FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
SERTOMA CENTRE— 10-040-9007
HUMAN RIGHTS AUTHORITY— South Suburban Region

[Case Summary: The Authority did not find violations of discharge requirements in its investigation. Thepublic record on this case is recorded below. A provider response is not included in the public record.]

INTRODUCTION

According to the complaint, a resident was inappropriately terminated from services. If substantiated, this allegation would be a violation of the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/2-102 [a]), the Illinois Administrative Code (CILA Rules) (59 Ill. Admin. Code 115.215) and the Illinois Administrative Code for Medicaid Home And Community-Based Services Waiver Program (Medicaid Waiver Program) (59 Ill. Admin. Code 120.100 and 120.110).

Located in Alsip, Sertoma Centre, Inc., manages nine (9) Community Integrated Living Arrangements with a total population of 54 residents. It provides programming to more than 650 individuals with disabilities who attend the agency's day training facilities. This agency also provides various other services such as behavioral health, school transition and self advocacy.

METHODOLOGY

To pursue the investigation, the allegation was discussed with the agency's Director of Community Integrated Living Arrangement (CILA) Services during closed sessions at the South Suburban Regional public meetings. The HRA conducted a site visit and the Director of CILA Services, the Associate Director of Program Services and a Direct Services Professional were interviewed. The complaint was discussed with the resident's guardian by telephone. Relevant agency policies were reviewed.

Sections of the adult resident's record and a copy of his Guardianship Order, dated May 2nd, 1996, were reviewed with consent. This order appoints guardianship over the resident's personal care and finances.

COMPLAINT STATEMENT

The complaint stated that a resident in a Community Integrated Living Arrangement managed by Sertoma Centre was discharged from the agency's program during an inpatient

hospital stay. The agency reportedly would not accept the resident back from the hospital nor assist with finding another placement.

FINDINGS

An HRA review of the record indicated that the resident was placed in Sertoma Centre's Community Integrated Living Arrangement program on June 30th, 2003. His diagnosis included Mild Mental Retardation, Bipolar Disorder, Hypertension, Lymphedema, Hyperlipidemia and Grand Mal Seizure. Seroquel 300 mg daily, Furosemide 20 mg daily, Depakote Extended Release 500 mg twice daily, Topamax 100 mg daily and medications for his physical problems were prescribed in 2009.

The resident lived in a Sertoma home with five peers who ranged from 27 to 67 years old, with diagnoses of autism to profound mental retardation. According to the resident's semi-annual "Individual Service Plan" (ISP) dated January 18th, 2009, he had a good relationship with his roommate. He was allowed nine hours of unsupervised time in the home and six hours in the community. He attended the agency's workshop and worked part-time in the community. He was doing well in regards to achieving his objectives. There were no changes recommended by the interdisciplinary team. The signature documented that the resident and the prescreening caseworker participated in the development of the plan. His guardian later signed the plan. The resident's Intervention Plan targeted inappropriate verbal and physical interactions, verbal and physical aggression, and hyperactivity behaviors. It indicated that Depakote had been added to his medication regimen in April 2009. His plan was reviewed by the agency's Human Rights Committee (HRC) and its Interventions Rights Committee (IRC) on a regular basis.

The HRA reviewed three incident reports indicating that the resident had exhibited physical aggression toward his peers. On April 21st, 2009, the resident walked over to a peer at his workshop. He grabbed her hair, threw her on the floor, started pulling her hair and punching her in the face. The resident's Intervention Plan reviewed on June 2nd, 2009 stated that he was "very aware that what he did was wrong" concerning the above incident. According to the plan, the resident might occasionally lose his patience with his housemates, but this behavior was becoming increasingly rare. It stated that Depakote was increased. The plan was approved by the agency's HRC and the IRC. Another report documented that his guardian gave consent for the medication change.

According to the resident's ISP dated June 19th, 2009, he continued to exhibit positive relationships with his housemates, staff, coworkers, family and his girlfriend. It stated that the resident was very disappointed because his work hours had been significantly reduced. He was referred to the agency's Insight Department for community employment services. The plan referenced that the resident would be redirected to a specified area if he was verbally or physically inappropriate. He would not be allowed to attend the next scheduled community outing when this occurred. His psychotropic medications were reviewed by the psychiatrist every three months. Rights are reviewed yearly, and a copy of these rights was given to his guardian.

