needs, to achieve a ratio of one full-time equivalent position for each five residents (1:5 F.T.E.). When the work hours are combined, the facility shall have written documentation that the supervision required by 7.c. and 8.c. is provided.

c. The program shall have one quarter-time equivalent in-service training coordinator for each forty residents (1/4:40 F.T.E.). The number of work hours performed by this individual may be combined with those of another program staff position.

Q. Additional requirements for Category II programs. In addition to the requirements of A.-O., Category II programs shall meet the requirements of 1. to 8.

1. Capacity. Facilities existing as of July 1, 1980, with a capacity exceeding 25 beds shall have a three-year period from the effective date of 12 MCAR § 2.036 to divide the facility into living units which do not exceed 25 beds. Facilities existing as of July 1, 1980, with a capacity exceeding 25 beds per living unit shall not increase the total capacity of the facility. New facilities shall not exceed a maximum capacity of 25 beds.

2. Department of health licensing standards. Each program shall have a board and lodging license or a health care license.

3. Intake information. Each facility shall maintain in the facility documentation that:

a. A mental health assessment or reassessment has been completed to determine appropriateness of admission; and

b. Medical, social, psychological and psychiatric histories were obtained for each resident.

4. Medical information. Each program shall require that a physical exam be done 30 days prior to admission or within three days following admission. Each resident shall have an annual physical and dental examination. Records shall be kept of annual medical and dental examinations, including records on all prescription medications the resident is taking. Records shall also be maintained regarding the general medical condition of the resident, including any disabilities and limitations.

5. Program director. An individual shall be designated as the program director. The positions of program director and administrator may be filled by the same person. This individual shall meet the following qualifications:

a. A master's degree in the behavioral sciences or related field and at least one year of work experience providing services to mentally ill persons, or a bachelor's degree in behavioral sciences or related field with a minimum of two years' work experience providing services to mentally ill persons; and

b. One year of experience or training in administration or supervision.

6. Administrator. An individual shall be designated as administrator of the mental health residential program. The administrator shall be responsible for continuous overall operation, including maintenance and upkeep of the facility. In the administrator's absence, a staff member who is familiar with operations of the organization shall be designated to assume the responsibilities of the administrator. An individual who is functioning as administrator but not as program director shall meet qualifications determined by the governing body which are consistent with the training and education needed to meet the stated goals of the facility.

7. Mental health counselors and workers. If program services are offered within the facility, they shall be provided by mental health counselors or mental health workers, or both. The minimum qualifications for these positions shall be consistent with those of Category I specified in P.7. and P.8.

8. Staffing ratios. Staffing patterns shall be developed to ensure 24-hour coverage within the mental health residential treatment facility. The hours of the day devoted to treatment programming shall be identified. The following minimum staff-to-resident ratios shall be maintained. The requirement of b. represents a full-time equivalency and may be prorated based on licensed resident capacity.

a. The number of work hours performed by the program director shall be prorated based on resident capacity with the ratio of 1 to 40 (1:40 F.T.). No more than one program director per program is required.

KEY: PROPOSED RULES SECTION — Underlining indicates additions to existing rule language. ~~Strike outs~~ indicate deletions from existing rule language. If a proposed rule is totally new, it is designated "all new material." ADOPTED RULES SECTION — Underlining indicates additions to proposed rule language. ~~Strike outs~~ indicate deletions from proposed rule language.

b. The number of work hours performed by the mental health counselor and mental health worker may be combined to achieve a ratio of one full-time equivalent staff position for each ten residents (1:10 F.T.E.). When the work hours are combined, the facility shall have written documentation that the supervision required by P.7.c. and P.8.c. is provided.

R. Variances. A residential program may request in writing a variance of a specific provision of 12 MCAR § 2.036. The request for a variance must cite the specification of the rule in question; reasons for requesting the variance; the period of time, not to exceed one year, the licensee wishes to have the provision varied; and the equivalent measures planned for assuring that programmatic needs of residents are met. Variances granted by the commissioner shall specify in writing the time limitation and required equivalent measures to be taken to assure that programmatic needs are met. Variances denied by the commissioner shall specify in writing the reasons for the denial. No variance shall be granted that would threaten the health, safety, or rights of residents.

S. Appeals. Revocation, suspension or denial of a license may be appealed pursuant to Minn. Stat. ch. 15.

Repealer. 12 MCAR § 2.036 which was effective February 4, 1974, is repealed.

ADOPTED RULES

The adoption of a rule becomes effective after the requirements of Minn. Stat. § 15.0412, subd. 4, have been met and five working days after the rule is published in the *State Register*, unless a later date is required by statutes or specified in the rule.

If an adopted rule is identical to its proposed form as previously published, a notice of adoption and a citation to its previous *State Register* publication will be printed.

If an adopted rule differs from its proposed form, language which has been deleted will be printed with strike outs and new language will be underlined, and the rule's previous *State Register* publication will be cited.

A temporary rule becomes effective upon the approval of the Attorney General as specified in Minn. Stat. § 15.0412, subd. 5. Notice of his decision will be published as soon as practicable, and the adopted temporary rule will be published in the manner provided for adopted rules under subd. 4.

Board of Accountancy

Adopted Rules Governing Licensure and Fees, Continuing Professional Education and the Professional Conduct of Certified Public Accountants and Licensed Public Accountants

The rules published and proposed at *State Register*, Volume 5, Number 48, pp. 1907-1913, June 1, 1981 (5 S.R. 1907) are now adopted with the following amendments:

Rules as Adopted

Chapter One: Definitions and General (4 MCAR §§ 6.001-6.019)

4 MCAR § 6.006 In public practice and rendering professional service. In public practice and rendering professional service mean:

A. When used in reference to a CPA or LPA, that he individually or as an employer performs professional accounting services for a fee within this state.

Chapter Four: Certificate; Qualifications of Accountant (4 MCAR §§ 6.040-6.049)

Certificate; To Whom Granted
Certificate; Examination

4 MCAR § 6.040 The following requirements are to be observed in submitting applications to the board for examination~~,~~ and re-examination for the certificate as certified public accountant and reciprocal certificate as certified public accountant~~.~~:

C. ~~Applicants~~ Applications for CPA examination or re-examination not reaching the board 60 or more days prior to the initial examination date may, at the board's discretion, be deferred for consideration for a subsequent examination.

4 MCAR § 6.041 An application for CPA examination or ~~re-reexamination~~ reexamination shall expire five years from the date of the board's approval to sit for the initial examination. Once expired, the board may refuse to consider a new application or may require the applicant to be re-examined in all subjects.

STATE OF MINNESOTA

COUNTY OF RAMSEY

ARTHUR E. NOOT, COMMISSIONER

DEPARTMENT OF PUBLIC WELFARE

In the Matter of the Proposed Adoption of the Department of Public Welfare Rule Governing the Licensure of Residential Facilities for Adult Mentally Ill Persons (12 MCAR 2.036)

ORDER ADOPTING RULE

The above-entitled matter came before Hearing Examiner Richard C. Luis, on October 1, 1981, beginning at 9:00 a.m. in Room 83 of the State Office Building, St. Paul, Minnesota. The Department of Public Welfare (DPW) served proper notice as required by Minn. Stat. § 15.0412, subd. 4 (Supp. 1981), upon all persons, associations and other interested groups registered with the Secretary of State for that purpose.

At said hearing, the proposed rule as published in 4 State Register 252-262, on Monday, August 31, 1981, was considered. Ellen C. Dubuque, Special Assistant Attorney General, appeared as counsel for DPW, and the following persons appeared to testify on behalf of DPW: Jay Bambery, Assistant Director, Mental Illness Program Division; Terry Sarazin, Director, Mental Illness Program Division; John Sauer, Mental Health Program Consultant, Mental Illness Program Division; John Buzzell, Director, Licensing Division; Thomas Eberhart, Director, Management Support Division; Steven Barta, Program Education Specialist, Policy Analysis Office; Roland Peek, Director, Client Protection Office; and John Zakelj, Welfare Specialist, Management Support Division. DPW also called the following persons as witnesses: Representative John Brandl, co-author of the Rule 36 appropriation legislation; Bill Conley, Director of Public Affairs, Minnesota Mental Health Association; Tish Halloran, Director, Mental Health Programs, Hennepin County Community Services; Mila Hundly, Treatment Director, Sharing Life in the Community; Harriet Grinstead, Executive Director, Hope Transition Center; Bob Ryan, Administrator, Guild Hall; Marge Wherley, Residential Program Consultant, Hennepin County Mental Health Services; and Terry Ford, student at Inver Hills Community College and former mental health "consumer". The hearing continued until all interested groups and persons had an opportunity to be heard. Pursuant to order of the Hearing Examiner, the record was held open for twenty (20) days for the submission of written comments and statements.

Based upon all the records and proceedings, the Hearing Examiner issued a Report on December 15, 1981, which included Findings of Fact, Conclusions and a Memorandum. This report is attached as Exhibit A.

Pursuant to the requirements of Minn. Stat. § 15.0412, subd. 4d (Supp. 1981), this Report was available to all affected parties for at least five (5) days.

Having considered all of the evidence adduced and upon the records, files and proceedings herein, the applicable statutory standards and criteria, and having confirmed the need for the adoption of the above-captioned Rule and the reasonableness thereof,

NOW, THEREFORE, IT IS ORDERED that the Findings, Conclusions and Recommendations of the Hearing Examiner as contained in the Report of the Hearing Examiner, with exceptions or modifications as noted below, are hereby adopted and incorporated herein. In addition, in accordance with the Recommendations of the Hearing Examiner, the Commissioner makes the following additional:

FINDINGS OF FACT

1. In Finding 13, the Hearing Examiner recommended a change to conform with a statutory definition. The Commissioner accepts the recommendation and amends section A.1. to read "adult foster homes" deleting the word "care" from that phrase. The Commissioner finds that this amendment is necessary and reasonable and constitutes a clarification, not a substantial change.

2. In Finding 16, the Hearing Examiner recommended that the word "rule" at the beginning of subsections A.1. and A.2 be deleted. The Commissioner rejects the recommendation and retains the word "rule" on advice from the Revisor's office that for form only, when a sentence begins with a citation to an administrative rule, that the word "rule" precede the citation.

3. In Finding 18, the Hearing Examiner recommended that the Department, at its option, could include definitions of "residential facility", "regularly", and "on a regular basis" in the rule in the definition section. The Commissioner does not exercise the option, and adopts the language as originally proposed, and specifically finds that such language as originally proposed, is necessary and reasonable for ease in reading and understanding the rule.

4. In Finding 18, the Hearing Examiner recommended a change to conform with definitions in Sections B.3 and B.4. The Commissioner accepts the recommendation and amends Section A.1 by amending the last sentence to delete the word "facilities." The last sentence shall read "these entities must be licensed as either Category I or Category II." The Commissioner finds this amendment to be a necessary and reasonable clarification and not a substantial change, and adopts the rationale in Hearing Examiner Finding No. 18.

