

**East Central Regional Human Rights Authority
Shapiro Developmental Center
Report of Findings
Case #19-060-9007**

The East Central Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission voted to pursue an investigation of Shapiro Developmental Center in Kankakee after receiving the following complaints of possible rights violations:

Complaints:

- 1. Provider failed to keep the consumer free from abuse by not taking any action to prevent another peer in the residence from physically assaulting the consumer on 3 or more occasions.**
- 2. Inadequate Treatment Planning, including not following the treatment team plan to move the abusive peer from the unit in which the consumer lives.**

If the allegations are substantiated, they would violate protections under the Mental Health and Disabilities Code (405 Ill. Comp. Stat. Ann. 5/2-102, 405 Ill. Comp. Stat. Ann. 5/2-112, and 405 Ill. Comp. Stat. Ann. 5/3-211) and the Code of Federal Regulations (42 C.F.R. § 483.420).

Complaint Summary: The consumer (who is blind) was reportedly physically attacked by a peer on 3 occasions. After the first two occasions the provider assigned the perpetrator to a 1 on 1 supervisor and the peer was still allegedly to physically assault the consumer; the supervising staff was able to restrain the peer. The guardian (in agreement with the treatment team) has requested that the peer be moved to another unit. The provider has reportedly not responded to the guardian's communication in a timely manner. In one correspondence, the provider stated that they are aware of the situation but that they did not want to make a "move of this magnitude" because Public Health was visiting the facility as per the complaint.

Investigation

The HRA proceeded with the investigation after having received written authorization from the consumer's state appointed guardian. In addition, written authorization was received to review the consumer's and the perpetrator's Office of State Guardian records. To pursue the matter, the HRA visited the facility and the program representatives were interviewed. Relevant practices, policies and sections of the consumer's record were reviewed.

Interviews:

On May 22, 2019 at 10:30am, the HRA met with Shapiro staff members, including The Facility Director, Mental Health Administrator, Qualified Intellectual Disabilities Professional, and Interim Assistant Center Director. The meeting occurred at 100 E Jefferson St in Kankakee and began with introductions, a review of HRA procedures, and a review of the allegations being addressed in this investigation.

The staff provided some general information about Shapiro Developmental Center. Shapiro is a State Operated Developmental Center that currently houses 475 individuals with intellectual disabilities. The 302 men and 173 women come from all over the state to reside at Shapiro while receiving intensive support services with the goal of reintegrating them into the community. The 1157 staff are comprised of psychiatrists, special education teachers, vision and hearing specialists, registered nurses, licensed practical nurses, physicians, and social workers. These staff oversee 32 residential living areas and 4 day training sites. All staff receive semi-annual training on abuse, neglect and human rights.

Shapiro reports that they have a Human Rights Committee that meets twice a month. Consumers are made aware of this committee and the procedures via posters throughout the campus. The committee has not discussed any of the issues being discussed in these complaints. Shapiro also has a grievance procedure that is provided to consumers and guardians when they are admitted and is also posted.

Both the consumer and the perpetrator in the above-mentioned complaints reside on the same floor in the same housing unit. They have shared a bedroom in this location for over 15 years without incident. While both individuals are diagnosed with intellectual disabilities, the consumer is also legally blind, and the perpetrator has extensive mental health and behavioral issues.

Shapiro staff stated that on 1/20/19 the perpetrator was in the hallway, separated from other consumers, because he was having some behavioral concerns and staff were addressing them with him according to his behavioral plan. The perpetrator then became more upset and ran off and assaulted the first individual that he encountered (the consumer). The consumer had visible scratches that were treated, and the consumer was evaluated by the psychiatrist. The treatment team acted by moving the consumer and the perpetrator to separate bedrooms.

On 2/22/19 the consumer and the perpetrator were on the bus preparing to go to the day training site as usual. The perpetrator got upset and attacked the consumer on the bus by hitting and scratching him. The consumer again had visible marks from the encounter and was treated and evaluated. The treatment team acted by separating the consumer and the perpetrator and requiring there to be "same room supervision". The team also changed the order that the individuals board the bus every day to assure that the consumer is safely to the back of the bus before the perpetrator is allowed to board.

On 2/28/19 the consumer and the perpetrator were getting ready for work with a small group of 7-8 individuals that attend day programming together. The perpetrator became upset and ran across the room and attacked the consumer. Staff intervened before another consumer was injured. The consumer was again treated for physical injuries and evaluated. The treatment team acted by requiring the perpetrator to have 1:1 supervision at all times. There have been no further incidents since the perpetrator was placed on 1:1 supervision.

