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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 08-030-9017
SEGUIN SERVICES INCORPORATED

Case Summary: The HRA did not substantiate the complaint that Seguin discharged a recipient without the proper notice.

INTRODUCTION

The Human Rights Authority of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at Seguin Services Incorporated (Seguin). It was alleged that the agency discharged a recipient without the proper notice. If substantiated, this allegation would be a violation of the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.), the Illinois Administrative Code for Community Integrated Living Arrangements (the CILA Rules) and the Medicaid Home and Community-Based Services Waiver Program (59 Ill. Admin. Code 115 and 120).

Seguin serves over 500 adults and children with developmental disabilities and other special needs in 62 Chicago area communities. The Community Integrated Living Arrangement (CILA) in Berwyn, Illinois provides individual care within a family-like environment for six adult residents.

To review these complaints, the HRA conducted a site visit and interviewed the Vice-President of Residential and Case Management Services and the Director of Case Management. The recipient's clinical records were reviewed with written guardian consent.

FINDINGS

The recipient is an adult male who resided in a Seguin CILA in Berwyn, IL. He had been a recipient at Seguin since November of 2000, when he left the home of his guardians because he had chased his mother with a knife. He was admitted on an emergency basis into the residential housing program and remained with Seguin until his discharge in December of 2007. He was diagnosed with Psychosis NOS, Moderate Mental Retardation, Seizure Disorder, and a rare birth defect, Macrocephaly Agenesis Corpus Callosum, which occurs when the corpus callosum of the brain is absent.

At approximately 7:50 pm on December 17, 2007, the recipient was involved in an incident that resulted in the recipient's hospitalization and emergency discharge from Seguin Services. The record contains two accounts of these events; one from an incident report written by staff from the CILA and another which is the police report.

The Seguin Incident Report states, "According to reporting staff G.C. and K.C. [recipient] was making several calls. Staff asked [recipient] who he was calling. He stated a friend who would not answer the phone. Staff suggested to [recipient] to wait a couple of minutes and call again so another consumer could call his mother. He then stated that K.C. was rude and placed the phone on the charge and went to his room and remained there for a couple of minutes. K.C. remained upstairs in the office area reviewing the schedules and looking for a Request for Time Off form, [recipient] was very calm and went downstairs. Staff G.C. was interacting with other clients in the living room as [recipient] passed by and she asked him where he was going. He stated to get a glass of water. When staff G.C. saw him he was carrying a big knife that was placed in the dishwasher from earlier use for dinner. Staff G.C. asked for the knife but [recipient] said he was going to 'kill K.C.' and continued heading upstairs for staff K.C. Staff G.C. advised K.C. to run and staff K.C. ran in the bathroom upstairs while staff G.C. gathered clients and placed them in another consumer's bedroom for safety. Staff K.C. was yelling, 'Call the police.' While [recipient] was trying to get into the bathroom staff G.C. ran to the kitchen to call the police. When she turned around, [recipient] was standing about to stab her. So staff ran around the table and managed to get out the front door while [recipient] was yelling, 'I'm going to kill you' so staff G.C. ran to neighbor's house to complete the call to police. [Recipient] came back upstairs trying to get into the bathroom. Staff K.C. tried to redirect him by asking him to call his mother. According to staff, he continued to yell and open the bathroom door stating he was going to 'kill staff and police.' While in the bathroom staff K.C. also called police after noticing she had a phone with her and didn't see [recipient] shadow anymore in the process. G.C. was trying to get the other clients out. When [recipient] heard the door open he ran downstairs and tried to stab staff again; so staff backed to the sidewalk and that is when the police came….."

The police report describes the event upon arrival at the CILA:

"We were dispatched to Seguin Residences in reference to a man attacking residents of a house with a knife. Prior to arrival we were informed by Berwyn Central that the offender's name was …… and that he was at the door of the second floor bathroom attempting to kick it in and attack the occupant. I knew due to previous calls at that address and prior dealings with [recipient] that the house was occupied by mentally challenged individuals and that [recipient], who himself is mentally challenged, had a past history towards violence. Upon arrival I observed a female, later identified as ….. who was standing outside the residence in a visibly distraught state and yelling into a cellular telephone. She related she is a caretaker for the Seguin residents and that the [recipient] began running around after her and her co-worker, with a large butcher knife after they had disciplined him. ……further related that she was on the phone with …….who locked herself in a second floor bathroom in an attempt to keep [recipient] away from her and was yelling that he was currently attempting to break down the door. I ascertained that there were 7 occupants in the residence and observed through the front window two mentally challenged individuals in the living room area of the first floor, one jumping around in what

appeared to be a frenzied state and the other one confined in a wheelchair. Armed with the knowledge that [recipient] was on the second floor of the residence and the serious nature of the situation may escalate into the use of deadly force being employed I made an effort to secure the safety of the two observable first floor occupants prior to backup units arrived because of the layout of the first floor I could easily extract them out of the front door. I approached the front door of the residence with my Taser at ready position. I opened the front door of the residence and at this time my Taser was repositioned to a low one handed carry.