5. In Finding 18, the Hearing Examiner recommended that the word "programs" as used throughout the Rule be defined in Section B for the purpose of clarifying the entire Rule. The Commissioner accepts the recommendation and amends Section B.15 to read as follows:

> 15. Mental health residential program, and programs. "Mental health residential program" and "programs" mean a planned combination of living conditions, services and resources for the treatment and rehabilitation of five or more mentally ill adults on a 24-hour per day basis.

The Commissioner finds that the amendment of this definition is necessary and reasonable, and not a substantial change since the addition is merely clarifying.

6. In Finding 29, the Hearing Examiner recommends a change in Section H to delete an incorrect reference to a statute. The Commissioner accepts the recommendation and amends Section H.6. to read as follows:

> 6. Each applicant shall document compliance with provisions of ~~the Vulnerable Adults Act,~~ Minn. Stat. § 626.557.

The Commissioner finds that the deletion of the above language is necessary and reasonable since the reference is to a title which is not part of the statute.

7. In Finding 32, the Hearing Examiner recommended a change in Section I. The Commissioner accepts the recommendation and amends Section I. by adding a subsection 10. to read as follows:

> 10. Training of non-direct care staff. Personnel of the program not referenced in this rule shall receive continuing education as appropriate to their role and function within the program.

The Commissioner finds that including this provision in the Rule is not a substantial change. Such a change is necessary and reasonable and consistent with the purposes of the Rule to provide residents in facilities with consistently therapeutic contacts with those around them.

8. In Finding 33, the Hearing Examiner recommends the addition of a specific statutory reference. The Commissioner accepts the recommendation and amends Section J.2. to read as follows:

Each employee shall be able to review their personnel file, subject to the provisions of the Minnesota Government Data Practices Act, Minn. Stat. §§ 15.1611 et seq.

The Commissioner finds that this is not a substantial change and is reasonable and necessary.

9. In Finding 34, the Hearing Examiner recommends a change in word order to Section J.2.a. The Commissioner accepts the recommendation and amends Section J.2.a. by inserting the words "or a resume" after the word "employment" rather than after the word "application." The Commissioner finds this amendment to be a clarifying grammatical change.

10. In Finding 35, the Hearing Examiner recommended a change to Section J.1. to reflect the changes made in Section I. The Commissioner accepts the recommendation and amends Section J.1. by inserting the words: "The orientation and continuing education required by I. shall be documented by each program in a central training file." after the phrase "Central training file." The Commissioner finds that this change is reasonable and necessary and clarifies the original meaning of the section. The Commissioer further finds that the change is not substantial.

11. In Finding 44, the Hearing Examiner found that Section M.7., as amended, cannot be adopted because it violates substantive provisions of law. The Hearing Examiner recommended an alternative change. The Commissioner accepts the recommendation and amends Section M.7. by deleting language as originally proposed and subsequently amended, and adding language to read as follows:

7. Photographs of residents. A resident shall not have his or her photograph taken for any purpose beyond identification unless he or she consents.

The Commissioner finds that this change is not substantial and is reasonable and necessary.

12. In Finding 49, the Hearing Examiner found that Section O.2., as amended, could not be adopted because DPW had failed to demonstrate the need for and reasonableness of the second sentence. The Hearing Examiner recommended several alternative amendments. The Commissioner accepts the third alternative recommendation and amends Section O.2. to read:

2. Ratios. For each ~~existing~~ programs, there shall be one living room or lounge area per living unit for ~~every~~ up to 25 residents. ~~For new programs there shall be one living room or lounge area for every 16 residents.~~

The Commissioner finds that the amendment does not constitute a substantial change to the Rule, is needed and reasonable and is consistent with DPW's determination that 25 beds per living unit or lounge area is appropriate to a "home-like" setting, and should apply to both current and new programs.

13. In Finding 54, the Hearing Examiner found that the education and experience requirements in Section P.6.c., P.7.b. and c., and P.8. cannot be adopted. The Hearing Examiner recommended that a) DPW allow "grandfathering" of persons currently serving in the positions identified in P.6., P.7., and P.8.; b) the experience requirements found at Sections P.6.c., P.7.b. and c., and P.8. be deleted; and c) the education requirements be maintained to affect future hirings. The Commissioner accepts the Hearing Examiner's recommendations, and accepts the accompanying rationale with modifications noted, and adopts amendments set forth below. Among the rule provisions rejected by the Hearing Examiner are P.7.c. and P.8.c. Both of those sections are sections which require supervision while on the job. Deletion of these sections is not supported by the rationale of the Hearing Examiner. However, the Commissioner accepts their deletion since they are duplicative of the supervision requirements which are contained in the definitions for mental health counselor and mental health worker in Sections B.14 and B.18, and in Sections P.9.b. and Q.8.b. of the rule.

Based on Finding 54 of the Hearing Examiner's Report, with modifications stated above, the Commissioner adopts the following amendments to Section P:

> P.6. Mental health therapist. If mental health therapy is provided within the mental health residential ~~treatment facility~~ program a mental health therapist shall be hired. Persons employed as mental health therapists prior to the effective date of 12 MCAR § 2.036 shall not be required to meet the qualifications of a. and b. Persons employed as mental health therapists after the effective date of 12 MCAR § 2.036 shall be required to meet the qualifications of a. and b. The mental health therapist shall be qualified in at least the following ways:
>
> a. A bachelor's degree ~~in one of the behavioral sciences or related fields;~~ and
>
> b. A master's degree in the behavioral sciences or related field or two years of advanced level, certificate training in mental health therapy~~; and~~.

~~c. One year of experience providing services to mentally ill persons.~~

7. Mental health counselors. If program services other than mental health therapy are provided within the mental health residential ~~treatment facility~~ program, they shall be provided by mental health counselors or mental health workers, or both. Persons employed as mental health counselors prior to the effective date of 12 MCAR § 2.036 shall not be required to meet any specific education requirements. Persons employed as mental health counselors after the effective date of 12 MCAR § 2.036 shall have at least an Associate of Arts degree in one of the behavioral sciences or a related field, or a registered nurse degree. ~~Mental health counselors shall meet the following qualifications:~~

~~a. A bachelor's degree in one of the behavioral sciences or related field;~~

~~b. A minimum of one year's experience working with mentally ill persons; and~~

~~c. Supervision by a mental health therapist or the program director.~~

8. Mental health workers. Persons employed as mental health workers after the effective date of 12 MCAR § 2.036 shall meet the qualifications as determined by the governing body to be consistent with those needed to meet the stated goals of the program. ~~Mental health workers shall qualify in one of the following ways:~~

~~a. One year of experience working with mentally ill persons;~~

~~b. One year as a resident of a mental health residental program with three months training relevant to the job responsibilities of a mental health worker; or~~

~~c. Three months of on-the-job training with continued supervision by at least a mental health counselor.~~

The Commissioner finds that these amendments are necessary and reasonable and that they are not substantial in nature. The Commissioner also specifically finds that the alternative requirement for the position of mental health counselor of a bachelor's degree must be deleted (although proposed by DPW in its Memorandum), in order to be consistent with the adopted Finding 54 of the Hearing Examiner, and the rationale stated herein. The Commissioner specifically finds that this change is not substantial and is a necessary and reasonable change.

14. In Finding 56, the Hearing Examiner recommended a change in Section Q, regarding qualifications for mental health therapist for Category II programs. The Commissioner accepts the recommendation and amends Section Q. by amending Q.7. to read:

> 7. Mental health <u>therapists</u>, counselors and workers. If program services are offered within the facility, they shall be provided by mental health <u>therapists</u>, <u>mental health</u> counselors or mental health workers~~, or both~~. The minimum qualifications for these positions shall be consistent with those of Category I specified in <u>P.6.,</u> P.7. and P.8.

The Commissioner finds that this amendment is necessary and reasonable, and does not constitute a substantial change. The Commissioner also finds that the phrase "mental health therapist" should be added to section Q.8.b. in order to be consistent with the changes recommended for Q.7. The Commissioner adopts such a change so that Q.8.b. shall now read, in relevant part:

> b. The number of work hours performed by the <u>mental health therapist,</u> mental health counselor and mental health worker . . . .

The Commissioner finds this change to be necessary and reasonable, and not substantial.

15. In Finding 56, the Hearing Examiner found that the experience requirements contained in Section Q.7. could not be adopted for the same reasons as set forth with respect to Sections P.6.c., P.7.b. and c. and P.8. at Hearing Examiner's Finding 54. The Commissioner accepts the recommended change, with the same modifications as set forth in Commissioner's Finding 13,

and further finds that no change is necessary to Section Q.7. since that section refers back to the relevant subsections of Section P. The Commissioner finds that because the subsections of Section P. have been amended, that Section Q.7., as it stands, is amended by implication. The Commissioner further finds specifically that this amendment by implication is necessary and reasonable and does not constitute a substantial change.

16. The Commissioner finds that in order to be consistent with Hearing Examiner Findings 54 and 56, as herein adopted, that the following changes to the second sentence of P.9.b. shall be adopted:

> When the work hours are combined, the facility shall have written documentation that ~~the~~ supervision ~~required by 7.e. and 8.e.~~ is provided.

The Commissioner finds that the deletions adopted are reasonable and necessary in light of the changes made to the subsections of Section P., and are not substantial changes.

17. The Commissioner finds that in order to be consistent with Hearing Examiner Findings 54 and 56, as herein adopted, that the following changes to the second sentence of Q.8.b. shall be adopted:

> When the work hours are combined, the facility shall have written documentation that ~~the~~ supervision ~~required by P.7.e. and P.8.e.~~ is provided.

The Commissioner finds that this change is necessary and reasonable in light of the amendments to the subsections of Section P., and is not a substantial change.

18. In Finding 53, the Hearing Examiner found that the reordering of Section P.5. to place it prior to Section P.4 was more logical, necessary and reasonable, and not a substantial change. The Commissioner finds that this reasoning also applies to Sections Q.5. and 6. and adopts such a change. The Commissioner finds that placing current Section Q.6. before Section Q.5. is necessary and reasonable, and is not a substantial change.

19. In Finding 43, the Hearing Examiner found the use of "his or her" in M.6. to be necessary and reasonable, and not to be a substantial change. This finding extends to the use of "his or her" at M.5. The Commissioner adopts this amendment at M.5.

20. The Commissioner finds that Hearing Examiner's Finding 18 regarding the use of "program" in place of "facility" also applies to P.4., P.6., P.7., P.9., Q.5. and Q.8., in which "program" is substituted for "facility" or "treatment facility". The Commissioner adopts these changes at those sections and finds them necessary and reasonable, and not substantial changes.

