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East Central Regional Human Rights Authority
Report of Findings
Case 11-060-9003
Chamness Square

The East Central Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegations concerning residential health services at Chamness Square located in Bradley, Illinois:

Complaints:

1. **Resident safety measures are inadequate.**
2. **Adequate service and needed supports are not provided.**

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/1 et seq.) and the MR/DD Community Care Act.

Per the Illinois Department of Public Health website, Chamness Square is an Intermediate Care Facility for the Developmentally Disabled (ICF/DD) 16 bed group home. It is part of **Pinnacle Opportunities.** Per the Public Health website, this facility does not accept individuals who are aggressive/antisocial, have chronic alcoholism, drug addiction and are ventilator dependent.

COMPLAINT STATEMENT

According to the complainant, the resident was battered on 07/29/10 and the guardian was not notified. Speech therapy was recommended for the resident but it was denied. The resident has not been allowed to make calls, (but may only receive them), but even that has been very limited. He was denied access to his personal cell phone, the only phone he can use independently. He was not allowed to watch TV. His TV was broken. Counseling was not provided to the resident. Some rights restrictions may be court ordered.

The HRA proceeded with the investigation having received written authorization to review the consumer's record. To pursue the matter, the HRA visited the facility where the program representatives were interviewed. Relevant practices, policies and sections of the consumer's record were reviewed. The HRA met with the Administrator, 2 Residential Programmers, the Facility Representative Trainer, direct care and social work staff.

Findings

When asked by the HRA if Chamness Square is a part of a larger agency, the response was that it was a part of Pinnacle Opportunities. Chamness Square is a 16 bed home, at this time there are 14 individuals residing in the home. There is one individual recuperating at a nursing facility who is expected to return.

When asked about training, Chamness staff shared that training included direct service personnel (DSP) certified training through DHS Rule 116 for medication administration and also the DSP protocol. Also, staff were trained on behavior aggression, behavior management, and medication.

A list of staff courses was provided to the HRA. These courses must be completed within a staff person's first 120 days of employment. In-service training provided to staff. Staff receive refresher training on abuse/neglect and resident rights.

The HRA asked the location of the advocacy contact information for residents and staff.. The response was that advocacy information and resident rights were posted; staff are tested quarterly on rights information along with abuse and neglect protocol.

The HRA asked if staff are trained in recognizing and reporting incidences of abuse and whether confidential reporting occurs. The response was yes. Chamness staff stated there are two phones available in the general area, accessible to staff and residents. If an individual is unhappy they can call anybody they want. There are two cordless phones. Policy is if staff see or believe that other staff are acting inappropriately, they are to document and notify the administrator, executive director or director of operations. This is posted in the facility.

Regarding the altercation between the two individuals, the HRA received a copy of the report of the incident. Staff stated this individual was not battered but had a dime size bruise. The other individual was transferred to a behavioral health unit of a local hospital. The incident report was sent to the Department of Public Health. It was reported to a co-guardian and the guardian ad litem. There is a no contact order between the other co-guardian and the home. There is a policy for notifying the guardian regarding incidents.

When asked what procedures are in place to insure resident safety and protection, the HRA was informed that behavior programs exist for all residents who have behavioral challenges. All staff are trained and are very aware of issues involved with the residents, including identifying warning signs that they can see before an incident occurs. Both residents have a behavioral program in place. There are several different staff in the home, including the QSP, the trainer and facility representatives.

Regarding procedures that are in place for documenting, reporting and reviewing behavioral incidents or resident injuries, there is a behavioral tracking form to see if there is a necessity. There is also a Behavior Management Committee. They utilize the Department of Human Service (DHS) clinical administrative review team (CART) and the DHS service and support team (SST). It was explained to the HRA that a pre-admission screening (PAS) agent may recommend a SST for an individual who is facing difficult challenges in the community. The DHS website states: "The Support Services Teams (SSTs) will provide an interdisciplinary

technical assistance and training response to persons with a developmental disability in a medical or behavioral situation that challenges their ability to live and thrive in the community. The SSTs will observe, assess, evaluate, consult with family members and providers working to support the person and provide training as necessary. They will have nurses, Qualified Support Professionals (QSPs), psychologists, and Board Certified Behavior Analysts (BCBAs) on staff and have ready access to other needed specialty providers, such as psychiatrists and speech therapists."

