

Viol. No.	Applicable Law or Rule	Requirement	Item met or not met	Notes
		Chemical Dependency Treatment - Self Monitoring - Rule 31 - CLIENT RECORDS - 20090211		
		Requirements at Service Initiation - All Programs		
	9530.6470, Subp. 1	Rights: Clients have the rights identified in Minnesota Rules, part 4747.1500 (Client Bill of Right), and Minnesota Statutes section 253B.03 (committed clients) as applicable (also see P/P section		
	9530.6440, Subp. 3,A	the client file must contain documentation that the client was given a written statement of client rights and responsibilities, upon service initiation, and		
	9530.6470, Subp. 1	the staff reviewed the statement with the client.		
	9530.6470, Subp. 1	Additional Rights: Residential Programs only. Clients in residential programs have the rights identified in Minnesota Statutes 144.651, except subd. 28 and 29.		
	9530.6470, Subp. 2	Grievance Procedure: Upon service initiation, the license holder must explain the grievance procedure to the client or their representative and document that the information was given to the client as required by 9530.6440, subpart 3,A		
	245A.19, (b)	HIV: the file must document that the client received orientation to the HIV minimum standards within 72 hours of admission to the program.		
	9530.6440, Subp. 3,A	Tuberculosis: there must be documentation in the client record that the client received information on tuberculosis and tuberculosis screening. (Also see 9530.6455, item C)		
	245A.65, Subd. 1,(c)	Within 24 hours of admission to the program, or 72 hours for persons who would benefit more from a later orientation, each new person receiving services from the program must receive orientation to the following policies and procedures governing maltreatment of vulnerable adults: the internal and external reporting policies, including the telephone number for the Common Entry Point (CEP); AND		
	245A.65, Subd. 2,(a),(4)	The program abuse prevention plan. Documentation of this orientation must be contained in the client record as required by 9530.6440, subp. 3,A.		
	626.557, Subd. 3a,(a)	The license holder must seek consent to the disclosure of suspected maltreatment from the resident, or a guardian, conservator, or legal representative upon the resident's admission		

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	626.557, Subd. 3a,(a)	If upon admission the client refused consent for disclosure of suspected maltreatment, and an incident of suspected maltreatment was reported, the mandated reporter immediately sought consent again from the resident to make a report.		
	9530.6440, Subp. 1	Release of Information: client records were protected against unauthorized disclosure in compliance with Minnesota Statutes, section 254A.09, code of Federal Regulations, title 42, chapter 1, part 2, subpart B, sections 2.1 to 2.67, and if applicable, Minnesota Statutes, chapter 13.		
Initial Services Plan - All Programs				
	9530.6440, Subp. 3,B	The file must contain an Initial Services Plan		
	9530.6420,	The license holder must complete the initial services plan during or immediately following the intake interview that:		
	9530.6420,	addresses the client's immediate health and safety concerns		
	9530.6420,	identifies the issues to be addressed in the first treatment sessions; and		
	9530.6420,	makes treatment suggestions for the client during the time between intake and completion of the treatment plan.		
	9530.6420,	Includes a determination whether a client is a vulnerable adult as defined in Minnesota Statutes, section 626.5572, subdivision 21. An Individual Abuse Prevention Plan is required for all clients who meet the definition of vulnerable adult.		
Individual Abuse Prevention Plan And Or VA Determinations				
	245A.65, Subd. 1a	Determination of vulnerable adult status. (For Out Patient only)(a) A license holder that provides services to adults who are excluded from the definition of vulnerable adult section 626.5572, Subd. 21, clause (2), must determine whether the person is a vulnerable adult under section 626.5572, Subd. 21, clause (4) as follows:		
	626.5572, Subd. 21	The person is 18 years of age or older who:		
	626.5572, Subd. 21,(4)	possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction;		