21. In Finding 38, the Hearing Examiner found that the substitution of the phrase "skills training" for the phrase "services" in section L.3. to be necessary and reasonable and not a substantial change. The Commissioner finds that a similar change is necessary at B.10. in order to be consistent with the change at section L.3. The Commissioner adopts the following change at B.10.:

> 10. Independent living ~~services~~ skills training. "Independent living ~~services~~" skills training" means . . . ."

The Commissioner finds this change to be necessary and reasonable and not a substantial change.

22. In Finding 55, the Hearing Examiner found that it was necessary and reasonable and not a substantial change to delete section P.9.c. The Commissioner finds that this deletion necessitates a change to section P.9., in order to be consistent. The Commissioner adopts the following change to sentence five of section P.9.:

> The requirements of b. ~~and~~-c represent full-time equivalencies and may be prorated based on licensed resident capacity.

The Commissioner finds this change to be necessary and reasonable, and not a substantial change.

23. The Commissioner specifically finds that the amendments to the Rule as originally published, as proposed at the public hearing, and as proposed in the Memorandum of DPW submitted after the hearing, but which are not specifically discussed in either the Report of the Hearing Examiner or this Order, are necessary and reasonable, are either clarifying or editorial in nature, or corrections of grammatical, spelling and clerical errors, and are further found not to constitute a substantial change from the rule as originally published in the State Register. The Commissioner hereby adopts these amendments, which are listed below and have been incorporated in the Rule attached as Exhibit B:

Section of the Rule	Discussed in Memorandum at Page
B.1.	p. 39
B.2.	p. 39
B.3.	p. 41
B.6.	p. 43
B.11.	p. 43
New B.14 (original 13)	p. 43
New B.16 (original 15)	p. 43
New B.18 (original 17)	p. 43
New B.23 (original 22)	p. 44
New B.27 (original 26)	p. 44
New B.28 (original 27)	p. 44
New B.29 (original 28)	p. 44
N.2.f.	p. 69

IT IS FURTHER ORDERED that this Rule identified as 12 MCAR § 2.036 -- In the Matter of the Proposed Adoption of the Department of Public Welfare Rule Governing the Licensure of Residential Facilities for Adult Mentally Ill Persons -- is adopted this ___ day of December, 1981, and after this day, Rule 36 shall read in its entirety as set forth in the attached Exhibit B, pursuant to the authority vested in me, and pursuant to Minn. Stat. Chapters 15 and 245.

Dated: December 23, 1981.

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE

Arth E Noot

ARTHUR E. NOOT
Commissioner

DA24
1/12/82

OFFICE OF THE REVISOR OF STATUTES
Disapproval of Form of Rules

__X__ The form of the attached rules is not approved. The revisor requests the changes described below before the rules will be approved.

See Attached

Steven C. Cross
Revisor of Statutes

Name: Lorna M. Breiter
Lorna M. Breiter

Title: Assistant Revisor

Phone: 296-2778

_____ The changes requested by the revisor are approved by the agency.

_____ The changes requested by the revisor are not approved by the agency

_____
Agency's Representative

_____ The attorney general agrees that the changes requested by the revisor are form changes, not substantive changes.

_____
Assistant Attorney General

Page 2, line 27, delete "citizen's" and insert "citizens'"

Page 3, line 31, after "services" insert an underlined comma

Page 4, line 16, after "worker" insert an underlined comma

Page 4, line 30, delete the comma after "realistically"

Page 6, line 13, after "organization" insert an underlined comma

Page 7, line 24, after "to" insert an underlined comma

Page 9, line 25, strike "8." and insert "9."

Page 9, line 35, after "C." insert an underlined comma

Page 10, line 24, strike "8." and insert "9."

Page 13, line 8, delete "Each employee" and insert "Employees"

Page 13, line 9, after "their" insert "own" and delete "file" and insert "files"

Page 13, line 11, delete "15.1698" and insert "15.1699"

Page 14, line 20, strike "10" and insert "11"

Page 14, line 23, after "resident" insert an underlined comma

Page 14, line 24, delete the comma before "if"

Page 16, line 25, delete ", and" and insert ". They"

Page 17, line 4, delete "their" and insert "the admittee's"

Page 17, line 34, after "staff" insert an underlined comma

Page 20, line 10, delete "less" and insert "fewer"

Page 25, line 10, after "counselors" insert an underlined comma

Page 26, line 3, after "counselor" insert an underlined comma

Always insert new material after stricken material.

AG copy shows changes from Rules as Proposed. (A) (B)

Department of Public Welfare

Adopted Rule Governing Residential Programs for Adult Mentally Ill Persons (12 MCAR S 2.036)

Rule as Adopted

12 MCAR S 2.036 Licensing of residential facilities for adult mentally ill persons.

A. Applicability.

1. Rule 12 MCAR S 2.036 applies to all providers offering residential care and ~~treatment~~ program services to five or more adult mentally ill persons at one time for more than 30 days in any 12-month period and is based, in part, on Minn. Stat. S 245.782, subds. 6 and 9. This rule applies to mental health residential ~~treatment facilities~~ programs which are Category I programs as defined in B.3. and semi-independent or supportive group living ~~facilities~~ programs which are Category II programs as defined in B.4. This rule applies to mental health residential programs for the adult mentally ill within state hospitals, and adult foster ~~care~~ homes ~~or safe houses~~ with five or more adult residents who are mentally ill. These entities must be licensed as either Category I or Category II ~~facilities~~.

2. Rule 12 MCAR S 2.036 does not apply to programs located within a licensed ~~private~~ hospital ~~which has a psychiatric or chemical dependency program located within the hospital or to a mental health residential program~~, except state institutions under the control of the commissioner; nor does it apply to programs located within a licensed nursing home.

B. Definitions. As used in 12 MCAR S 2.036, the following terms have the meanings given them.

1. Applicant. "Applicant" means an individual, organization, association, partnership, corporation or unit of a state institution which submits an application for licensure under 12 MCAR S 2.036 ~~to provide care and treatment for five or more adult mentally ill persons in a mental health residential program~~.

2. Case management services. "Case management services" means the arranging and coordinating of direct services for a resident with the involvement of the resident. These direct services include, but are not limited to: assuring a diagnosis ~~when needed~~, assessing the resident's strengths and weaknesses in order to determine the resident's needs, developing an individual treatment plan, and evaluating the plan's effectiveness.

3. Category I program. "Category I program" means a mental health residential program which provides ~~intensive treatment for persons who are mentally ill and~~ program services in which there is an emphasis on services being offered on a regular basis within the facility with the use of community resources being encouraged and practiced.

4. Category II program. "Category II program" means a mental health residential program which provides either a transitional semi-independent living arrangement or a supervised group supportive living arrangement for mentally ill persons. This type of program offers a combination of in-house and community resource services with emphasis on securing community resources for most daily programming and employment.

5. Commissioner. "Commissioner" means the Commissioner of the Department of Public Welfare or a duly authorized representative.

6. Community representative. "Community representative" means an individual who represents ~~a broad base of citizen interest~~ citizen's interests and who is neither an employee or board member, nor has any other official affiliation with the mental health residential program.

7. Crisis services. "Crisis services" means a set of activities designed to respond to medical, situational, and psychiatric emergencies.

8. Department. "Department" means the Department of Public Welfare.

9. Full-time. "Full-time" means work time equalling at least 37 1/2 hours per week.

10. Independent living ~~services~~ skills training. "Independent living ~~services~~ skills training" means services which both emphasize development of an individual's skills required to perform increasingly independent daily living functions and which are appropriate to the needs of the individual. FoF 21

11. Individual program plan. "Individual program plan" or "individual treatment plan" means a written plan of intervention and treatment developed on the basis of assessment results and ~~modified at frequent~~ revised, if necessary, at certain intervals. The plan specifies goals and objectives and a means for their accomplishment, and also identifies responsible staff persons. FoF 23

12. License. "License" has the meaning given it in Minn. Stat. S 245.782, subd. 11.

13. Living unit. "Living unit" means a set of rooms which are physically self-contained, which have the defining walls extending from floor to ceiling, and which include bedrooms, living rooms or ~~large~~ lounge areas, bathrooms and connecting areas. HE 48

~~13.~~ 14. Mental health counselor. "Mental health counselor" means an individual who, under the supervision of a mental health therapist or program director, provides treatment for mentally ill residents in a mental health residential program and who meets the requirements of P.7. The specific title of the individual employed in this position is at the discretion of the program as long as the title selection fairly reflects the responsibilities defined in 12 MCAR S 2.036 for a mental health counselor. FoF 23

~~14.~~ 15. Mental health residential program. "Mental health residential program" or "program" means a planned combination of living conditions, services and resources for the treatment and rehabilitation of five or more mentally ill adults on a 24-hour per day basis. HE 18, FoF 5.

~~15.~~ 16. Mental health therapist. "Mental health therapist" means an individual skilled in providing mental health therapy in a mental health residential program and who

meets the requirements of P.6. The specific title of the individual employed in this position is at the discretion of the program as long as the title selection fairly reflects the responsibilities defined in 12 MCAR S 2.036 for a mental health therapist. FofF 23

~~16.~~ 17. Mental health therapy. "Mental health therapy" means various treatment modalities which may reasonably be expected to improve the resident's condition.

~~17.~~ 18. Mental health worker. "Mental health worker" means an individual who, under the supervision of a mental health counselor, mental health therapist, or program director, provides care, support, or assistance to mentally ill residents in a mental health residential program and who meets the requirements of P.8. Possible job titles for this staff position are resident manager, human services technician, independent living skills worker and licensed practical nurse. The specific title of the individual employed in this position is at the discretion of the program as long as the title selection fairly reflects the responsibilities defined in 12 MCAR S 2.036 for a mental health worker. FofF 23

~~18.~~ 19. Mentally ill person. "Mentally ill person" means a person ~~with a functional, nonorganic, emotional disorder which has been diagnosed by a physician or a licensed consulting psychologist, and who has demonstrated by his or her behavior an inability to interpret realistically the environment, cope with independent daily living or form meaningful relationships~~ who has been diagnosed by a physician, a licensed psychologist, or a licensed consulting psychologist as having a condition which results in an inability to interpret the environment realistically, and in impaired functioning in primary aspects of daily living such as personal relations, living arrangements, work and recreation; or which is listed in the International Classification of Diseases (ICD-9-CM), code range 290, 293-302.9 or 306-314.9, or the corresponding code in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III), Axes I, II or III. HE 26

~~19.~~ 20. Motivation and remotivation services. "Motivation and remotivation services" means a set of activities which encourages the development of positive attitudes and self-concept, and which encourages the resident to develop goals and to use available community resources.

~~20.~~ 21. Program director. "Program director" means a person who is responsible for the development and implementation of the mental health residential program and who meets the requirements of ~~P. 4~~ P.5.

~~21.~~ 22. Provisional license. "Provisional license" has the meaning given it in Minn. Stat. S 245.782, subd. 12.