After each incident the staff held a meeting that included the guardian to discuss the incident, what the results of the consumer and perpetrator evaluations were, and what changes needed to

be implemented. Shapiro staff believe that the perpetrator was not targeting the consumer but rather that the consumer was “in the wrong place at the wrong time” when the perpetrator was triggered. Staff believes that the consumer has not been negatively affected by the incidents and support that the consumer does not require any changes to his residence or treatment plan because of being a victim of the attacks. Shapiro stated that there was discussion of the perpetrator being moved to another unit because the guardian was concerned that the consumer was being targeted. Staff stated that they did not agree to move the perpetrator and believe that the current plan of the consumer being placed on 1:1 has been effective and a move is not needed.

When asked about documenting the correspondence between the Shapiro staff and the guardian, staff stated that there is no documentation of guardian conversations, no documentation of the guardian being notified of the decision not to move the perpetrator, and therefore, no notification of appeal for the decision. Staff stated that they have frequent conversations with all guardians and those discussions are not documented in any way (outside of team meetings when the guardian’s signature would indicate presence). Shapiro also reports that there is no policy or procedure that would require staff to document guardian notification or interaction and no policy or procedure that would require staff to notify the guardian in writing that the request for a move had been denied. If the guardian did not like a decision the grievance procedure could be followed.

The HRA asked the staff about an email sent from the guardian to Shapiro staff on 3/5/19 requesting that the perpetrator be moved. The email from the guardian stated that the treatment team “all agrees that [the perpetrator] needs to be moved off unit 201 as soon as possible to keep [the consumer] safe and to provide proper supervision for [the perpetrator].” Shapiro staff then responded to this email on 3/15/19 stating it was “probably not a good idea to make a move of this magnitude with Public Health here. [Perpetrator] is currently 1:1 and staff are aware of the importance of keeping them separated until a decision is made. I’ll let you know when a decision is made.” Shapiro staff explained that it took staff several days to respond to the email because Public Health was at the facility, and staff were busy. Staff indicated that the guardian was informed at a later date that the perpetrator was doing well with 1:1 supervision and a move was not needed at this time, however, there is no documentation of that discussion or any official notification of the guardian’s request being denied.

At the time of this interview, Shapiro’s treatment team believes that the consumer is safe. The perpetrator still resides on the same unit in another bedroom and has 24/7, 1:1 supervision. Staff explained that because the treatment planning is working, a move is not needed.

Before leaving the facility, the HRA received a tour of the consumer and perpetrator’s unit. Staff reiterated that the consumer and the perpetrator have separate living, sleeping, bathing, and eating areas. While it is possible, and likely, that the two individuals will cross paths in the course of a day, those interactions are limited as much as possible and a 1:1 staff supervisor would be available to intervene. Staff also added that they feel that, because of the length of time that both individuals have resided on the unit, moving either of the individuals could result in a decline for either of them if moved.

Records Reviews:

Shapiro Developmental Center provided the HRA with the following records:

The Shapiro Individual Support Plan Team meeting record indicated that a “Special Team Meeting” was held on 1/23/19 to discuss the 1/20/19 incident. The participation record indicates that all team members were present for this meeting, including the consumer’s guardian. These records indicate that the consumer’s group was changed, and the perpetrator was moved to another bedroom. There is also a notation that this is the first time these two individuals were involved in an altercation and that the team believed that the consumer was in “the right place and the wrong time”. The team decided that no supervision changes or other environmental changes were warranted at this time.

The Shapiro Individual Support Plan Team meeting record indicated that a “Special Team Meeting” was held on 2/26/19 to discuss the 2/22/19 incident. The participation record indicates that the guardian was not available for this meeting, there is no documentation to indicate why the meeting was held without the guardian. These records confirm that the second incident occurred on the bus and that the altercation again resulted in the consumer having an injury. A plan to get the consumer on the bus first and have a staff member sit next to the perpetrator was put in place.

The Shapiro Individual Support Plan Team meeting record indicated that a “Special Team Meeting” was held on 3/5/19 to discuss the 2/28/19 incident. The participation record indicates that all team members were present for this meeting; including the consumer’s guardian. The meeting discussed that this incident occurred in the group living area and that the consumer again sustained an injury as a result of the perpetrator. The perpetrator was immediately placed on 1:1 supervision level. The documentation shows that the team discussed moving the consumer to another unit for his safety since it appears that the perpetrator may be targeting the consumer, however, the team recommended that the consumer not be moved because he is blind and hard of hearing and has lived on the unit for 17 years and can ambulate independently with his cane because he is familiar with the unit.