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	626.5572, Subd. 21,(4),(i)	that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and		
	626.5572, Subd. 21,(4),(ii)	because of the dysfunction or infirmity and the need for assistance, the individual has an impaired ability to protect the individual from maltreatment.		
	245A.65, Subd. 1a	This determination must be made within 24 hours of: (1) admission to the license program; and		
	245A.65, Subd. 1a	(2) any incident that: (i) was reported under section 626.557; or		
	245A.65, Subd. 1a	(ii) would have been required to be reported under section 626.557, if one or more of the adults involved in the incident had been vulnerable adults.		
	9530.6440, Subp. 3,E	Information related to determination of vulnerable adult status must be contained in the client's file.		
	245A.65, Subd. 1a	(b) Upon determining that a person receiving services is a vulnerable adult under section 626.557, Subd. 21, clause (4), all requirements relative to vulnerable adults under section 626.557 and chapter 245A must be met by the license holder.		
	245A.65, Subd. 2,(b),(2)	For each vulnerable adult receiving program services an individual abuse prevention plan shall be developed as part of the initial service plan. The plan must be contained in the client's file as required by 9530.6440, subpart 3,E and include		
	626.557, Subd. 14,(b),(1)	an individualized assessment of the person's susceptibility to abuse by other individuals, including other vulnerable adults, and self abuse; AND		
	626.557, Subd. 14,(b),(2)	an assessment of the person's risk of abusing other vulnerable adults; and		
	245A.65, Subd. 2,(b),(1)	a statement of the specific measures that will be taken to minimize the risk of abuse to that person when the individual assessment indicates the need for measures in addition to the specific measures identified in the program abuse prevention plan.		
	245A.65, Subd. 2,(b),(1)	The measures shall: include the specific actions the program will take to minimize the risk of abuse within the scope of the licensed services; AND		

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	245A.65, Subd. 2,(b),(1)	identify referrals made when the vulnerable adult was susceptible to abuse outside the scope or control of the licensed services.		
	626.557, Subd. 14,(c)	If the facility knows that the vulnerable adult has committed a violent crime or an act of physical aggression towards others the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. The facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority, a medical record prepared by another facility, another health care provider, or the facility's ongoing assessment of the vulnerable adult.		
	245A.65, Subd. 2,(b),(1)	When the assessment indicates that the vulnerable adult does not need specific risk reduction measures in addition to those identified in the program abuse prevention plan, the IAPP must document this determination.		
	245A.65, Subd. 2,(b),(2)	The person receiving services shall participate in the development of the IAPP to the full extent of the person's abilities. If applicable the person's legal representative shall be given the opportunity to participate in the development of the plan.		
Additional Client File Requirements - Methadone Programs Only				
	9530.6500, Subp. 6,A	The license holder must maintain the original copy of the Central registry information in the client file. The information must include full name and all aliases; (Note: see also P/P section)		
	9530.6500, Subp. 6,B	date of admission;		
	9530.6500, Subp. 6,C	date of birth;		
	9530.6500, Subp. 6,D	social security number or INS number, if any;		
	9530.6500, Subp. 6,E	enrollment status in other current or last known opiate treatment programs;		
	9530.6500, Subp. 6,F	government-issued photo-identification card number; and		
	9530.6500, Subp. 6,G	driver's license number, if any.		

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Comprehensive Assessment - All Programs				
9530.6422, Subp. 1	The Comprehensive Assessment of the client's substance use disorder must be coordinated by an alcohol and drug counselor; and (Note: The counselor may rely on current information provided by a referring agency or other sources as a supplement when information is available. Information gathered more than 45 days before the date of admission is not current.)			
9530.6440, Subp. 3,C	The comprehensive assessment must be contained in the client record, and			
9530.6422, Subp. 1	completed within three calendar days after service initiation for a residential program or three sessions of the client's initiation of services for all other programs;			
9530.6422, Subp. 1	If not completed in the time specified, the treatment plan must indicate how and when the comprehensive assessment will be completed.			
9530.6422, Subp. 1	The assessment must include sufficient information to complete the assessment summary according to subpart 2, and part 9530.6425.			
9530.6422, Subp. 1,A	The comprehensive assessment must include information about the client's problems related to chemical use and personal strengths that support recovery including: age, sex, cultural background, sexual orientation, living situation, economic status, and level of education;			
9530.6422, Subp. 1,B	Circumstances of service initiation;			
9530.6422, Subp. 1,C	previous attempts at treatment for chemical use or dependency, compulsive gambling, or mental illness;			
9530.6422, Subp. 1,D	chemical use history including amounts and types of chemicals used, frequency and duration of use, period of abstinence; and circumstances of relapse, if any. For each chemical used within the previous 30 days, the information must include the date and time of the most recent use and any previous experience with withdrawal.			
9530.6422, Subp. 1,E	specific problem behaviors exhibited by the client when under the influence of chemicals;			
9530.6422, Subp. 1,F	current family status, family history, including history or presence of physical or sexual abuse, level of family support, and chemical use, abuse, or dependency among family members and significant others;			