~~22.~~ 23. Recreation and leisure time services. "Recreation and leisure time services" means a set of activities designed both to meet a resident's personal and therapeutic needs of self-expression, social interaction, and entertainment, and to develop skills and interests that lead to enjoyable and satisfying use of leisure time. A ~~major~~ An objective of ~~these~~ these services is the integration of residents into the recreational mainstream of the community.

~~23.~~ 24. Restraint. "Restraint" means any physical device that limits the free and normal movement of body and limbs.

~~24.~~ 25. Seclusion. "Seclusion" means involuntary removal into a separate room which prevents social contact with other persons.

~~25.~~ 26. Socialization services. "Socialization services" means a set of activities in which residents learn interpersonal relationship and communication skills.

~~26.~~ 27. Social services. "Social services" ~~includes~~ may include psychosocial evaluation; counseling based on social work problem-solving methods; activities designed to assist residents in dealing with tasks of daily living; utilization of community resources; psychotherapy for individuals, families and groups; and education, planning, and advocacy for the social needs of residents.

~~27.~~ 28. Support group services. "Support group services" means a ~~forum~~ group process designed ~~for~~ to allow residents to

participate with other individuals in ~~a group process of~~ sharing feelings, experiences, and constructive feedback.

~~28.~~ 29. Vocational services. "Vocational services" means a set of activities emphasizing development of skills required to perform work functions in a competitive ~~or quasi-competitive~~ , semi-competitive or volunteer work setting. FofF 23

C. Licensing process.

1. License required. No mental health residential program shall operate in Minnesota unless it has a current and valid license or provisional license as required by Minn. Stat. SS 245.781-245.812.

2. Information furnished. Upon written request, each individual, organization or agency shall be furnished with a copy of 12 MCAR S 2.036 and other pertinent materials such as an application form and instructions for obtaining a license.

3. Application. Persons interested in obtaining licensure under 12 MCAR S 2.036 shall submit to the commissioner ~~a completed~~ an application on forms supplied by the department. The applicant shall either document compliance with all applicable building codes, fire and safety codes, health rules, zoning ordinances, and other applicable rules and regulations or submit documentation that appropriate variances have been granted. HE 22

4. Decision. The commissioner shall make a decision on licensure after completion of the following steps:

a. A review of the application;

b. A visit to the program site; and

c. Interviews with staff and a ~~random~~ sample of residents ~~and staff, in the case of existing facilities~~. HE 23

5. Fee. Each applicant shall pay to the commissioner a nonrefundable fee not to exceed $150 for the costs of processing the license application. Information regarding the specific amount and the timing of the payment shall be made available to the applicant.

6. Renewals. Application for renewal of a license shall be made on forms furnished by the department at least 30 days

prior to the date of expiration of the license.

D. License changes; report. Any changes in the following areas shall be reported in writing to the department at least 20 days prior to the change:

1. A change in licensed capacity;

2. The location of the program;

3. A change in program director;

4. A change in ownership; or

5. Major changes in programming. Major changes in programming include such areas as a change in the target population or shifting from the internal provision of services to the external provision of services through a purchase of service contract. Changes in programming which do not have to be reported include such changes as the addition of staff, reassignment of staff, and establishing new groups.

E. Program policy and procedures manual. Each mental health residential program shall develop a written policy and procedures manual. The manual shall contain all materials required by F.-M. The manual shall be available for inspection by the department.

F. Statement of purpose and policies. The manual shall contain a complete statement describing the mental health residential program's philosophy and goals. This statement shall include, but not be limited to a description of:

~~a.~~ 1. The geographical area to be served;

~~b.~~ 2. The ~~treatment~~ design and methodology of program services; and

~~c.~~ 3. The scope of services offered.

G. Program organization and administration.

1. Advisory committee. Each program shall have an advisory committee which provides for ~~reasonably broad~~ community representation and public participation in its operation. The advisory committee shall have a core group which comprises a quorum. The core group shall include at least one program resident, the facility's administrator, and a community representative. The advisory committee shall document the

procedure whereby residents are assured access to the advisory committee. The committee shall meet at least quarterly. Minutes of the meetings shall be recorded and kept on file at the facility. Each program shall provide to the department a list of names and titles of the members of the advisory committee who are members at the time of submitting an application or renewal of a license under 12 MCAR S 2.036.

2. Governing body. All programs shall have a governing body which is accountable for, and has authority over, the policies and activities of the program. In the case of a program owned by a proprietor or partnership, the proprietor or partners shall be regarded as the governing body for the purpose of this part. Each program shall provide to the department a list of names and titles of the members of its governing body.

3. Designated authority. A program operating within Minnesota with headquarters outside of the state shall have a duly authorized representative with decision-making responsibility designated within this state.

H. Required documentation and reports.

1. Insurance coverage. Each program shall have written documentation of insurance coverage in an amount sufficient to protect the interests of residents and staff. Each program must document the specific types and amounts of coverage and the carrier or carriers.

2. Bonding. Each program shall have written documentation that all employees are bonded or otherwise appropriately insured if they have access to or responsibility for handling money.

3. Financial information. Each program shall make available to the commissioner an annual fee schedule. A new program shall document in writing ~~assurance~~ a plan of funding sufficient to meet total projected program costs for a period of at least one year in addition to start-up costs.

4. Maintenance. Each program shall document that the maintenance and upkeep of the facility is being done by staff hired by the program or through a written working agreement with

an outside person or firm.

5. Non-discrimination policy. Each program shall have a written policy which requires that no resident be discriminated against in admission, termination, or ~~treatment~~ the provision of program services on the basis of race, creed, color, national origin, ~~relation~~ religion, physical handicap, sexual preference, public assistance status or marital status.

6. Each applicant shall document compliance with provisions of Minn. Stat. S 626.557.

~~6.~~ 7. Accident reports. Each program shall have a written policy regarding accidents and missing persons. Each program shall maintain in central files at the facility reports regarding accidents or missing persons if the reports pertain to facility residents.

~~7.~~ 8. Annual comprehensive report. Each program shall give a comprehensive annual report to its governing body ~~and~~ , its advisory committee and to the host county. The report shall also be available to the commissioner. The report shall include documentation in at least the following areas:

a. A current organizational chart listing the number of full-time equivalent positions in each ~~category~~ job class;

b. Training, staff development, and continuing education activities of staff;

c. Administrative policy and procedure changes;

d. Program evaluation as required in 8.; and

e. A financial report.

~~8.~~ 9. Program evaluation.

a. Process required. Each program shall institute an evaluation process to be conducted on an ongoing basis. ~~An annual report of this evaluation shall be submitted to the program's governing body and advisory committee and to the host county.~~ The evaluation process shall be outcome-based and consistent with the emphasis of 12 MCAR S 2.036 on individual treatment planning. In a format developed by the commissioner, the data and documentation required by b., c. and d. shall be submitted to the commissioner on an annual, aggregate basis for

state-wide summaries and for planning the use of state resources.

b. General data. Each program shall systematically collect data that includes, but need not be limited to: resident demographic data, program service data, and data on concurrent services. Each program shall submit the data to the host county for combination with follow-up data collected by county case workers. ~~In a format developed by the commissioner, the data shall be submitted by each program to the commissioner on an annual, aggregate basis for statewide summaries and for planning the use of state resources.~~

c. Individual data. Each program shall also, for the purpose of examining the program's impact, assess the progress of each resident relative to the resident's individual treatment plan. Progress shall be assessed by rating each resident within 30 days of admission and thereafter at the time of quarterly review on uniform level of functioning scales determined by the commissioner.

d. County technical assistance. Each program shall collaborate with available county technical assistance staff to examine the evaluation results, to assess the overall progress of residents in the program, and to ~~demonstrate~~ document how the results are used in administrative and program development.

e. Data restrictions. Each program shall collect the statistical data described in 8. for the purpose of program evaluation. The categories of data shall be compatible with the evaluation requirement of the Community Social Services Act, Minn. Stat. ch. 256E, and shall not require duplicate data collection. Dissemination shall be in accordance with provisions of the Minnesota Government Data Practices Act, Minn. Stat. SS 15.1611-15.1699, and all applicable federal rules or laws.

I. Personnel policies and procedures.

1. General requirements. Each program shall have a written personnel policy and shall make a copy of it available to each employee upon employment and to the department for review. Personnel policies shall be carried out in accordance

with affirmative action policies and equal employment opportunity regulations.

2. Job description. The personnel policy shall contain job descriptions for each position specifying responsibilities, degree of authority to execute job responsibilities, standards of job performance, and qualifications.

3. Job evaluation. The personnel policy shall provide for job performance evaluations conducted on a regular and ongoing basis with a written annual review. As part of the annual performance review, each staff member shall have a growth and development plan. Each program shall develop a policy and establish procedures for resident input into staff evaluations.

4. Conditions of employment. The personnel policy shall describe the employees' conditions of employment, including their benefits, hours of work, methods of promotion, and the general conditions which constitute grounds for dismissal and suspension~~, and the ways in which staff stress will be recognized and addressed~~.

HE 30

5. Organizational chart. The personnel policy shall also include a chart or definition of organizational structure indicating lines of authority.

6. Grievance procedure. The personnel policy shall describe a grievance procedure for use by staff. This procedure shall allow the aggrieved party to bring the grievance to the highest level of authority in the operation of the facility. A list of other community resources, such as the Health Facilities Complaint Office in the Department of Health, the Licensing Division in the Department of Public Welfare, and the Department of Human Rights, shall be made available to staff by the facility.

7. Personnel data. Program employee personnel data shall be accessible to the department.

8. Staff orientation. The personnel policy shall include a program of orientation for all new staff and the orientation shall be based on a written plan. At a minimum, the plan of orientation shall provide for training related to the specific

job functions for which the employee was hired, facility policies and procedures, and the needs of mentally ill persons.

9. Staff training. The program shall have a staff development plan, including ~~in-service or outside training~~ continuing education opportunities. The plan shall be ~~developed~~ reviewed annually. The plan shall be relevant to the facility's program and resident population. There shall be at least 15 hours of ~~in-service training, or training through community resources, or both,~~ continuing education annually for each staff person working directly with mentally ill persons. The training shall include, but need not be limited to, the following areas:

a. ~~Red Cross certified~~ First-aid training ~~or equivalent, to be updated at least every three years~~;

b. Crisis intervention training for psychiatric emergencies;

c. Problems and needs of mentally ill persons and their families;

d. Community resources locally available to mentally ill adults;

e. Psychotropic medications and their side effects;

f. Resident rights;

g. Cultural awareness training;

h. Rules governing the operation of residential facilities for adult mentally ill persons; ~~and~~

i. Staff stress or burnout; and

~~i.~~ j. Other topics, such as case management, individualized goal planning, chemical use and abuse, health and nutrition, and services for multiple disability residents.