The Shapiro Individual Support Plan Team meeting record indicated that a “Special Team Meeting” was held on 4/5/19 to discuss how the consumer has been doing since the multiple incidents. The participation record indicates that all team members were present for this meeting, including the consumer’s guardian who attended via conference call. Documentation states that the consumer does not appear to be negatively impacted by the events, the psychologist continues to monitor his behavior, and that no additional changes are warranted at this time.

A 4/9/19 memorandum between Shapiro staff states that the guardian participated in the 4/5/19 meeting and “understands our position on moving the peer to another living area and would not continue to pursue a living transfer”. It is unclear why this note was not placed in the meeting records/summary or whether the staff members were discussing the move of the consumer or the perpetrator.

Nursing progress notes for each incident indicate that the injuries the incidents were all treated and monitored by a nurse.

Shapiro progress notes report that the consumer was injured and that follow up care was provided after each individual incident. There are also monthly behavior notes that the consumer did not have any behavioral incidents in January but did have a “few behaviors” noted in February and March. There are no notations tying the behaviors to the incidents.

The Office of State Guardian provided the HRA with the following records:

Emails sent between the guardian and the Shapiro staff on 3/5/19 as described previously.

A case note for the consumer dated 3/5/19 states that the team discussed the 3 incidents and whether or not it was in the consumer’s best interest to move since the perpetrator appears to be targeting the consumer. It was decided that due to the consumer being blind and deaf that a move would not be beneficial at this time. The team did, however, “agree that the aggressor needs to be moved to another unit”.

A case note for the perpetrator dated 3/5/19 states that the team agrees that the perpetrator needs to be moved off the unit as soon as possible for the consumer’s safety.

A case note for the perpetrator dated 4/5/19 states that the team agreed that the perpetrator was targeting the consumer. The guardian for the perpetrator requested that the perpetrator be transferred to another unit and the team agreed. The note continues to state that the perpetrator was not moved due to facility lacking placement for the perpetrator and the unit director did not feel like the perpetrator was targeting the consumer. At this time, the perpetrator was on 1:1 supervision and was being monitored for progress.

Policy Review:

Shapiro Policy and Procedure titled “Behavior Intervention Programs” outlines efforts to modify maladaptive or problem behaviors. Each level of intervention (Level I, II, or III) is given parameters, however, states that a given procedure on the list may not be appropriate for each person depending on situation, behavior, and disability. One-on One staff supervision is considered a level IIA intervention because it involves “some restriction of rights, but do not involve highly restrictive, controversial and/or noxious or painful stimulation.” The policy also indicates that, due to the restriction of rights, Level IIA procedures require review and approval by the Behavior Intervention Committee and the Human Rights Committee prior to implementation.

It should be noted that Shapiro staff stated that there is no policy or procedure that would require staff to document guardian notification or interaction and no policy or procedure that would require staff to notify the guardian in writing that the request for a move had been denied.

Conclusions

Complaint 1: Provider failed to keep the consumer free from abuse by not taking any action to prevent another peer in the residence from physically assaulting the consumer on 3 or more occasions.

The Mental Health and Developmental Disabilities Code (405 Ill. Comp. Stat. Ann. 5/2-102) states “(a) A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan.” Section 5/3-211 states “When an investigation of a report of suspected abuse of a recipient of services indicates, based upon credible evidence, that another recipient of services in a mental health or developmental disability facility is the perpetrator of the abuse, the condition of the recipient suspected of being the perpetrator shall be immediately evaluated to determine the most suitable therapy and placement, considering the safety of that recipient as well as the safety of other recipients of services and employees of the facility.” And Section 5/2-112 states “Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect.”

On 1/20/19, 2/22/19, and 2/28/19 a consumer residing at Shapiro Developmental Center was the victim of abuse at the hands of another resident. Each incident was followed up with a medical and psychiatric assessment of the consumer, a team meeting, and additional preventative measures were put in place to separate the perpetrator from the consumer. Preventative measures were discussed in a timely manner with the entire treatment team for both the consumer and the perpetrator, with the consumer and perpetrator’s disabilities and safety taken into consideration.

Based on the findings above the East Central Human Rights Authority concludes that the consumer’s rights were not violated and, therefore, the complaint is **unsubstantiated**. No recommendations or suggestions are being made in relation to this complaint.

Complaint 2: Inadequate Treatment Planning, including not following the treatment team plan to move the abusive peer from the unit in which the consumer lives.