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	9530.6422, Subp. 1,G	physical concerns or diagnoses, the severity of the concerns, and whether or not the concerns are being addressed by a health care professional		
	9530.6422, Subp. 1,H	mental health history and current psychiatric status, including symptoms, disability, current treatment supports, and psychotropic medications needed to maintain stability.		
	9530.6422, Subp. 1,I	arrests and legal interventions related to chemical use;		
	9530.6422, Subp. 1,J	ability to function appropriately in a work and educational setting;		
	9530.6422, Subp. 1,K	ability to understand written treatment materials, including rules and client rights;		
	9530.6422, Subp. 1,L	risk-taking behavior, including behavior that puts the client at risk of exposure to blood borne or sexually transmitted diseases;		
	9530.6422, Subp. 1,M	social network in relation to expected support for recovery and leisure time activities that have been associated with chemical use;		
	9530.6422, Subp. 1,N	whether the client is pregnant and if so, the health of the unborn child and current involvement in prenatal care		
	9530.6422, Subp. 1,O	whether the client recognizes problems related to substance use and is willing to follow treatment recommendations.		
Assessment Summary - All Programs				
	9530.6422, Subp. 2	Non-residential programs: An assessment summary must be prepared within three treatment sessions of service initiation.		
	9530.6422, Subp. 2	Residential Programs only - An assessment summary must be prepared within three calendar days of service initiation.		
	9530.6440, Subp. 3,D	The assessment summary must be contained in the client file.		
	9530.6422, Subp. 2,A	The assessment summary must be prepared by an alcohol and drug counselor and include: (Note: may be prepared by intern and co-signed by ADC)		
	9530.6422, Subp. 2,A,(1)	a risk description according to 9530.6622 for each dimension listed in item B		
	9530.6422, Subp. 2,A,(2)	narrative supporting the risk descriptions; and		

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	<i>9530.6422, Subp. 2,A,(3)</i>	a determination of whether the client meets the DSM criteria for a person with a substance use disorder; and		
	<i>9530.6422, Subp. 2,B</i>	Information relevant to treatment planning and recorded in the dimensions in subitems (1) to (6):		
	<i>9530.6422, Subp. 2,B,(1)</i>	Dimension 1, acute intoxication/withdrawal potential. The license holder must consider the client's ability to cope with withdrawal symptoms and current state of intoxication.		
	<i>9530.6422, Subp. 2,B,(2)</i>	Dimension 2, biomedical conditions and complications. The license holder must consider the degree to which any physical disorder would interfere with treatment for substance abuse, and the client's ability to tolerate any related discomfort. The license holder must determine the impact of continued chemical use on the unborn child if the client is pregnant.		
	<i>9530.6422, Subp. 2,B,(3)</i>	Dimension 3, emotional, behavioral, and cognitive conditions and complications. The license holder must determine the degree to which any condition or complications are likely to interfere with treatment for substance abuse or with functioning in significant life areas, and the likelihood of risk of harm to self or others.		
	<i>9530.6422, Subp. 2,B,(4)</i>	Dimension 4, readiness for change. The license holder must also consider the amount of support and encouragement necessary to keep the client involved in treatment.		
	<i>9530.6422, Subp. 2,B,(5)</i>	Dimension 5, relapse, continued use, and continued problem potential. The license holder must consider the degree to which the client recognizes relapse issues and has the skills to prevent relapse of either substance use or mental health problems.		
	<i>9530.6422, Subp. 2,B,(6)</i>	Dimension 6, recovery environment. The license holder must consider the degree to which key areas of the client's life are supportive of or antagonistic to treatment participation and recovery.		
Individual Treatment Plans - All Programs				
	<i>9530.6425, Subp. 1</i>	General: The Individual treatment plan must be completed within seven calendar days of completion of the assessment summary and continually updated, based on new information gathered about the client's condition and on whether planned treatment interventions have had the intended effect. The individual treatment plan must be contained in the client record as required by 9530.6440, subp. 3,F.		
	<i>9530.6425, Subp. 1</i>	Treatment planning must include ongoing assessment in each of the six dimensions according to part 9530.6422, subpart 2.		