An incident report dated July 28th, 2009 stated that the resident held a male peer down with one hand and beat him in the head and face with his fist. The resident was redirected many times to cease this behavior, but the workshop staff had to physically intervene before he was willing to do so. It was recorded that the resident's physical aggression had increased towards peers at his workshop. His guardian was notified of the incident. Another incident report dated September 21st, 2009 documented that the resident repeatedly punched his roommate in his chest around 11:30 p.m. There was reportedly blood on his roommate's lip, mouth, nose, and bed sheets. His eyes were blackened, and first aid was administered. His roommate was transported to a local hospital for medical care. The Residential Director, the Residential Services Coordinator and the nurse were informed of the incident. The resident was subsequently hospitalized for psychiatric care. A note written by the Residential Services Coordinator (RSC) stated that the resident's guardian was informed, and the staff person attempted to notify the victim's guardian. According to the note, the resident's roommate suffered a broken nose and required one suture in his lip.

On September 24th, 2009, the agency's clinical team met with the prescreening caseworker to discuss the case. According to the meeting report, the resident's physical aggression had increased with intensity and severity during the past 18 months. The precipitating factors causing his behaviors were few or unknown. The resident had inflicted serious injuries on three peers in separate incidents. The resident physically attacked his roommate for allegedly turning on a light during the night. His roommate reportedly was surprised by the attack that he did not realize that the resident was hitting him during the altercation. His injuries were described as extensive and serious. According to the report, there were many staff members at the day training program, but they were not able to stop the resident because of increased strength. His three peers who had been physically attacked were traumatized by the incidents, per the report.

The report further stated that the resident had participated in counseling sessions for a few years, but he never acknowledged any problems. The clinical team had agreed that the resident was a danger to his peers in the home and the day training program. There was a concern that the resident might cause irreversible physical harm or death to another individual. It stated that he could not return to his CILA home because of safety concerns. The HRA notes that the resident had been admitted to a psychiatric inpatient unit after physically attacking his roommate. According to the report, the guardian, the Illinois Department of Human Services (IDHS) and the prescreening agency would be notified about the discharge decision. On that same day the agency's nurse wrote that the 268 pound resident was difficult to stop when he became physically aggressive. She recorded that the resident was a danger to others in the program. And, several of the agency's residents would not be able to call for help if attacked because they were nonverbal. According to the note, the nurse and the agency's psychiatrist had recommended another placement for the resident.

A letter dated September 24th, 2009 addressed to the guardian stated that the agency could no longer provide services because the resident's behaviors placed him and others at serious risk. It stated that the resident had physically assaulted three peers who required emergency medical care in separate incidents. And, the incident on September 21st, 2009 could

have resulted in death if the staff had not intervened. According to the letter, police reports were filed concerning two of the altercations and charges might be pending regarding the last incident. The letter documented that services were terminated effective immediately. A notice of the resident's appeal rights was reportedly enclosed. And, a copy of the letter was sent to the prescreening agency, the hospital and two representatives with the IDHS.

A Clinical Administrative Review Team (CART) Consultation Request form was found in the record, but the space designated for the date of completion was left blank. A fax cover sheet dated October 2nd, 2009 indicated that information was sent the IDHS' Chicago area office. On October 7th, 2009, the RSC reportedly asked the resident's guardian if the agency could provide any additional assistance. She replied that the prescreening agency might have found another placement for the resident. Thirteen days later, the RSC wrote that a discharge and intake meeting was scheduled for November 11th, 2009 with the receiving agency. The RSC later recorded that the guardian was pleased with the resident's new CILA placement because he had a private bedroom. The staff person reportedly told the guardian to call the agency if she needed help.

A signature sheet documented that the resident, the guardian and the prescreening caseworker attended the service closure meeting held on November 11th, 2009. According to the meeting report, the resident's placement outcome was "very successful" except for several incidents of physical aggression. The clinical services team had determined that these incidents were too severe for continuation of placement. The resident's housemates were vulnerable to injury. It stated that he was not appropriate for the agency's other homes according to the Residential Department. The service closure plan was signed by the resident and his guardian on November 12th and December 15th, 2009 respectively.

When the complaint was discussed with Sertoma's staff, they said that the resident had lived in another CILA before being placed at their agency. He was behaviorally appropriate prior to the 2009 incidents. The staff reportedly never determined why the resident physically attacked a female peer on April 21st, but Depakote was increased days later. The physical altercation on July 28th allegedly occurred because of a previous incident. The reason for the incident on September 21st was also never determined. A Direct Services Professional (the overnight staff person) said that the resident had shared a room with his roommate for some time. She repeated that the resident had a good relationship with his housemates before the incident.

According to the Director of CILA Services, the resident was seen by the agency's psychiatrist every three months, and the HRC and IRC reviewed the medication change. However, his level of aggression increased and lack of remorse decreased. He was usually remorseful because of consequences that followed his behaviors. One time he reportedly verbalized remorse after his guardian revoked his unsupervised time. According to the clinical staff interviewed, the resident was a danger to others. He could not return to the same home because of the incident with his roommate, and there were no beds available in the agency's other homes. He was discharged from the agency on September 24th, 2009.