10. Training for non-direct care staff. Personnel of the program not referenced in this rule shall receive continuing education as appropriate to their role and function within the program.

J. Personnel files.

1. Central training file. The orientation and ~~in-service and training through community resources~~ continuing education required by I. shall be documented by each program in a central

training file. The file shall be available to the department for review. Documentation shall include, but need not be limited to: the date, the subject, the name of the person who conducted the training, the names of staff attending, and the number of hours attended.

2. Individual files. Each program shall maintain a separate personnel file for each employee. The files shall be available to the department for review. Each employee shall be able to review their personnel file, subject to the provisions of the Minnesota Government Data Practices Act, Minn. Stat. SS 15.1611-15.1698. At a minimum, each file shall contain the following:

a. An application for employment or a resume;

b. Verification of employee's credentials;

c. An annual job performance evaluation;

d. An annual growth and development plan;

e. Documentation of orientation; and

f. A record of training and education activities during employment.

K. Admission, discharge, and transfer policies.

1. Admission criteria. Each program shall develop admission criteria delineating the types and characteristics of persons who can and cannot be served by the program. Intake policies and procedures shall be developed including the role ~~and responsibility~~ of community resources.

2. Discharge and transfer policies. Each program shall develop detailed discharge and transfer policies and procedures. The policies and procedures shall include:

a. A planned discharge or transfer conference with the resident, staff representatives, and others requested by the resident if possible;

b. Identification of community resources which directly relate to the continuing needs of the resident;

c. A description of the process by which a discharged or transferred resident would or would not have access to the staff and other residents in order to facilitate readjustment in

the community.

L. Program services. The following services shall be offered either ~~within~~ by the ~~facility~~ program or through a ~~contract~~ working agreement with other community resources:

~~a.~~ 1. Case management services;

~~b.~~ 2. Crisis services;

~~c.~~ 3. Independent living ~~services~~ skills training;

~~d.~~ 4. Mental health therapy;

~~e.~~ 5. Motivation and remotivation services;

~~f.~~ 6. Recreation and leisure time services;

~~g.~~ 7. Socialization services;

~~h.~~ 8. Support group services;

~~i.~~ 9. Social services;

~~j.~~ 10. Vocational services; and

~~k.~~ 11. Other services if their need is indicated by the resident assessment.

M. Policies and procedures guaranteeing resident rights.

1. Explanation of rights. A written statement of residents' rights and responsibilities shall be developed encompassing 2.-10. Program staff shall explain to each resident the resident's rights and responsibilities. A written statement of residents' rights and responsibilities shall be given to each resident and to his or her responsible party ~~within 30 days of~~ , if the resident has a legal guardian, on admission. A list of residents' rights and responsibilities shall be posted in a place accessible to the residents and shall be available to the department for review.

2. Grievance procedure. ~~Within 30 days of~~ Upon admission each resident shall be informed of grievance procedures available to the resident, and a copy of the procedures shall be posted in a place accessible to the resident. The grievance procedures shall include the following:

a. An offer of assistance by the ~~facility~~ program staff in development and process of the grievance; and

b. A list of internal resources for use by the resident, such as the resident council or a grievance committee,

and a list of community resources available to the resident, such as the health facilities complaint office in the Department of Health, the Licensing Division in the Department of Public Welfare, and the Department of Human Rights.

3. Resident council. Each program shall have a resident council through which residents have an opportunity to express their feelings and thoughts about the program and to affect policies and procedures of the program. Minutes of council meetings shall be recorded and made available to the program director.

4. Personal funds policy. ~~If~~ Staff ~~supervises~~ will not supervise the use of residents' personal funds or property, unless policies governing the supervision ~~shall be~~ have been written~~.~~ and unless the resident ~~shall sign~~ has signed a consent form prior to the exercise of supervision indicating an awareness of and consent to procedures governing the program's use of the resident's personal funds. In order to encourage independent living skills, any restriction of a resident's personal funds must be documented in the individual treatment plan. Resident fund accounts shall be maintained separately from program fund accounts.

HE 41

5. Resident compensation. A resident who performs labor ~~which contributes to the operation and maintenance of the facility for which the facility would otherwise employ someone~~ other than labor of a housekeeping nature shall be compensated appropriately and in compliance with applicable state and federal labor laws, including minimum wage and minimum wage reduction provisions. ~~This provision shall not apply to labor of a personal housekeeping nature, nor to labor performed as a condition of residence in a small group living arrangement~~ Labor of a housekeeping nature shall be limited to household chores which a person living in his or her own residence in the community would normally perform.

HE 42

6. Physician appointments. A resident shall be allowed to see ~~a private~~ his or her physician at any reasonable time.

HE 43

7. Photographs of residents. ~~Photographs may be taken~~

~~and used for personal or social purposes unless the resident has indicated his or her objection. Photographs may be taken for informational purposes only upon written consent of the resident~~ A resident shall not have his or her photograph taken for any purpose beyond identification unless he or she consents. HE 44 + F&F 11

8. Telephone use. Residents shall have access within the facility to a telephone for incoming, local outgoing, and emergency calls. They shall have access within the facility to a pay phone or its equivalent for outgoing long distance calls. Any restriction on resident access to telephones shall be documented in the individual treatment plan. HE 45 HE 45

9. Mail. Residents shall be allowed to receive and send uncensored mail. Any restrictions shall be documented in the individual treatment plan.

10. Restraints. The facility shall have a written policy that defines the uses of restraint, seclusion, and crisis medications as a treatment mode; the staff members who may authorize its use; and a mechanism for monitoring and controlling its use. Physical restraint and seclusion shall be used only when absolutely necessary to protect the resident from injury to himself or to others. Restraint, seclusion, and medications shall not be used as punishment, for the convenience of staff, or as a substitute for a program.

11. Visitors. Residents shall be allowed to receive visitors at reasonable times, and shall be allowed to receive visits at any time from their personal physician, religious advisor, and attorney. The right to receive visitors other than those specified above may be subject to reasonable written visiting rules and hours established by the head of the facility for all residents. The head of the facility may impose limitations on visits to an individual resident only if he or she finds the limitations are necessary for the medical welfare of the resident and if the limitation and reasons are fully documented in the resident's individual treatment plan. HE 46

N. Resident records.

1. Individual program plan development. ~~Each~~ The mental

health residential program staff shall ~~develop and complete a written individual program plan for each resident~~ , within ten days after admission, write short-term goals with each resident in order to address their immediate needs. The program staff shall, within 30 days of admission, write an individual program plan which contains the components specified in 2. Medical, social, psychological, and psychiatric histories of the resident shall be used in the development of the plan. The plan shall be developed by an interdisciplinary team including the resident, the program staff, a representative of the referring agency and other appropriate resources, such as family, concerned others, and health care providers requested by the resident. Each resident shall be actively involved in developing his or her plan, unless contraindicated. The persons involved in the development of the individual program plan shall be noted on the plan. The extent of the resident's participation in developing the program plan shall also be noted on the plan. The plan and documentation related to it shall be kept in the facility where the mental health program is located.

HE 47

2. Plan contents. An individual program plan shall contain at least the following components:

a. An assessment, including a strength and need list, of the resident in at least the following areas of life: social, medical, legal, family, leisure and recreation, spiritual or religious, psychological, financial, vocational and educational;

b. The specific problems to be resolved;

c. A list of goals in order of priority;

d. Specific, measurable, and time-limited objectives which relate directly to the goals;

e. Specific methods, strategies, and resources, including medications, to be used by the staff in assisting the resident to accomplish the goals and objectives;

f. The ~~agency~~ names of community resource personnel, program staff or other persons designated to assist the resident in implementing the various components of the plan; and

g. Notes indicating progress in achieving the goals

and objectives.

3. Progress report. A quarterly review of the resident's response to the individual treatment plan and his or her involvement in the facility's overall program shall be written. Copies of this report shall be given to the resident and shall be sent to the representative of the referring agency and other persons deemed appropriate by the program director and resident. The resident's level of participation in the development and the review of the report shall be documented. The report shall be kept at the facility.

4. Discharge or transfer summary. A discharge or transfer summary shall be written for each person transferred or discharged. The summary shall include at least the following information:

a. A brief review of the resident's problems, strengths and needs while a resident of the program;

b. The response of the resident to his or her individual treatment plan and to the facility's overall program;

c. An aftercare plan which identifies the persons, including at least the resident, a program staff member, and a representative of the referring agency, who participated in the development of the aftercare plan; goals and objectives for the first three months after discharge or transfer; and individuals or agencies who will be working with the resident after discharge or transfer; and

d. A forwarding address and telephone number for follow-up contacts.

5. Accidents and missing persons. A copy of any report regarding accidents and missing persons must be documented in the individual's resident record if the resident is involved in the report.

6. Release of information. Private data regarding a resident shall not be used or released by the facility to any person or agency, except pursuant to the Minnesota Government Data Practices Act. The facility shall use written consent forms for any release of resident information or data. add cite

O. Living unit requirements.

1. ~~Structure. Each living unit of a mental health residential program shall be physically self-contained and shall include bedrooms, living rooms or lounge areas, bathrooms and connecting areas. Walls defining the living unit shall extend from floor to ceiling. These units shall be patterned after a home-like atmosphere, and~~ Furnishings. Each living unit shall include furnishings appropriate to the psychological, emotional, and developmental needs of each resident.

2. Ratios. For ~~existing programs~~ each program, there shall be one living room or lounge area per living unit for ~~every~~ up to 25 residents. ~~For new programs there shall be one living room or lounge area for every 16 residents.~~

3. Program space. There shall be space available for program services as indicated in the individual treatment plans such as an area for learning recreation and leisure time skills, and an area for learning independent living skills, such as laundering and cooking.

4. Gender of residents. The unit or complex of units shall house both male and female residents insofar as this conforms to prevailing cultural norms, unless contraindicated by the facility's overall program plan. The unit shall provide for appropriate separation of male and female residents.

5. Privacy. The living unit shall allow for individual privacy and group socialization. Each resident shall have the opportunity for privacy during assessment, interviews, counseling sessions and visitations.

6. Storage space. Each facility shall provide to each resident storage space for clothing and other personal property, including a secure place for valuables. Each facility may exclude particular kinds of personal property from the facility for reasons of space limitations or safety. Any exclusions shall be documented and included in the policies and procedures manual of the facility.

P. Additional requirements for Category I programs. In addition to the requirements of A.-O., Category I programs shall

meet the requirements of 1.-9.