The HRA asked if speech therapy had been provided. Chamness staff stated there was an evaluation of the individual's speech and speech therapy was not recommended.

There have been numerous changes the resident has had to face. We asked if the resident had been referred for counseling and was told that he sees a psychiatrist and he has been consulting through the Down Syndrome Clinic. He has obsessive compulsive disorder issues and is being medicated, but not for OCD.

Regarding the allegation that his TV was broken at the facility, the staff said the one he has works just fine. When asked was it recommended that this resident not be allowed to watch TV, the response was no.

The HRA asked with who the resident has been allowed to talk. There is a non-contact order from the court limiting who may contact the resident, but he may talk to whoever he wants. When asked why he was not allowed to make personal phone calls, the HRA was told that the court determined who he was allowed to call. Per the order, his sister may call him once a week. He can call her anytime he wants. He would be assisted by staff that would help him dial the number. There was a no contact order issued by the court regarding the other co-guardian.

We asked how staff reported to a physician when ordered medication was not provided to a resident. It was explained that they would contact the nurse and then call the administrator. There are three nurses: a full time RN, RN consultant and a LPN, who begin their workdays at Chamness.

In describing the grievance process at Chamness, the staff said that the QSP is contacted first to discuss the issue. If the issue is not resolved by the QSP, the issue would be taken to a higher authority to be resolved. There is a resident council that can address the issues as well. When asked how residents and families are informed of the grievance process, the HRA was told they are informed at admissions. In this resident's case, his guardian ad litem would also be contacted to assist in advocating on behalf of the resident to resolve any issues.

All residents participate in a dining out activity once a month which is paid for by the company. This consumer participates in the Special Olympics. He also participates in special recreations and enjoys movie Mondays. He has signed up to see several movies. He attends day trips. When the resident first came to the home he seemed isolated; he told them he was too tired to participate in activities. He now wants to go and has started to come out of his shell. He likes to go shopping. He likes to go to day training (DT). He also likes to participate in theatrical productions.

When asked if the home has an active, internal Human Rights Committee and an active Behavioral Management Committee, their response was that the committees meet once a quarter. The committees discuss programming, any rights restrictions and behavioral restrictions and are comprised of two community representatives, two qualified support professionals, nursing staff, an administrator and a psychiatrist. They also discuss medication increases or medication changes. There is discussion of how to prevent fall risks. The committees have discussed the issues in this case. Regarding rights restrictions for this resident there are the court orders and his medication which consists of Ativan, Zoloft and Trazodone. The court has ordered no contact at all with one of the co-guardians and limited contact with the other co-guardian. The second co-guardian can be contacted by phone, attend ISP's and see the resident periodically.

Site Visit

The HRA was given a tour of the residence and the HRA observed about a one staff member ratio to about every 3 residents. Residents were participating in art activities and all appeared to be happily engaged and very comfortable in their surroundings. The home itself was very nice, warm and very clean. Every room was large and accessible. This home could serve individuals with varying disabilities. It was well decorated and furniture was updated. The kitchen and dining areas were clean and comfortable. Several cordless phones were cradled in the commons area. The HRA visited with several of the residents. All of the residents whom the HRA conversed indicated that they liked living there. Residents stated that they liked the food and the staff. Menus were posted in the kitchen area where residents could access them any time. They appeared to be nutritious and have some choices for the residents.

The HRA visited with the resident in question and he told us how much he loved various staff members. The resident was neatly groomed and well dressed. The resident appeared to truly care about certain staff and seemed to enjoy interacting with staff members. He told us he liked living at the home. The resident then told us we had to leave. The resident did allow the HRA to observe his room, but it was observed by the HRA team that he had a working television that happened to be on. The room was very neat and clean. The resident had it decorated with items that he enjoyed.

The HRA did respect the resident's wishes and did not stay at the home much longer. The HRA had been given a tour of the whole home and was able to observe other bedrooms of residents which were all in good condition and it appeared that the personal taste of each resident was respected. All residents had access to their personal belongings in their rooms.