As soon as I made my entry into the house I observed a male white with a large silver butcher knife in his raised right hand. I recognized the individual, through past experiences, to be [recipient] and noticed that he was approximately three feet away from me and lunging in my direction with the knife. I immediately backpedaled out the front door in an effort to gain distance and in an effort to draw [recipient] outside and away from the occupants and gain a tactical advantage over him in the wide open area……. We then observed [recipient] in the front door and verbally persuaded him to walk out on the front porch area…… I verbally asked [recipient] to drop the knife and come to us because we were there to help him and he responded in a garbled tone." The recipient was then Tasered and taken to a hospital where he was seen in the emergency room before being transferred to a hospital psychiatric unit.

The police included in their report their interview of staff involved in the event and they stated in the report that "[recipient] became agitated over being disciplined and grabbed a butcher knife from a drawer ……and began chasing staff and her co-worker out of the kitchen area."

The Vice-President of Residential and Case Management Services for Seguin was interviewed by the HRA and he stated that he was notified the evening of the event at the same time that the guardians were notified, shortly after the event. He then contacted a director at the Illinois Department of Human Services (DHS) who gave approval for the discharge of the recipient from the facility and a pre-admission screening (PAS) agent was notified. On December 20, 2007 the Vice-President notified the Berwyn police and received a briefing of the event. He stated that the police had felt that the recipient should be arrested due to the seriousness of the event, however they were assured that the recipient would be stabilized and placed in a secure setting. The record indicated that on December 21, 2007 there was a teleconference with the recipient's guardians, the Vice-President of Residential and Case Management Services, and the Director of Case Management. At this time the guardians were informed that that the recipient was discharged from the residence. The Vice-president of Residential and Case Management Services indicated that the PAS agent interviewed the recipient for eligibility for emergency state placement, and this documentation would be part of the case file for the PAS agent since the recipient was no longer a resident at Seguin.

According to the record the guardians received official written notice of the discharge on January 7, 2008, stating that the recipient was hospitalized on 12/21/07 due to an incident in his home and that "Due to the extreme severity of this incident, and those that have preceded this instance, Seguin is no longer in a position to provide a safe environment for [the recipient], his peers, nor staff." At this time the guardians were asked to contact Suburban Access and the DHS for help in securing further placement for the recipient. A signed copy of their Consumer Rights

Acknowledgment was included in the packet with instructions on how to appeal the decision. This notice includes the process for contacting the Illinois Department of Health and Family Services in accordance with the Medicaid waiver rule (59 ILL. Admin. Code 120.110) and the Department of Health and Family Services appeal rule (89 Ill. Admin. Code 104.70). It instructs appellants to provide a written notice of appeal within 60 days of the discharge and indicates that the appeal process will include a review by an impartial hearing officer appointed by Health and Family Services. The guardians did not appeal the decision to terminate services.

The complaint indicated that the recipient was given a Behavioral Management Plan at his October 10, 2007 Annual Staffing. This behavior plan clearly indicated that all knives were to be locked up at all times at the recipient's CILA, and the guardians felt that the event would never have occurred if this protocol had been followed. The record indicated that the recipient's staffing paperwork documented numerous times that all knives within the residence were to be locked in a secure place when not in use. The Behavior Management Plan indicated that the recipient's functional assessment tests showed that aggression toward others, disruptive behavior, and socially offensive behaviors occur "at significant frequency and/or severity to warrant formal programming and are considered serious to very serious problems." The Plan also outlines detailed protocols with antecedent measures to prevent behavioral problems as well as replacement behaviors to help train and reinforce adaptive responses. There is also an extensive response protocol for procedures to enact when the recipient is displaying aggression toward others, and staff reported that behavior incident reports document that these protocols appeared to have been followed.

The Seguin staff stated that the recipient had an extensive history of aggression toward others and would probably have been incarcerated without the intervention of the Seguin staff. They stated that the recipient had four placements in the 7 years that he was a client at Seguin, and that there were no other options for his placement. Also, the staff as well as residents were extremely fearful of his aggression and would have been unable to carry on normal household chores, including the preparation of meals, with the recipient in the home.

The record contained a discrepancy between the staff report of the placement of the knife on the evening of the event and the police report. Specifically, the staff report indicated that the knife had been in a dishwasher, and the police report indicated that the knife had been taken from a drawer. Seguin staff were asked about compliance with the directive to keep all knives locked up and they stated that staff had reported that the knife had been in the dishwasher at the time and that when not being cleaned, the knives were securely locked.