The Mental Health and Developmental Disabilities Code (405 Ill. Comp. Stat. Ann. 5/2-102) states “(a) A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient.” The Code of Federal Regulations (42 C.F.R. § 483.420) states “(c) Standard: Communication with clients, parents, and guardians. The facility must—(1) Promote participation of parents (if the client is a minor) and legal guardians in the process of providing active treatment to a client unless their participation is unobtainable or inappropriate; (2) Answer communications from clients' families and friends promptly and appropriately... (6) Notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death,

abuse, or unauthorized absence.” The Illinois Probate Act (755 Ill. Comp. Stat. Ann. 5/11a-23) states “(b) Every health care provider and other person (reliant) has the right to rely on any decision or direction made by the guardian, standby guardian, or short-term guardian that is not clearly contrary to the law, to the same extent and with the same effect as though the decision or direction had been made or given by the ward.”

Documentation clearly supports that on three occasions the perpetrator abused the consumer while in the care of Shapiro Developmental Center. After each of the three incidents, which resulted in the perpetrator causing physical harm to the same consumer, there was a treatment team meeting during which the guardian requested that the perpetrator be moved to another unit for the consumer’s safety. The request from the guardian was also made in writing via email on 3/5/19. The staff responded to the guardian’s request on 3/15/19 that a move of that magnitude could not occur while Public Health was visiting and that the provider would get back to the guardian when a decision had been made. During interviews, the Shapiro staff reported that a decision to leave the perpetrator on the unit with 1:1 supervision was later made and that the guardian was notified of this decision, however, no documentation is available. Given the fact that it took the provider 10 days to respond to the email, the fact that a decision was put on hold further due to a Public Health visit, and the fact that there is no documentation that the provider ever notified the guardian that a safety decision had been made, the HRA determines that the standards of communication with the guardian outlined in 42 C.F.R. § 483.420 were not met. In addition, there is no evidence that, after 3/15/19, the guardian was included in the decision-making process for determining whether adequate and humane care and services are being provided in the least restrictive environment pursuant to the consumer’s service plan as stated in 405 Ill. Comp. Stat. Ann. 5/2-102.

In addition, the HRA notes that Shapiro Policy and Procedure titled “Behavior Intervention Programs” requires that one-on-one supervision be reviewed by the Human Rights Committee before implementation. Staff reported during the interviews that this case had not been reviewed by the Human Rights Committee and no documentation of such review was provided. A Human Rights Committee review of this case may have assisted both the staff and the guardian in determining whether one-on-one supervision was the most appropriate level of intervention for both the consumer’s safety as well as the perpetrators rights.

Based on the findings above the East Central Human Rights Authority concludes that the consumer’s rights were violated and, therefore, the complaint is **substantiated**. **The HRA makes the following recommendations:**

1. Shapiro Developmental Center will comply with 42 C.F.R. § 483.420 by promoting participation of guardians in the process of providing active treatment to a consumer, answer communications promptly and appropriately, and promptly notify the consumer's guardian of any significant incidents, or changes in the client's treatment (specifically with notice to any change of placement or decision not to change placement).
2. Shapiro Developmental Center will comply with 405 Ill. Comp. Stat. Ann. 5/2-102 by including the guardian in the treatment process to assure adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan.

3. Shapiro Developmental Center will ensure that their policy on “Behavior Intervention Programs” is followed and properly documented any time that the Human Rights Committee has reviewed any action taken to move a consumer to a Level IIA or higher intervention.

The HRA also **strongly suggests** that Shapiro review all documentation practices within the agency and consider creating policies for documentation and written guardian notification. Limited documentation and conflicting reports of the outcome of treatment team meetings could have been easily clarified by better (timely) communication and proper documenting. Documentation repeatedly indicated that the treatment team agreed to moving the perpetrator; the HRA specifically suggests that the documentation include a review of the treatment team’s recommendation and, if not followed, the facility should ensure that the rationale for not following the treatment team’s recommendation be documented as well.

The HRA would like to thank the Shapiro staff for their cooperation with this investigation.

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, some provider responses appear verbatim in retyped format.



Illinois Department of Human Services

JB Pritzker, Governor

Grace B. Hou, Secretary Designate

Shapiro Center

100 East Jeffery Street • Kankakee, Illinois 60901

August 23, 2019

Human Rights Authority
Illinois Guardianship and Advocacy Commission
East Central Regional Office
2125 South First Street
Champaign, Illinois 61820
ATT: Laura Hart, HRA Coordinator

RE: Human Rights Authority Case #19-060-9007

In response to your report on the above case, the following is offered:

Shapiro Center followed the Policy and procedures title "Behavior Intervention Programs" in relation to Level IIA procedures involving some restrictions of rights by placing a resident on one-to-one supervision. A Notice Regarding Restriction of Rights of an Individual form (IL462-2004D) and the Supplemental Report on the Use of Restraint and/or Emergency Behavior Intervention Procedures (IL462-6200) were completed for the resident who was placed on a one-to-one supervision level to prevent harm to self and others. The guardian was notified each time the Restriction of Rights were completed by the Residential Unit Director; and a copy of the Use of Restraint and/or Emergency Behavior Intervention Procedures (IL462-6200) was provided to the Chairperson of the Behavior Intervention Committee (BIC) and the Chairperson of the Human Rights Committee (HRC).