Consumer rights were posted, but the HRA did not see advocacy contact information posted. The HRA contacted the administrator after the site visit and was sent a copy of the emergency call list and was informed that this is posted in all homes. The lack of posted advocacy contact information was an oversight that was fixed immediately when it was brought to their attention.

The HRA reviewed the following Chamness Square Policies:

- *Behavior Management/Resident Rights Committee (11/08)*
- *Quality Assurance Committee (11/08*
- *Resident Rights (11/08)*

- *Physical Injury and Illness/Individual Medical Emergencies (09/09)*
- *Training of Authorized Staff to Administer Medications (1/10)*
- *Self-Medication Assessment, Training and/or Monitoring (11/08)*
- *Investigative Committee (11/08)*
- *Roles for Facility/Responsibility (11/08)*
- *In-Service Training Schedule (no date)*
- *In-Service Education Meeting Report Orientation with DSP*
- *Administer In-Service Education Meeting Report Orientation with DSP*

These polices were in accordance with the Mental Health Code and the MR/DD Community Care Act.

RECORD REVIEWS

Psychosocial 3/11/09

In the record was the Psychosocial completed on 03/11/09 by the Adult Down Syndrome Clinic. It documented that the resident was embroiled in a conflict, between the co-guardians. There is currently a court case to decide who actually maintains guardianship for him. The main purpose of the evaluation was to look at how that affected the resident, as follows:

Psychosocial Mental Health Issues

It documented that the purpose of the report was to look at the effects of conflicts over the resident's guardianship between the different individuals responsible for his care. There would be recommendations to reduce conflict and make it more manageable for him. Some of the issues documented were:

- numerous allegations by one co-guardian about home to state agencies.
- Allegations by co-guardians against each other.
- The resident not wanting to be with any other family member but his mother.
- The residence is embroiled in the constant conflict and complaints by the co-guardian.

It was documented that the resident had a great deal of anxiety, that he has had difficulty going to sleep and he has difficulty getting along with people, resulting in a high level of agitation.

According to the report, there was a long history of obsessive/compulsive behaviors which is common in persons with Downs Syndrome. It was stated this could be beneficial in following a routine schedule and managing their room and personal items. It explained that most people with Downs Syndrome are highly sensitive to people around them. An individual with Down Syndrome may have difficulty blocking out situations of conflict if there are intense conflicts such as what exists between the resident's family and his residence, because they are unable to manage and can be overly affected by these conflicts.

It was stated in the document: "This individual has sided with his [one co-guardian] against others. He may have some need to help or be with her in some way. Although it is admirable, it is not necessarily beneficial for his mental health and well being. Therefore I would suggest anything that could help relieve the conflicts and tensions between people because that would help the resident a great deal. It sounds like there were times in the past when this conflict was

regulated or visits between different people were managed. That as long as he is not caught between people, not carrying messages or expressing conflicts or is a witness to these conflicts or tension, he seems to do better. It should reduce the number of obsessive compulsive behaviors."

Summary and Recommendations: "The conflict existing between people is not the issue; it is how involved the resident is in the conflict. Again, if the resident carries messages back and forth between people or if he observes the situation and hears criticisms about others by one party towards the other, this is extremely unproductive for his mental health and well being. Therefore, anything that can be done to help better manage this would be productive for him.

Personal History

- No alcohol use.
- Co-guardians listed.
- No drug use.
- Exercise habits; He bowls and roller skates.
- Occupation: he attends a sheltered workshop
- No smoking"

Review Individual Service Plans dated 9/4/09 and 8/16/10

Per the documentation presented at the resident's admission, Resident Rights have been signed off that they were discussed with the resident. It is further documented that the resident's rights were discussed with him in the behavior support plan. Cognitive assessment by his clinical psychologist using the Stanford Binet Intelligence Scale 4th edition documents the resident's IQ score of 32 and the level of functioning as severe. The following is a comparison of the documentation of the last 2 Individual Service Plans (ISP) on 9/4/09 and 8/16/10.