1. Capacity. ~~Facilities, or treatment units within facilities existing as of July 1, 1980, not exceeding a maximum capacity of 40 beds shall be permitted. Facilities or units having over 40 beds shall have a three year period from the effective date of 12 MCAR S 2.036 to reduce the capacity to 40 beds or less~~ Applicants with facilities existing as of July 1, 1980, with a capacity exceeding 25 beds, shall have a three-year grace period from the effective date of 12 MCAR S 2.036 to reduce capacity to 40 beds or less, or to divide the facility into living units which do not exceed 25 beds. Applicants with facilities existing as of July 1, 1980, with a capacity exceeding 25 beds per living unit, shall not increase the total capacity of the facility. New facilities shall not exceed a maximum capacity of 25 beds. HE 50

2. Department of Health licensing standards. ~~Each program~~ The facility shall be licensed ~~either~~ as a supervised living facility ~~or as~~, a boarding care ~~facility~~ home, or a hospital. HE 51

3. Intake information. Each facility shall maintain in the facility documentation that:

a. A prospective resident has been diagnosed as being mentally ill and requires treatment;

b. The diagnoses are based on medical, social, psychological, and psychiatric information; and

c. Medical, social, psychological and psychiatric histories were obtained for each resident.

~~5.~~ 4. Administrator. An individual shall be designated as administrator of the mental health residential program. The administrator shall be responsible for continuous overall operation, including maintenance and upkeep of the facility. In the administrator's absence, a staff member who is familiar with operations of the organization shall be designated to assume the responsibilities of the administrator. An individual who is functioning as administrator but not as program director shall meet qualifications determined by the governing body which are HE 53

consistent with the training and education needed to meet the stated goals of the ~~facility~~ program. FOF 20

~~4.~~ 5. HE 53 Program director. An individual shall be designated as the program director. The positions of program director and administrator may be filled by the same person. This individual shall meet at least the following qualifications: HE 53

a. A master's degree in the behavioral sciences or related field with at least two years of work experience providing services to mentally ill persons, or a bachelor's degree in the behavioral sciences or related field with a minimum of four years of work experience providing services to mentally ill persons; and

b. One year of experience or training in administration or supervision.

6. Mental health therapist. If mental health therapy is provided within the mental health residential ~~treatment facility~~ program, a mental health therapist shall be hired. Persons employed as mental health therapists prior to the effective date of 12 MCAR S 2.036 shall not be required to meet the qualifications of a. and b. Persons employed as mental health therapists after the effective date of 12 MCAR S 2.036 shall be required to meet the qualifications of a. and b. The mental health therapist shall be qualified in at least the following ways:

a. A bachelor's degree ~~in one of the behavioral sciences or related field~~; and HE 53

b. A master's degree in the behavioral sciences or related field or two years of advanced level, certificate training in mental health therapy~~; and~~.

~~c. One year of experience providing services to mentally ill persons.~~

7. Mental health counselors. If program services other than mental health therapy are provided within the mental health residential ~~treatment facility~~ program, they shall be provided by mental health counselors or mental health workers, or both. FOF 20

~~Mental health counselors shall meet the following~~

HE 54 FOF

~~qualifications.~~ Persons employed as mental health counselors prior to the effective date of 12 MCAR S 2.036 shall not be required to meet any specific education requirements. Persons employed as mental health counselors after the effective date of 12 MCAR S 2.036 shall have at least an Associate of Arts degree in one of the behavioral sciences or a related field or a registered nurse degree.

~~a. A bachelor's degree in one of the behavioral sciences or related field;~~

~~b. A minimum of one year's experience working with mentally ill persons; and~~

~~c. Supervision by a mental health therapist or the program director.~~

HE 54
F&F 13

8. Mental health workers. ~~Mental health workers shall qualify in one of the following ways:~~ Persons employed as mental health workers after the effective date of 12 MCAR S 2.036 shall meet the qualifications as determined by the governing body to be consistent with those needed to meet the stated goals of the program.

~~a. One year of experience working with mentally ill persons;~~

~~b. One year as a resident of a mental health residential program with three months' training relevant to the job responsibilities of a mental health worker; or~~

~~c. Three months of on-the-job training with continued supervision by at least a mental health counselor.~~

9. Staffing ratios. The ~~facility~~ program shall have sufficient staff to provide the required program services and implement the individual program plans. Staffing patterns shall be developed to ensure 24-hour coverage within the mental health residential ~~treatment facility~~ program and to reflect the need for more staff per number of residents during hours of concentrated programming. The hours of the day devoted to ~~active treatment~~ concentrated programming shall be identified. The following minimum staff-to-resident ratios shall be maintained. The requirements of b. ~~and c.~~ represent full-time equivalencies and

F&F 20

HE 55

F&F 22

may be prorated based on licensed resident capacity.

a. The number of work hours performed by the program director shall be prorated based on resident capacity with a ratio of ~~1 to 40 (1:40 F.T.).~~ ~~No more than one program director per program is required~~ 40 hours per week to 40 residents. With this ratio, applicants shall be allowed to use one program director to direct more than one program and shall be allowed to use one full-time program director for programs with less than a 40-bed resident capacity. With this ratio, applicants shall not be required to have more than one full-time program director for programs with more than a 40-bed resident capacity. ~~However, applicants~~ or programs with more than a 40-bed capacity shall describe whatever additional assistance they intend to provide for the program director function. HE 55

b. The number of work hours performed by the mental health therapist and mental health counselor and mental health worker may be combined in different ways, depending on program needs, to achieve a ratio of one full-time equivalent position for each five residents (1:5 F.T.E., averaged weekly). HE 55 When the work hours are combined, the facility shall have written documentation that ~~the~~ supervision ~~required by 7.e. and 8.e.~~ FOF 16 is provided.

~~e. The program shall have one quarter-time equivalent in-service training coordinator for each forty residents (1/4:40 F.T.E.). The number of work hours performed by this individual may be combined with those of another program staff position.~~ HE 55

Q. Additional requirements for Category II programs. In addition to the requirements of A.-O., Category II programs shall meet the requirements of 1. to 8.

1. Capacity. Facilities existing as of July 1, 1980, with a capacity exceeding 25 beds shall have a three-year period from the effective date of 12 MCAR S 2.036 to divide the facility into living units which do not exceed 25 beds. Facilities existing as of July 1, 1980, with a capacity exceeding 25 beds per living unit shall not increase the total capacity of the facility. New facilities shall not exceed a

maximum capacity of 25 beds.

2. Department of Health licensing standards. ~~Each program~~ The facility shall have a board and lodging license from the Minnesota Department of Health or its equivalent from a local health department or a health care license. HE 56

3. Intake information. Each facility shall maintain in the facility documentation that:

a. A mental health assessment or reassessment has been completed to determine appropriateness of admission; and

b. Medical, social, psychological and psychiatric histories were obtained for each resident.

4. Medical information. Each program with a board and lodging license shall require that a physical exam be done 30 days prior to admission or within three days following admission. Each resident shall have an annual physical and dental examination. Records shall be kept of annual medical and dental examinations, including records on all prescription medications the resident is taking. Records shall also be maintained regarding the general medical condition of the resident, including any disabilities and limitations. HE 56

~~6.~~ 5. FoF 18 Administrator. An individual shall be designated as administrator of the mental health residential program. The administrator shall be responsible for continuous overall operation, including maintenance and upkeep of the facility. In the administrator's absence, a staff member who is familiar with operations of the organization shall be designated to assume the responsibilities of the administrator. An individual who is functioning as administrator but not as program director shall meet qualifications determined by the governing body which are consistent with the training and education needed to meet the stated goals of the ~~facility~~ program. FoF 20

~~5.~~ 6. FoF 18 Program director. An individual shall be designated as the program director. The positions of program director and administrator may be filled by the same person. This individual shall meet at least the following qualifications:

a. A master's degree in the behavioral sciences or

related field and at least one year of work experience providing services to mentally ill persons, or a bachelor's degree in behavioral sciences or related field with a minimum of two years' work experience providing services to mentally ill persons; and

b. One year of experience or training in administration or supervision.

HE 56 FofF 14

7. Mental health therapists, counselors and workers. If program services are offered within the facility, they shall be provided by mental health therapists, mental health counselors or mental health workers~~, or both~~. The minimum qualifications for these positions shall be consistent with those of Category I specified in P.6., P.7. and P.8.

HE 56, FofF 14

8. Staffing ratios. The facility shall have sufficient staff to provide the required program services and implement the individual program plans. Staffing patterns shall be developed to ensure 24-hour coverage within the mental health residential ~~treatment facility~~ program and to reflect the need for more staff per number of residents during hours of concentrated programming. The hours of the day devoted to ~~treatment~~ concentrated programming shall be identified. The following minimum staff-to-resident ratios shall be maintained. The requirement of b. represents a full-time equivalency and may be prorated based on licensed resident capacity.

FofF 20

HE 56

a. The number of work hours performed by the program director shall be prorated based on resident capacity with the ratio of ~~1 to 40 (1:40 F.T.). No more than one program director per program is required~~ 40 hours per week to 40 residents. With this ratio, applicants shall be allowed to use one program director to direct more than one program and shall be allowed to use one full-time program director for programs with less than a 40-bed resident capacity. With this ratio, applicants shall not be required to have more than one full-time program director for programs with more than a 40-bed resident capacity. However, applicants with more than a 40-bed capacity shall describe whatever additional assistance they intend to provide for the program

HE 56

director function.

b. The number of work hours performed by the mental health counselor and mental health worker may be combined to achieve a ratio of one full-time equivalent staff position for each ten residents (1:10 F.T.E., averaged weekly). When the work hours are combined, the facility shall have written documentation that ~~the~~ supervision ~~required by P. 7. e.~~ and ~~P. 8. e.~~ is provided.

R. Variances. A residential program may request in writing a variance of a specific provision of 12 MCAR S 2.036. The request for a variance must cite the specification of the rule in question; reasons for requesting the variance; the period of time, not to exceed one year, the licensee wishes to have the provision varied; and the equivalent measures planned for assuring that programmatic needs of residents are met. Variances granted by the commissioner shall specify in writing the time limitation and required equivalent measures to be taken to assure that programmatic needs are met. Variances denied by the commissioner shall specify in writing the reasons for the denial of variances. No variance shall be granted that would threaten the health, safety, or rights of residents.

S. Appeals. Revocation, suspension or denial of a license may be appealed pursuant to Minn. Stat. ch. 15.

Repealer. 12 MCAR S 2.036 which was effective February 4, 1974, is repealed.

DPW-82-004-RL

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE DEPARTMENT OF PUBLIC WELFARE

In the Matter of the Proposed Adoption of the Department of Public Welfare Rule Governing the Licensure of Residential Facilities for Adult Mentally Ill Persons, 12 MCAR S 2.036.