CONCLUSION

The Mental Health and Developmental Disabilities Code guarantees that recipients of services shall be provided with "adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan" (405 ILCS 5/2-102 a). In this case a thorough and carefully developed plan was formulated with the input of staff and guardians to address the strengths and challenges of the recipient, so that he could enjoy the least restrictive environment of a community living arrangement. Four placements were attempted and sound therapeutic protocols to specifically address antecedent behaviors were implemented along with

response mechanisms for periods of aggression, and these interventions allowed the recipient to successfully remain in a family living arrangement for many years.

The Illinois Administrative Code, Standards and Licensure Requirements for Community-Integrated Living Arrangements (Section 115.215 Criteria for Termination of Individuals) states that the community support team shall consider recommending termination of services to an individual only if:

> 1. The medical needs of the individual cannot be met by the CILA Program; or
> 2. The behavior of an individual places the individual or others in serious danger; or
> 3. The individual is to be transferred to a program offered by another agency….; or
> 4. The individual no longer benefits from CILA services.

Action and appeal notice requirements under the Administrative Code's Medicaid Home and Community-Based Services Waiver Program state,

> (d) Individuals requesting or receiving program services have the right to a written notice of disposition of the request, or reduction, suspension, denial or termination of services. Such notice must be mailed at least 10 calendar days prior to the effective date of the action, except, in an emergency… Notices shall contain the following information: 1) A clear statement of the action to be taken; 2) A clear statement of the reason for the action; 3) A specific policy reference which supports such action; and 4) A complete statement of the individual's right to appeal, including the provider's grievance process, Department review and Department of Public Aid hearing. (Section 120.100).
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> (i) (1) Services may be suspended, terminated or reduced before the final administrative decision only if all of the following conditions are met: A) The physical safety of the individual or others is imminently imperiled; B) Appropriate services are not available at the provider agency; C) The provider agency has documented attempts to identify and ameliorate the probable causes of maladaptive behaviors and to seek training or technical assistance to meet the individual's needs; and D) The PAS agent has: i) Reviewed the individual's record; ii) Gathered the necessary clinical information; iii) Reviewed the action of the provider; iv) Met with the individual; and v) Determined that a delay in termination, suspension or reduction in services would imminently imperil the physical safety of the individual or others and has documented that fact in the individual's record …. Services to the individual may be terminated, suspended or

> reduced and the notice of action shall be given in accordance with Section 120.110 (d), but in no case later than 48 hours after the termination, suspension of reduction in services. (Section 120.110).

The Seguin Services Rights of Individuals document, signed by the guardians on an annual basis, states:

“Each person living in a CILA home shall remain in that home unless he/she is a danger to him/herself or others", and

> Each person served shall be allowed to submit complaints or recommendations concerning the policies and services of the agency to staff or outside representatives of the person's choice, or both, free from restraint, interference, coercion, discrimination or reprisal and shall receive timely, appropriate responses. If you have any complaints you may contact the Quality Assurance Analyst in writing at our office for further information. You may also complain to the Secretary of Health and Human Services if you believe Seguin has violated your privacy rights. A copy of Seguin Services Incorporated APPEAL AND GRIEVANCE POLICY AND PROCEDURE, HUMAN RIGHTS COMMITTEE POLICY AND PROCEDURES, as well as the name, address, and telephone numbers of Protection and Advocacy Commission and Office of State Guardianship Legal Resources, Illinois Department of Human Services, Office of the Inspector General local numbers, Secretary of Health and Human Services, and Equip for Equality shall be given to the person upon admission and reviewed at least annually.
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> In emergency situations, the individual's family, or guardian, and if indicated, the public or private agency financially responsible for his care, shall be immediately notified by the Case Manager that the person is being transferred to a hospital, another facility, or established in an alternate living arrangement, and will document that the individual is dangerous to himself or herself or others and the behavior cannot be corrected through special training procedures.

The HRA feels that the record adequately demonstrates a level of dangerousness that would warrant the immediate discharge of the recipient from the Seguin home. Although the decision to place the recipient in a home where meals would be prepared and served could be questioned, this was a clinical decision based on the treatment team and guardians' efforts to provide the best services to this recipient, and a procedure was in place and utilized to lock all knives when they were not in use. Additionally, the agency had attempted three other placements

for this recipient, so all efforts were being made to ensure his success. In terms of the discharge process, the record indicates that the guardians were notified immediately after the emergency event, a verbal discharge was issued on December 21 with a written discharge on January 7, which complies with all laws and practices for timely notification of emergency discharge. This paperwork included information for contacting both the placement agency as well as the DHS for a housing referral, and information to initiate an appeal process (as outlined in 89 ILL Admin. Code 104.70), if desired.

The HRA does not substantiate the complaint that Seguin Services discharged a recipient without proper notice.

SUGGESTION

1. The HRA asks that Seguin change the "Protection and Advocacy Commission and Office of State Guardianship Legal Resources" in the Rights of Individuals form to the Illinois Guardianship and Advocacy Commission.

2. Ensure that safety measures are thoroughly reviewed, particularly for residents with a known behavioral history, to reduce the potential for repeated behavioral incidents and/or resident injuries.