	ISP 9/4/09	**ISP 8/16/10**
Functional Assessment:		
Based on scales of Independent		
Behavior-Revised (SIB-R)	4 years, 9 months	4 years, 9 months
Completed by QSP on	9/2/09	8/13/10
Level of functioning:	severe	severe
General Observations:		
According to SIB-R, the		
Personal Living score:	5 years, 11 months	6 years, 2 months
Motor skills	4 years, 5 months	3 years, 9 months
.		
Community Support Team		
(CST) overall level of		
Functioning:	severe	severe
Medical		
Diagnosis:	moderate mental retardation Down Syndrome	moderate mental retardation Down Syndrome

	hypothyroidism toenail fungus	hypothyroidism toenail fungus obsessive compulsive disorder moderate to severe hearing loss in left ear

Current Medications and Reasons for Receiving :
(This is a comparison of the last two ISP's)

ISP 9/4/09	**ISP 8/16/10**
Levothyroxine tab, .088 1 tab daily Multivitamin, 1 tab daily Johnson's baby oil, 420 cc 2 drops in Lactic acid cream 10%, Apply to feet daily	Synthroid 0.1mg: 1 tablet PO daily; DX: Hypothyroidism Lexipro tablet 10mg; 1 PO DX: Major Depression Ativan Tablet 1 mg;1 tab PO bid DX: Generalized anxiety disorder Trazodone Tablet 100 mg; 1 tab PO @ HS; DX: Major Depression Multivitamin tablet; 1 tab daily

The HRA was provided copies of consent for medications that was signed by the co-guardian who does not have the order preventing any contact with the resident. Now the resident takes Sertraline (Zoloft) instead of Lexipro. Side effects of these drugs were taken from the Physician's Desk Reference (PDR) drug information for publication on the http://www.drugs.com/website:

- "Ativan side effects: Nervous system side effects have been common and have included drowsiness, fatigue, confusion, impaired cognition, daytime anxiety, asthenia, amnesia, headache, dizziness, and ataxia. Orofacial dyskinesias have been observed rarely.

- Zoloft side effects: Nervous system side effects including insomnia, somnolence, tremor, dizziness, headache, and fatigue have all been reported. The incidence of each of these effects ranges between 10% and 20% of treated patients. Akathisia, myoclonic jerking, and sleep abnormalities have also been reported. At higher doses, drowsiness often ensues. Increased alertness and enhanced cognition have been reported when Sertraline is taken at low doses. Excitement has been reported less frequently. Sertraline-induced facial paresthesia has also been reported.

- Trazodone side effects: Nervous system side effects are common and include drowsiness and sedation in as many as 50% of treated patients. Dizziness (10% to 30%), sleep abnormalities, headache, fatigue and, more rarely, seizures, dystonia, akathisia, myoclonus, palinopsia (persistence or reappearance of an image of a recently viewed object), and extrapyramidal symptoms have been reported."

Last Exams:	**ISP 9/4/09**	**ISP 8/16/10**
Physical exam	8/25/09	08/24/10 scheduled
Dental	10/19/09	10/19/09

Hearing (Per this exam, the consumer has essentially normal hearing acuity in his right ear, and moderate to severe hearing loss in his left ear.)

Eye 11/24/09 and will be scheduled one year after the last exam.

Labs drawn 9/09/09 7/19/10
The labs were reviewed by the physician and the nurse. On 7/19/10, the labs were reviewed by the Adult Downs Syndrome Clinic, which included the physician and nurse of the clinic.

Nursing Pre-screening 8/5/09 8/3/10

Dietary:
Weight: 195 pounds 187 pounds

Nutritional assessment was completed by a dietician for both ISP's - his ideal weight range is 151-161 pounds.

Motor Skills
It was documented on both individual service plans that this resident's motor skills are very limited. By the second ISP his motor skills were considered "negligible." Age-level tasks involving balance, coordination, strength, and endurance are extremely difficult for him. Age-level tasks requiring eye-hand coordination using the small muscles of the fingers, hands, and arms are extremely difficult to impossible for him. His performance is comparable to that of the following age averages for the last two ISPs:

ISP 9/4/09	**ISP 8/16/10**
4-5	3-9

Communication
The resident's communication skills are limited to "negligible," his performance is comparable to that of the following age averages for the last two ISP's are:

ISP 9/4/09	**ISP 8/16/10**
3-1	4-4

The resident is able to communicate his wants and needs. He is able to understand simple spoken directions and responds appropriately when asked simple questions.