The HRA was informed that the agency's clinical team and the prescreening caseworker met with the CART on the second Thursday in October. The CART reportedly recommended another living arrangement for the resident. On questioning, the investigation team was informed that the CART does not provide a written report of recommendations. The Associate Director of Program Services said that the guardian appealed the discharge decision with the IDHS. She said that a placement was found before the hearing date, and the resident was placed in another agency's CILA program post-hospital discharge in October.

Sertoma's policy states that discharge can occur when the interdisciplinary process has determined that: 1) the individual's medical needs cannot be met in the current program, 2) the individual's behavior represents a serious danger to self or others, 3) the individual no longer benefits from CILA services, or, 4) the resident or legal guardian requests discharge. The policy includes steps to be taken before discharging an individual from the agency's program: 1) contacting the guardian, the family, the Community Support Team and documenting all discussions in the resident's record, 2) the completion of a functional assessment, 3) implementation of all recommendations from clinical services prior to moving to the next step, 4) implementation of all recommendations from the CART or technical assistance, 5) if the resident's challenging behaviors still continue, the prescreening agency must be notified of the intent to discharge, the IDHS Network Facilitator's approval must be obtained, and a 30-day written notice must be provided to the individual, the guardian or family that includes appeal rights. Alternative resources will be discussed with the prescreening agency and the resident, and, 6) the agency may discharge a resident who poses a serious threat or danger to self or others at any time....

The agency's "Service Closure, Referral and Follow-Up" policy states that if service closure is being considered due to behavioral reasons, prior documentation of the severity and frequency of behaviors including evidence of attempts to utilize positive interventions to decrease the behaviors is usually required. All involuntary service closures will be reviewed by the Clinical Services Team prior to finalization. All individuals discharged from the agency must have a written Service Closure Plan developed with input from the team, the resident, the guardian and other appropriate individuals or agencies.

CONCLUSION

According to Section 5/2-102 (a) of the Mental Health and Developmental Disabilities Code,

> A resident 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 resident to the extent feasible and the resident's guardian, if appropriate.

According to termination criteria under the CILA Rules, Section 115.215 of the Illinois Administrative Code,

(a) 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 and the transfer has been agreed upon by the individual, the individual's guardian, the transferring agency and the receiving agency; or 4) The individual no longer benefits from CILA services.

(b) Termination of services shall occur only if the termination recommendation has been approved by the Department.

Section 120.100 of the Medicaid Waiver Program Notice of action states,

(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 120.110 of the Medicaid Waiver Program under Appeals and fair hearings states,

(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.

Three incident reports in the record indicated that the resident was physically violent toward three different peers. He was hospitalized following the last incident on September 21st, 2009. The agency's clinical team met with the prescreening caseworker to discuss the case on September 24th, 2009. On that same day a letter was sent to the guardian stating that the resident's behavior in the CILA placed the resident and others at risk. The letter documented that services were terminated effective immediately. The letter reportedly contained a notice of the guardian's right to appeal the agency's decision. A copy of the letter was also sent to the prescreening agency, the hospital and two representatives with the IDHS.

According to the agency's administrative staff, the case was discussed with the CART on October 8th, 2009, fifteen days after the formal notice was given. The CART recommended another placement for the resident, but they do not provide a written report of recommendations. Documentation indicated that the agency provided follow-up services after the resident was discharged. The guardian reportedly appealed the discharge decision but placement was found before the hearing date.

Sertoma's policy requires a 30-day notice except in emergency situations. Evidence in the record indicated that a written notice was given, which applies to an emergency discharge. The termination notice was given within the required time frame pursuant to Section 120.100 (d). The September 24th, 2009 notice contained a written statement of the guardian's right to appeal the termination decision under Section 120.100 (d) (4) and the agency's policy. The HRA also finds no violations of the Code's Section 5/2-102 (a) and the CILA Rules 115.215 and 120.110.

The Authority does not substantiate that a resident was inappropriately terminated from services. However, we are concerned about Sertoma's role in the ordeal. It seems that additional interventions should have been explored in addition to a psychiatry visit once every three months, medication increases and counseling that was not working. Best practice dictates that it would have been more reasonable for the agency to request assistance from the CART before the impending discharge occurred.

SUGGESTIONS

1. Consider utilizing resources such as the CART and Technical Assistance at the earliest identification of a problem or when a resident's behavior continues to decompensate resulting in multiple hospitalizations.

2. Document all meetings and discussions with the CART and Technical Assistance in residents' records.

3. Be sure to include the date of completion on consultation request forms.