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	<i>9530.6425, Subp. 1</i>	The plan must be developed after completion of the comprehensive assessment and is subject to amendment until services to the client are terminated.		
	<i>9530.6425, Subp. 1</i>	The plan must provide for the involvement of the client's family and those people selected by the client as being important to the success of the treatment experience at the earliest opportunity, consistent with the client's treatment needs and written consent.		
	<i>9530.6425, Subp. 1</i>	The client must have an opportunity to have active, direct involvement in selecting the anticipated outcomes of the treatment process and in developing the treatment plan.		
	<i>9530.6425, Subp. 1</i>	The individual treatment plan must be signed by the client and the alcohol and drug counselor.		
	<i>9530.6425, Subp. 1</i>	The individual treatment plan may be a continuation of the initial services plan required in part 9530.6420		
	<i>9530.6425, Subp. 2</i>	Plan contents: An individual treatment plan must be recorded in the six dimensions listed in part 9530.6422, subp. 2, B, and address each problem identified in the assessment summary, and include:		
	<i>9530.6425, Subp. 2,A</i>	specific methods to be used to address identified problems, including amount, frequency, and anticipated duration of treatment service. The methods must be appropriate to the client's language, reading skills, cultural background, and strengths; (NOTE: the treatment plan must identify how each of the treatment services required in 9530.6430, subp.1, and any of the additional treatment services listed in 9530.6430, subp.2 are provided.)		
	<i>9530.6425, Subp. 2,B</i>	resources to which the client is being referred for problems when the problems are to be addressed concurrently by another provider; and		
	<i>9530.6425, Subp. 2,C</i>	goals the client must reach to complete treatment and have services terminated.		
MH/CD Programs - Additional Treatment Plan Content Requirements				
	<i>9530.6495, Subp. E</i>	There was documentation of active interventions to stabilize mental health symptoms present in treatment plans and progress notes.		
	<i>9530.6495, Subp. F</i>	The license holder had continuing documentation of collaboration with continuing care mental health providers and involvement of those providers in treatment planning meetings.		

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Progress Notes and Plan Review - All Programs				
	9530.6425, Subp. 3,A	Progress Notes must reference the treatment plan and be entered in the client's file weekly or after each treatment service, whichever is less frequent, by the person providing the service. Progress notes must be recorded and address each of the six dimensions listed in 9530.6422, subpart 2, B. (Note: also see requirement 9530.6440, subp. 3, G)		
	9530.6425, Subp. 3,A,(1)	Progress Notes must be entered immediately following any significant event that has an impact on the client's relationship with other clients, staff, client's family, or the client's treatment plan;		
	9530.6425, Subp. 3,A,(2)	Progress Notes must indicate the type and amount of each treatment service the client has received;		
	9530.6425, Subp. 3,A,(3)	Progress Notes must include monitoring of any physical and mental health problems; and		
	9530.6425, Subp. 3,A,(4)	Progress Notes must document the participation of others; and		
	9530.6425, Subp. 3,A,(5)	Progress Notes must document that the client has been notified of each treatment plan change and whether or not the client agrees with the change.		
	9530.6425, Subp. 3,B,(1)	Treatment Plan Review must: occur weekly or after each treatment service, whichever is less frequent;		
	9530.6425, Subp. 3,B,(2)	address each goal in the treatment plan that has been worked on since the last review; and		
	9530.6425, Subp. 3,B,(3)	address whether the strategies to address the goals are effective, and if not, must include the changes to the treatment plan.		
	9530.6425, Subp. 3,B,(4)	Include a review and evaluation of the individual abuse prevention plan according to Minnesota Statutes, 245A.65 which requires that the interdisciplinary team shall review and evaluate the IAPP as part of the treatment plan review, using the individual assessment and any reports of abuse relating to this person. The plan shall be revised to reflect the review of the review.		
	9530.6425, Subp. 3a	Progress notes and plan reviews do not require separate documentation if the information in the client file meets the requirements of subpart 3, A and B.		