Social Services/Guardianship Section for both ISPs, document that the consumer moved to Chamness per court order. Only a few relatives are allowed to visit the consumer. One of his co-guardians is under a no contact court order at this time. It also shows that the other co-guardian has limited contact with the resident by court order. This co-guardian with limited contact by the court does contact the resident weekly by phone and attends the ISP via teleconference. The resident cannot go on home visits due to court order. He does see peers outside of the facility while working and when participating in special recreation activities. He does work at a sheltered workshop and he is paid for doing piece rate work. It was documented that the resident did not have an interest in attending church and that he did not want to register to vote.

Programs for Resident

There were programs to assist the resident to remember his autobiographical information, the addition of money, how to complete his laundry and self-medication.

Behavior Programs for the Resident

There were behavior programs to assist the resident with verbal aggression and inappropriate behaviors. When the resident first arrived at the home he tried to run out the door numerous times. Other behaviors included verbalizations, inappropriate touching, and posing as a female model and making faces to seek a response from staff and peers.

Documentation of incident on 4/15/10: "On 4/15/10 at approximately 4:30 p.m., resident called for the DSP, who was in the dining room, from his bedroom. As DSP was heading back to room she heard the resident tell his roommate 'you better not hit me.' When DSP got to the bedroom, the resident went behind her to avoid the other individual. The roommate struck the resident in the face with an open hand.

The individual left the room and went to the med room because another DSP had been calling him to come take his meds. The first DSP stayed with the resident to make sure he was OK. Another DSP heard the individual having the behavior, swearing as he was coming to the med room. This DSP attempted to redirect him. This individual continued and wouldn't allow the DSP out of the med room so she called emergency services. DSP called the QSP to inform him of the situation.

The individual who had the behavior was transported to the hospital for evaluation and admitted. Administrator & co-guardian were notified. The other resident was assessed and was calm. He had no injury and said he knew the individual who had the behavior wasn't mad at him.

There was documentation reviewed for the resident who was hit. There was behavior programming planned for the individual who had the behavior, hospital admission paperwork, and a report to IDPH.

Committee Findings: The individual who had the behavior has had increased agitation since his physician discontinued a medication due to his low white blood cell count. The committee feels that his physician needs to reevaluate this individual's needs. This had been an isolated incident of physical aggression. Safeguards were put in place at time of incident to ensure safety of both individuals. The resident indicated he is comfortable with his roommate at this time. Staff and RSD will continue to observe situation with the resident and the individual who had the behavior. The individual who had the behavior was hospitalized with diagnosis of Defective Disorder and medications were changed.

Committee Considerations: Staff will give either verbal praise to the individual who had the behavior when he is acting appropriately, or will spend one on one time with him every day. Staff will speak with the physician about the individual's agitation. Staff and RSD will continue to observe situation between the resident and his roommate who had the behavior when he would be discharged from the hospital."

Documentation of Incident on 7/17/10: Per the Progress Notes on 7/17/10, the QSP documented: "The resident had been hit by another resident. He was separated from that resident while staff called 911. When the EMT arrived they checked him over and found a scrape on his forehead and quarter sized bruise on the inside of his right bicep. The EMT said that he did require medical attention. The QSP also checked the resident over and found the same markings. The staff were to monitor his condition and report any changes to him. The RN would also assess him the following day. It was documented that the resident went to bed without problems."

Per Progress Notes on 7/18/10 the QSP reviewed the nursing notes and then met with the resident. The QSP explained he wanted the resident to feel safe. He also reviewed appropriate social interaction and went over what the consumer could do to feel safe. He also reviewed with the consumer appropriate social interaction and explained to the consumer what he could do to be safe. With prompting the consumer stated: "Ignore people who are bugging me; go to another room; get away from people when they are upset; Get staff for help." There was further discussion about social interaction and respecting the privacy and personal space of his house-mates.