On March 19, 2019, the Behavior Intervention Committee (BIC) met and discussed the changes to this resident's behavior intervention program. The BIC Committee meeting minutes document the committee discussed the requested change to the resident's program to add one-to-one supervision and response cost; and the reaffirmation of Risperidone to continue. During this same meeting, the Committee discussed the use of one-to-one supervision and approved the one-to-one supervision being added to the Behavior Intervention Program (BIP). The BIC committee approved this plan.

On March 21, 2019, the Human Rights Committee met and the HRC Meeting minutes document the committee discussed the one-to-one supervision for this resident due to incidents of physical aggression (PA), Property Destruction (PD), and Self-Injurious Behavior (SIB); and the renewal of risperidone to continue. The HRC approved this plan.

Therefore, based on the above it should be noted that Shapiro Center did follow the Shapiro Policy and Procedure titled "Behavior Intervention Programs", SC Policy #2/25.

The Interdisciplinary Team for this resident and his peer did take the necessary actions as it relates to the peer-to-peer interactions that occurred between these two residents for each incident that occurred including guardian notification. This same information was communicated at the meeting held at Shapiro

Center on May 22, 2019 to discuss this case. In addition, communication between Shapiro staff and the guardian occurred in writing and verbally.

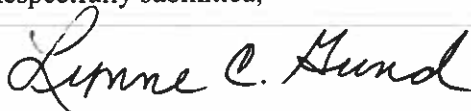
In summary, when each significant event occurred, including the changes in the resident's treatment program, the guardian was notified. For each incident that occurred between this resident and his peer, the guardian was notified of the incident and what occurred between the residents. When Emergency Behavior Intervention Procedures (IL462-6200) were implemented for the resident who was placed on a one-to-one supervision level to prevent harm to self and others, the guardian was notified each time the Restriction of Rights was completed by the Residential Unit Director, and the guardian was notified of the Special Team Meetings and the Behavior Intervention Committee Meeting. The guardian also received copies of the Special Team Meetings along with the Behavior Intervention Program revisions following the approval of the Behavior Intervention Committee and Human Rights Committee.

Further, in a Special Team Meeting (STM) held on April 5, 2019 where the guardian was present and participated, the IDT discussed the progress made with the resident who was placed on one-to-one supervision. The Interdisciplinary Team re-affirmed again that a move to another living area was not necessary. Both residents have lived and coexisted together on the living area in excessive of over 15 years and up until these incidents, there had been no issues between them; and there has been no further incidents. It was re-affirmed from previous discussions held with the guardian, that both residents need supports and services that this living area can provide for them. The Team along with the guardian determined that it would be very disruptive and detrimental to the resident's life and the services he requires to move him to another area where he is not familiar. At this Special Team Meeting that was held on April 5, 2019, the guardian indicated she understood the rationale and would not continue to pursue her request to move the resident to another area.

Shapiro Center will continue to implement the Behavior Intervention Programs policy as written and ensure it is properly documented through the meeting minutes maintained by each Committee Chair.

Shapiro Center will review all documentation practices within the Center as it relates to documentation of guardian notification including any verbal communication.

Respectfully submitted,



Lynne C. Gund
Center Director

REGIONAL HUMAN RIGHTS AUTHORITY

HRA CASE NO. 19-060-9007
SERVICE PROVIDER: Shapiro

Pursuant to Section 23 of the Guardianship and Advocacy Act (20 ILCS 3955/1 *et seq.*), we have received the Human Rights Authority report of findings.

IMPORTANT NOTE

Human Rights Authority reports may be made a part of the public record. Reports voted public, along with any response you have provided and indicated you wish to be included in a public document will be posted on the Illinois Guardianship and Advocacy Commission Web Site. (Due to technical requirements, your response may be in a verbatim retyped format.) Reports are also provided to complainants and may be forwarded to regulatory agencies for their review.

We ask that the following action be taken:

We request that our response to any recommendation/s, plus any comments and/or objections be included as part of the public record.

We do not wish to include our response in the public record.

No response is included.

Lynne C. Sturd
NAME

SPSA | Center Director
TITLE

August 23, 2019
DATE