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Record Keeping Requirements - All Programs				
	9530.6425, Subp. 3,C	All entries in the client record must be legible, signed, and dated.		
	9530.6425, Subp. 3,C	Late entries must be clearly labeled, "late entry."		
	9530.6425, Subp. 3,C	Corrections to an entry must be made in a way in which the original entry can still be read.		
Summary at Termination of Services - All Programs				
	9530.6425, Subp. 4	An alcohol and drug counselor must write a discharge summary for each client that is completed within five days of the client's service termination or within five days from the client's or program's decision to terminate services, whichever is earlier. The summary at termination of services must be contained in the client file as required by 9530.6440, subpart 3,H.		
	9530.6425, Subp. 4,A,(1)	The summary at termination of services must be recorded in the six dimensions listed in 9530.6422, subpart 2, B and include the following information: client's problems, strengths, and needs while participating in treatment, including services provided;		
	9530.6425, Subp. 4,A,(2)	the client's progress toward achieving each of the goals identified in the individual treatment plan; and		
	9530.6425, Subp. 4,A,(3)	the reasons for and circumstances of service termination.		
	9530.6425, Subp. 4,A,(4)	risk description according to part 9530.6622		
	9530.6425, Subp. 4,B,(1)	For clients who successfully complete treatment, the summary must also include: living arrangements upon discharge;		
	9530.6425, Subp. 4,B,(2)	continuing care recommendations, including referrals made with specific attention to continuity of care for mental health problems, as needed;		
	9530.6425, Subp. 4,B,(3)	service termination diagnosis; and		
	9530.6425, Subp. 4,B,(4)	the client's prognosis.		
Health Care - Programs providing Medication Administration or Assistance with Self Medication				
	9530.6435, Subp. 3,B,(2)	The client's file must include documentation indicating whether staff will be administering medication or the client will be doing self-administration, or a combination of both.		

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	9530.6435, Subp. 3,B,(7)	The client's use of medication must be recorded, including staff signatures with date and time.		
	9530.6435, Subp. 3,B,(8)	The guidelines were followed for informing a registered nurse of problems with self-administration, including failure to administer, client refusal of a medication, adverse reactions, or errors.		
		Additional Health Care Requirements - Programs serving Clients with Children whose services include Medication Administration or Assistance with self-medication		
	9530.6435, Subp. 3,B,(6)	If the license holder services clients who are parents with children, the parent may only administer medication to the child under staff supervision.		
		Residential Treatment Programs - Additional Health Care Requirements		
	9530.6505, Subp. 7	Health Services: The health of each resident must be assessed and monitored, and health related information about each client must be collected on a standardized data collection tool.		
		Additional Documentation of Services - Programs Serving Adolescents		
	9530.6485, Subp. 4	Academic program requirements: Clients who are required to attend school must be enrolled and attending an educational program approved by the Minnesota Department of Education.		
	9530.6485, Subp. 5,A	In addition to the requirements specified in the client's treatment plan under part 9530.6425, programs serving adolescents must include the following: coordination with the school system to address the client's academic needs;		
	9530.6485, Subp. 5,B	when appropriate, a plan that addresses the client's leisure activities without chemical use; and		
	9530.6485, Subp. 5,C	a plan that addresses family involvement in the adolescent's treatment.		
		Client Interviews		
		Is the client receiving services?		
		Is the client satisfied with treatment services provided?		
		Was the client involved with the development of their treatment plan?		
		What has the client learned in treatment that is helpful?		