COMPLAINTS

Complaint 1. Resident safety measures are inadequate. There were two altercations between the resident and his roommate. From the record in both cases, staff made every effort to diffuse the situation and protect both residents. In one of the incidents, the resident understood that his roommate was having a behavior that his roommate could not control. It was documented that the resident was not upset with him. His roommate's behavior was triggered due to a medication change that staff could not predict. They even called an ambulance when the resident only had a dime sized bruise. The roommate is no longer at the facility. It appears that there was adequate programming and staff to support a difficult situation. The situation was reported to IDPH pursuant to the MR/DD Community Care Act, 210 ILCS 47/2-107. Abuse or neglect; duty to report which states: "Abuse or neglect; duty to report. An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. It is the duty of any facility employee or agent who becomes aware of such abuse or neglect to report it as provided in the Abused and Neglected Long Term Care Facility Residents Reporting" Based on the documentation, it appears that Chamness staff instituted measures to protect the individual from abuse which is his right pursuant to Mental Health Code that mandates that every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect under 405 ILCS 5/2-112.

The home was very neat and there appeared to be no hazardous material that could hurt an individual inadvertently. The resident at the time of the site visit had his own room and a working flat screen television. It appeared that Chamness adhered to the Chapter 210. Health Facilities, Act 47 regarding a resident's right to personal property. It states: "a resident shall be permitted to retain and use or wear his or her personal property in his or her immediate living quarters, unless deemed medically inappropriate by a physician and so documented in the resident's clinical record." Based on the evidence in the record and the observations of the HRA team, **Complaint 1. Resident safety measures are inadequate is unsubstantiated.**

Complaint 2., Adequate service and needed supports are not provided. From the evidence in the two individual service plans that the HRA reviewed, there were adequate services provided by Chamness to support the resident. What service Chamness could not directly provide was provided through other agencies such as the SST teams from DHS, and the Adult Downs Syndrome Clinic. There was documentation that physicals, laboratory tests, dietary, mental health, vision, hearing, and communication needs were routinely addressed. He also received counseling to deal with the conflict involving the court and the guardians. It was determined that speech therapy was not needed. It appeared that there was adequate programming to meet habilitation needs and behavioral needs.

The HRA has some concern over the increase of psychotropic medications for the individual, the decrease in fine motor skills and the new diagnoses of depression, anxiety disorder, and obsessive compulsive disorder documented in the ISP within a year of being admitted to Chamness. All three medications could have long lasting side effects. These medications were prescribed by a physician and consent was renewed as of August 2011. There was documentation by the physician within the individual's record listing the rationale for continuing current medications pursuant to Title 59, Chapter 1, 115.240 Medical services and medications. This medication was part of the individual's service plan that was completed with him and with consent of the co-guardian that has been allowed limited contact with the resident per court order.

Chapter 405. Mental Health and Developmental Disabilities Code 5/1-101.2. defines adequate and humane care as "services reasonably calculated to result in a significant improvement of the condition of a recipient of services confined in an inpatient mental health facility so that he or she may be released or services reasonably calculated to prevent further decline in the clinical condition of a recipient of services so that he or she does not present an imminent danger to self or others." From the last ISP, this resident's fine motor skills had decreased by almost a year of development. In the psycho social evaluation he stated his favorite hobby was roller skating. This activity would require the use of large and fine motor skills. The HRA consulted with Chamness to see if this was an activity the resident still enjoyed and was told he has not mentioned any interest in roller skating which is surprising since it is documented as one of his favorite hobbies. Staff did express that it may not be safe since the resident's vision has declined.

This resident had his rights restricted by the court regarding unimpeded, private and uncensored communication by mail, telephone and visitation. One of his behaviors documented in both of his ISPs was that this resident would try to run out the door. The HRA questions if the behavior could be related to anxiety over his situation and the resultant three psychotropic medications to treat anxiety, obsessive compulsive disorder, and depression within his first year of living at Chamness Square.

It does seem that this individual has had further decline in his clinical condition, but there was no evidence in the record or observed by the HRA that Chamness failed to provide adequate and humane care. The documentation of the resident's record showed that support services

needed by resident had been provided. Based on the evidence in the record, **Complaint 2., Adequate service and needed supports were not provided is <u>unsubstantiated.</u>**

The HRA would like to thank Chamness Square for their complete cooperation with this investigation.