WHEREAS, a hearing was held on October 1, 1981 before Richard C. Luis, a Hearing Examiner of the State Office of Administrative Hearings, on the above-entitled matter in compliance with Minn. Stat. § 15.0412, subd. 4; and

WHEREAS, the Report of Hearing Examiner made pursuant to Minn. Stat. § 15.052, subd. 3, was issued to the Department of Public Welfare and;

WHEREAS, the Department of Public Welfasre has now determined to adopt rules pursuant to Minn. Stat. § 15.0412, subd. 4-4f; and

WHEREAS, the Department of Public Welfare has submitted said rules to the Chief Hearing Examiner for review pursuant to Minn. Stat. §§ 15.0412, subd. 4e and 15.052, subd. 4, and 9 MCAR § 2.111; and

WHEREAS, the Chief Hearing Examiner finds that the final proposed rules are not substantially different from those proposed at the public hearing and that the Department of Public Welfare has cured the defects in the rule as required.

NOW, THEREFORE, upon receipt of this Order, the Department of Public Welfare has the responsibility of submitting the complete hearing record and the rules as adopted by the Department of Public Welfare to the Attorney General and to publish in the State Register, all pursuant to Minn. Stat. § 15.0412, subd. 4e and 4f.

Dated this 31st day of December, 1981.

Duane R. Harves

DUANE R. HARVES
Chief Hearing Examiner

STATE OF MINNESOTA

COUNTY OF RAMSEY

ARTHUR E. NOOT, COMMISSIONER

DEPARTMENT OF PUBLIC WELFARE

In the Matter of the Proposed Adoption of the Department of Public Welfare Rule Governing the Licensure of Residential Facilities for Adult Mentally Ill Persons (12 MCAR 2.036)

ORDER ADOPTING RULE

Findings of Fact

The above-entitled matter came before Hearing Examiner Richard C. Luis, on October 1, 1981, beginning at 9:00 a.m. in Room 83 of the State Office Building, St. Paul, Minnesota. The Department of Public Welfare (DPW) served proper notice as required by Minn. Stat. § 15.0412, subd. 4 (Supp. 1981), upon all persons, associations and other interested groups registered with the Secretary of State for that purpose.

At said hearing, the proposed rule as published in 4 State Register 252-262, on Monday, August 31, 1981, was considered. Ellen C. Dubuque, Special Assistant Attorney General, appeared as counsel for DPW, and the following persons appeared to testify on behalf of DPW: Jay Bambery, Assistant Director, Mental Illness Program Division; Terry Sarazin, Director, Mental Illness Program Division; John Sauer, Mental Health Program Consultant, Mental Illness Program Division; John Buzzell, Director, Licensing Division; Thomas Eberhart, Director, Management Support Division; Steven Barta, Program Education Specialist, Policy Analysis Office; Roland Peek, Director, Client Protection Office; and John Zakelj, Welfare Specialist, Management Support Division. DPW also called the following persons as witnesses: Representative John Brandl, co-author of the Rule 36 appropriation legislation; Bill Conley, Director of Public Affairs, Minnesota Mental Health Association; Tish Halloran, Director, Mental Health Programs, Hennepin County Community Services; Mila Hundly, Treatment Director, Sharing Life in the Community; Harriet Grinstead, Executive Director, Hope Transition Center; Bob Ryan, Administrator, Guild Hall; Marge Wherley, Residential Program Consultant, Hennepin County Mental Health Services; and Terry Ford, student at Inver Hills Community College and former mental health "consumer". The hearing continued until all interested groups and persons had an opportunity to be heard. Pursuant to order of the Hearing Examiner, the record was held open for twenty (20) days for the submission of written comments and statements.

Based upon all the records and proceedings, the Hearing Examiner issued a Report on December 15, 1981, which included Findings of Fact, Conclusions and a Memorandum. This report is attached as Exhibit A.

Pursuant to the requirements of Minn. Stat. § 15.0412, subd. 4d (Supp. 1981), this Report was available to all affected parties for at least five (5) days.

Having considered all of the evidence adduced and upon the records, files and proceedings herein, the applicable statutory standards and criteria, and having confirmed the need for the adoption of the above-captioned Rule and the reasonableness thereof,

NOW, THEREFORE, IT IS ORDERED that the Findings, Conclusions and Recommendations of the Hearing Examiner as contained in the Report of the Hearing Examiner, with exceptions or modifications as noted below, are hereby adopted and incorporated herein. In addition, in accordance with the Recommendations of the Hearing Examiner, the Commissioner makes the following additional:

FINDINGS OF FACT

1. In Finding 13, the Hearing Examiner recommended a change to conform with a statutory definition. The Commissioner accepts the recommendation and amends section A.1. to read "adult foster homes" deleting the word "care" from that phrase. The Commissioner finds that this amendment is necessary and reasonable and constitutes a clarification, not a substantial change.

2. In Finding 16, the Hearing Examiner recommended that the word "rule" at the beginning of subsections A.1. and A.2 be deleted. The Commissioner rejects the recommendation and retains the word "rule" on advice from the Revisor's office that for form only, when a sentence begins with a citation to an administrative rule, that the word "rule" precede the citation.

3. In Finding 18, the Hearing Examiner recommended that the Department, at its option, could include definitions of "residential facility", "regularly", and "on a regular basis" in the rule in the definition section. The Commissioner does not exercise the option, and adopts the language as originally proposed, and specifically finds that such language as originally proposed, is necessary and reasonable for ease in reading and understanding the rule.

4. In Finding 18, the Hearing Examiner recommended a change to conform with definitions in Sections B.3 and B.4. The Commissioner accepts the recommendation and amends Section A.1 by amending the last sentence to delete the word "facilities." The last sentence shall read "these entities must be licensed as either Category I or Category II." The Commissioner finds this amendment to be a necessary and reasonable clarification and not a substantial change, and adopts the rationale in Hearing Examiner Finding No. 18.

5. In Finding 18, the Hearing Examiner recommended that the word "programs" as used throughout the Rule be defined in Section B for the purpose of clarifying the entire Rule. The Commissioner accepts the recommendation and amends Section B.15 to read as follows:

> 15. Mental health residential program, and programs. "Mental health residential program" and "programs" mean a planned combination of living conditions, services and resources for the treatment and rehabilitation of five or more mentally ill adults on a 24-hour per day basis.

p.3

The Commissioner finds that the amendment of this definition is necessary and reasonable, and not a substantial change since the addition is merely clarifying.

6. In Finding 29, the Hearing Examiner recommends a change in Section H to delete an incorrect reference to a statute. The Commissioner accepts the recommendation and amends Section H.6. to read as follows:

> 6. Each applicant shall document compliance with provisions of ~~the Vulnerable Adults Act,~~ Minn. Stat. § 626.557.

p.9

The Commissioner finds that the deletion of the above language is necessary and reasonable since the reference is to a title which is not part of the statute.

7. In Finding 32, the Hearing Examiner recommended a change in Section I. The Commissioner accepts the recommendation and amends Section I. by adding a subsection 10. to read as follows:

> 10. Training of non-direct care staff. Personnel of the program not referenced in this rule shall receive continuing education as appropriate to their role and function within the program.

p.12

The Commissioner finds that including this provision in the Rule is not a substantial change. Such a change is necessary and reasonable and consistent with the purposes of the Rule to provide residents in facilities with consistently therapeutic contacts with those around them.

8. In Finding 33, the Hearing Examiner recommends the addition of a specific statutory reference. The Commissioner accepts the recommendation and amends Section J.2. to read as follows:

Each employee shall be able to review their personnel file, subject to the provisions of the Minnesota Government Data Practices Act, Minn. Stat. §§ 15.1611 et seq.

The Commissioner finds that this is not a substantial change and is reasonable and necessary.

9. In Finding 34, the Hearing Examiner recommends a change in word order to Section J.2.a. The Commissioner accepts the recommendation and amends Section J.2.a. by inserting the words "or a resume" after the word "employment" rather than after the word "application." The Commissioner finds this amendment to be a clarifying grammatical change.

10. In Finding 35, the Hearing Examiner recommended a change to Section J.1. to reflect the changes made in Section I. The Commissioner accepts the recommendation and amends Section J.1. by inserting the words: "The orientation and continuing education required by I. shall be documented by each program in a central training file." after the phrase "Central training file." The Commissioner finds that this change is reasonable and necessary and clarifies the original meaning of the section. The Commissioer further finds that the change is not substantial.

11. In Finding 44, the Hearing Examiner found that Section M.7., as amended, cannot be adopted because it violates substantive provisions of law. The Hearing Examiner recommended an alternative change. The Commissioner accepts the recommendation and amends Section M.7. by deleting language as originally proposed and subsequently amended, and adding language to read as follows:

7. Photographs of residents. A resident shall not have his or her photograph taken for any purpose beyond identification unless he or she consents.

The Commissioner finds that this change is not substantial and is reasonable and necessary.

12. In Finding 49, the Hearing Examiner found that Section O.2., as amended, could not be adopted because DPW had failed to demonstrate the need for and reasonableness of the second sentence. The Hearing Examiner recommended several alternative amendments. The Commissioner accepts the third alternative recommendation and amends Section O.2. to read:

2. Ratios. For each ~~existing~~ programs, there shall be one living room or lounge area per living unit for ~~every~~ up to 25 residents. ~~For new programs there shall be one living room or lounge area for every 16 residents.~~

The Commissioner finds that the amendment does not constitute a substantial change to the Rule, is needed and reasonable and is consistent with DPW's determination that 25 beds per living unit or lounge area is appropriate to a "home-like" setting, and should apply to both current and new programs.

13. In Finding 54, the Hearing Examiner found that the education and experience requirements in Section P.6.c., P.7.b. and c., and P.8. cannot be adopted. The Hearing Examiner recommended that a) DPW allow "grandfathering" of persons currently serving in the positions identified in P.6., P.7., and P.8.; b) the experience requirements found at Sections P.6.c., P.7.b. and c., and P.8. be deleted; and c) the education requirements be maintained to affect future hirings. The Commissioner accepts the Hearing Examiner's recommendations, and accepts the accompanying rationale with modifications noted, and adopts amendments set forth below. Among the rule provisions rejected by the Hearing Examiner are P.7.c. and P.8.c. Both of those sections are sections which require supervision while on the job. Deletion of these sections is not supported by the rationale of the Hearing Examiner. However, the Commissioner accepts their deletion since they are duplicative of the supervision requirements which are contained in the definitions for mental health counselor and mental health worker in Sections B.14 and B.18, and in Sections P.9.b. and Q.8.b. of the rule.

Based on Finding 54 of the Hearing Examiner's Report, with modifications stated above, the Commissioner adopts the following amendments to Section P:

P.6. Mental health therapist. If mental health therapy is provided within the mental health residential ~~treatment facility~~ program a mental health therapist shall be hired. Persons employed as mental health therapists prior to the effective date of 12 MCAR § 2.036 shall not be required to meet the qualifications of a. and b. Persons employed as mental health therapists after the effective date of 12 MCAR § 2.036 shall be required to meet the qualifications of a. and b. The mental health therapist shall be qualified in at least the following ways:

a. A bachelor's degree ~~in one of the behavioral sciences or related fields;~~ and

b. A master's degree in the behavioral sciences or related field or two years of advanced level, certificate training in mental health therapy~~; and~~.

~~c. One year of experience providing services to mentally ill persons.~~

7. Mental health counselors. If program services other than mental health therapy are provided within the mental health residential ~~treatment facility~~ program, they shall be provided by mental health counselors or mental health workers, or both. Persons employed as mental health counselors prior to the effective date of 12 MCAR § 2.036 shall not be required to meet any specific education requirements. Persons employed as mental health counselors after the effective date of 12 MCAR § 2.036 shall have at least an Associate of Arts degree in one of the behavioral sciences or a related field, or a registered nurse degree. ~~Mental health counselors shall meet the following qualifications:~~

~~a. A bachelor's degree in one of the behavioral sciences or related field;~~

~~b. A minimum of one year's experience working with mentally ill persons; and~~

~~c. Supervision by a mental health therapist or the program director.~~

8. Mental health workers. Persons employed as mental health workers after the effective date of 12 MCAR § 2.036 shall meet the qualifications as determined by the governing body to be consistent with those needed to meet the stated goals of the program. ~~Mental health workers shall qualify in one of the following ways:~~

~~a. One year of experience working with mentally ill persons;~~

~~b. One year as a resident of a mental health residental program with three months training relevant to the job responsibilities of a mental health worker; or~~

c. ~~Three months of on-the-job training with continued supervision by at least a mental health counselor.~~

The Commissioner finds that these amendments are necessary and reasonable and that they are not substantial in nature. The Commissioner also specifically finds that the alternative requirement for the position of mental health counselor of a bachelor's degree must be deleted (although proposed by DPW in its Memorandum), in order to be consistent with the adopted Finding 54 of the Hearing Examiner, and the rationale stated herein. The Commissioner specifically finds that this change is not substantial and is a necessary and reasonable change.

14. In Finding 56, the Hearing Examiner recommended a change in Section Q, regarding qualifications for mental health therapist for Category II programs. The Commissioner accepts the recommendation and amends Section Q. by amending Q.7. to read:

> 7. Mental health <u>therapists</u>, counselors and workers. If program services are offered within the facility, they shall be provided by mental health <u>therapists</u>, <u>mental health</u> counselors or mental health workers~~, or both~~. The minimum qualifications for these positions shall be consistent with those of Category I specified in <u>P.6.,</u> P.7. and P.8.

✓p.25

The Commissioner finds that this amendment is necessary and reasonable, and does not constitute a substantial change. The Commissioner also finds that the phrase "mental health therapist" should be added to section Q.8.b. in order to be consistent with the changes recommended for Q.7. The Commissioner adopts such a change so that Q.8.b. shall now read, in relevant part:

> b. The number of work hours performed by the <u>mental health therapist,</u> mental health counselor and mental health worker . . . .

✓p.26

The Commissioner finds this change to be necessary and reasonable, and not substantial.

15. In Finding 56, the Hearing Examiner found that the experience requirements contained in Section Q.7. could not be adopted for the same reasons as set forth with respect to Sections P.6.c., P.7.b. and c. and P.8. at Hearing Examiner's Finding 54. The Commissioner accepts the recommended change, with the same modifications as set forth in Commissioner's Finding 13,

and further finds that no change is necessary to Section Q.7. since that section refers back to the relevant subsections of Section P. The Commissioner finds that because the subsections of Section P. have been amended, that Section Q.7., as it stands, is amended by implication. The Commissioner further finds specifically that this amendment by implication is necessary and reasonable and does not constitute a substantial change.

16. The Commissioner finds that in order to be consistent with Hearing Examiner Findings 54 and 56, as herein adopted, that the following changes to the second sentence of P.9.b. shall be adopted:

> When the work hours are combined, the facility shall have written documentation that ~~the~~ supervision ~~required by 7.e. and 8.e.~~ is provided.

The Commissioner finds that the deletions adopted are reasonable and necessary in light of the changes made to the subsections of Section P., and are not substantial changes.

17. The Commissioner finds that in order to be consistent with Hearing Examiner Findings 54 and 56, as herein adopted, that the following changes to the second sentence of Q.8.b. shall be adopted:

> When the work hours are combined, the facility shall have written documentation that ~~the~~ supervision ~~required by P.7.e. and P.8.e.~~ is provided.

The Commissioner finds that this change is necessary and reasonable in light of the amendments to the subsections of Section P., and is not a substantial change.

18. In Finding 53, the Hearing Examiner found that the reordering of Section P.5. to place it prior to Section P.4 was more logical, necessary and reasonable, and not a substantial change. The Commissioner finds that this reasoning also applies to Sections Q.5. and 6. and adopts such a change. The Commissioner finds that placing current Section Q.6. before Section Q.5. is necessary and reasonable, and is not a substantial change.

19. In Finding 43, the Hearing Examiner found the use of "his or her" in M.6. to be necessary and reasonable, and not to be a substantial change. This finding extends to the use of "his or her" at M.5. The Commissioner adopts this amendment at M.5.

20. The Commissioner finds that Hearing Examiner's Finding 18 regarding the use of "program" in place of "facility" also applies to P.4., P.6., P.7., P.9., Q.5. and Q.8., in which "program" is substituted for "facility" or "treatment facility". The Commissioner adopts these changes at those sections and finds them necessary and reasonable, and not substantial changes.

21. In Finding 38, the Hearing Examiner found that the substitution of the phrase "skills training" for the phrase "services" in section L.3. to be necessary and reasonable and not a substantial change. The Commissioner finds that a similar change is necessary at P.10. in order to be consistent with the change at section L.3. The Commissioner adopts the following change at P.10.:

> 10. Independent living ~~services~~ skills training. "Independent living ~~services~~" skills training" means . . . ."

The Commissioner finds this change to be necessary and reasonable and not a substantial change.

22. In Finding 55, the Hearing Examiner found that it was necessary and reasonable and not a substantial change to delete section P.9.c. The Commissioner finds that this deletion necessitates a change to section P.9., in order to be consistent. The Commissioner adopts the following change to sentence five of section P.9.:

> The requirements of b. ~~and~~ c represent full-time equivalencies and may be prorated based on licensed resident capacity.

The Commissioner finds this change to be necessary and reasonable, and not a substantial change.

23. The Commissioner specifically finds that the amendments to the Rule as originally published, as proposed at the public hearing, and as proposed in the Memorandum of DPW submitted after the hearing, but which are not specifically discussed in either the Report of the Hearing Examiner or this Order, are necessary and reasonable, are either clarifying or editorial in nature, or corrections of grammatical, spelling and clerical errors, and are further found not to constitute a substantial change from the rule as originally published in the State Register. The Commissioner hereby adopts these amendments, which are listed below and have been incorporated in the Rule attached as Exhibit B:

Section of the Rule	Discussed in Memorandum at Page
B.1.	p. 39
B.2.	p. 39
B.3.	p. 41
B.6.	p. 43
B.11.	p. 43
New B.14 (original 13)	p. 43
New B.16 (original 15)	p. 43
New B.18 (original 17)	p. 43
New B.23 (original 22)	p. 44
New B.27 (original 26)	p. 44
New B.28 (original 27)	p. 44
New B.29 (original 28)	p. 44
N.2.f.	p. 69

IT IS FURTHER ORDERED that this Rule identified as 12 MCAR § 2.036 -- In the Matter of the Proposed Adoption of the Department of Public Welfare Rule Governing the Licensure of Residential Facilities for Adult Mentally Ill Persons -- is adopted this ___ day of December, 1981, and after this day, Rule 36 shall read in its entirety as set forth in the attached Exhibit B, pursuant to the authority vested in me, and pursuant to Minn. Stat. Chapters 15 and 245.

Dated: December 23, 1981.

STATE OF MINNESOTA
DEPARTMENT OF PUBLIC WELFARE

Arth E Noot

ARTHUR E. NOOT
Commissioner

In the Matter of the Proposed
Adoption of the Department of
Public Welfare Rule Governing the
Licensure of Residential Facilities
for Adult Mentally Ill Persons
(12 MCAR 2.036)

STATEMENT OF
COMPLIANCE WITH
RULE-MAKING PROCEDURES

I, Ellen C Dubuque do hereby declare that I have examined the rules and all related documents and that, based on my examination and my personal familiarity with the applicable procedures, the Administrative Procedures Act, the rules of the Office of Administrative Hearings, and the rules of the Attorney General have been followed. Any exceptions are noted below.

Ellen C Dubuque
Special Assistant Attorney General

Dated: 1/4/82

In the Matter of the Proposed Adoption of the Department of Public Welfare Rule Governing the Licensure of Residential Facilities for Adult Mentally Ill Persons (12 MCAR 2.036)

AFFIDAVIT OF MAILING NOTICE OF SUBMISSION TO THE ATTORNEY GENERAL

STATE OF MINNESOTA)
) SS
COUNTY OF RAMSEY)

John Sauer, being first duly sworn, deposes and says:

That on the 4th day of January, 1982, in the City of St. Paul, County of Ramsey, State of Minnesota, he served the attached Notice of Submission to the Attorney General by depositing in the (State of Minnesota Central Mail System for United States mailing (or) United States mail) at said City of St. Paul, a copy thereof, properly enveloped, with postage prepaid, on all persons and associations who requested notice that the rules in the above-entitled matter have been submitted to the Attorney General.

John Sauer

Subscribed and sworn to before me this 4th day of Jan., 1982.

DOROTHY HAIDER
Notary Public, Ramsey Co., Minn.
My Commission Expires
Aug. 27, 1982

In the Matter of the Proposed
Adoption of the Department of
Public Welfare Rule Governing the
Licensure of Residential Facilities
for Adult Mentally Ill Persons
(12 MCAR 2.036)

NOTICE OF
SUBMISSION TO THE
ATTORNEY GENERAL

Pursuant to your request and in accordance with Minnesota Statutes, section 15.0412:

PLEASE TAKE NOTICE that the above-captioned rules have been submitted to the Office of the Attorney General on this date, January 4, 1982, for review as to form and legality. Pursuant to 1 MCAR S 1.206 B., the Attorney General will not approve the rules for at least 10 calendar days after receipt to allow any person or association time to comment on the legality of the rules, after which that Office will complete its review. If you desire to comment on the legality of the above-captioned rules, you should direct your comments to the Office of the Attorney General, G-25 State Administration Building, 50 Sherburne Avenue, St. Paul, Minnesota 55155, telephone (612) 296-7030. Please note that the above-cited rule of the Attorney General also provides that a copy of any written comments submitted to the Attorney General must be submitted simultaneously to this agency.

If you are interested in determining what changes, if any, were made in the proposed rules after the hearing/publication in the State Register and before submission to the Attorney General, you may contact John Sauer, Mental Illness Program Division, Department of Public Welfare, 297-2831.