FOR IMMEDIATE RELEASE

North Suburban Regional Human Rights Authority
Report of Findings
HRA #11-100-9005
Clearbrook

Case Summary: The HRA concluded that Clearbrook violated the client's rights when it did not follow its own policy by ensuring that a CST meeting was held regarding the discharge and no discharge plan was developed. The HRA's public record on this case is recorded below; the provider's response immediately follows this report.

Introduction

The North Suburban Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation of alleged rights violations at Clearbrook. In September 2010, the HRA notified Clearbrook of its intent to conduct an investigation, pursuant to the Guardianship and Advocacy Act (20 ILCS 3955). The complaint accepted for investigation was that a consumer's rights were violated during a voluntary discharge.

If found substantiated the allegation would violate the Illinois Administrative Code (59 IL Adm. Code 115).

Background

Clearbrook has been providing services for people with developmental disabilities for more than 55 years. Clearbrook works with more than 3,300 children and adult clients each year, and their families, in more than 80 communities throughout Chicago and the surrounding suburbs. The focus of this investigation is a Community Integrated Living Arrangement (CILA) site. Clearbrook owns and/or manages 28 CILAs. According to Clearbrook Literature, Clearbrook's approach offers a customized goal plan for each client, based on the desires and wishes of both client and family. The clients actively participate in and support their neighborhood. Clients attend a wide variety of activities and outings such as: theaters, restaurants, sporting events, shopping, fitness centers, bowling, religious services, vacations, dances and holiday parties. Client need, choice and preference guide the services provided; self-advocacy is promoted.

Method of Investigation

To investigate the allegation, the HRA reviewed portions of the client's clinical record, with consent. Also reviewed were agency policies relevant to the allegation. The allegation was discussed with the Director of the CILA programs and a CILA Coordinator. The allegations were also discussed with the Community Alternatives Unlimited Case Manager (CAU) and the client.

Findings

The complaint reported that the client's rights were violated during a voluntary discharge, because the client did not fully understand what was meant by voluntarily discharging herself from the agency. At the time that the client signed the voluntary discharge form, she was receiving services in a nursing facility following a medical hospitalization.

The HRA met with the CAU Caseworker and the client who is a 33 year-old female who was residing at a Nursing and Rehabilitation Center; she maintains her legal rights. It was stated that she is being treated for a urinary infection and will possibly be ready for discharge in the near future. The client makes use of a wheelchair as she has spina bifida and does not have feeling from the waist down. She has had a Foley catheter for years due to a neurogenic bladder. The client explained the difficulties that she has in transferring, but with help she stated she is able to transfer. Where she currently resides, a Hoyer lift is available if needed. The client reported she is able to take a shower 2-3 times a week and needs minimal help to reach areas she cannot reach; otherwise she reports she can take care of her daily needs.

The CAU Caseworker reported that the client was in isolation for her protection and anyone entering her room had to wear a gown, gloves and a mask. The HRA observed the client was out of her room, going up and down the hallways and down to the lobby. We met in a separate room and were not asked to take any isolation precautions.

The HRA noted that as a person with a hearing impairment, the client did very well lip reading. She stated that she has had hearing aids in the past. She is deaf per her records, but the extent of her hearing loss is unknown to the HRA and if hearing aids would be beneficial to help her hear speech. The client stated that she knows sign language a little, but does not rely on it. She did sign a few words as she talked, i.e. TTY, telephone.

The voluntary discharge letter was signed 8/10/10. The letter stated that "We are formally notifying you that we are discharging you from the Clearbrook CILA Program effective 8/10/10. It is our opinion that we cannot safely meet your medical and therapeutic needs. Over the past several months you have consistently stated to us that you want to live in a setting that has more direct on site medical and therapy care than the Clearbrook CILA Program provides. Your signature below provides consent to this voluntary discharge from the Clearbrook CILA Program." In response to questions concerning the circumstances surrounding her signing of the voluntary discharge papers, the client said that the staff from Clearbrook came to visit her "a couple of times" while she was at the nursing facility. She said that they brought the discharge paper for her to sign. She said "I didn't mind because the staff (at Clearbrook) was not helping me as they were supposed to be doing". She said that she understood that it was a discharge paper that she was signing but did not mind "As long as I get everything from the house (Clearbrook) brought up to me here". Both the Case Worker and the client stated that a CST (Community Support Team) meeting was not held before the client was offered the voluntary paper to sign.

A review of the documentation from the CAU Caseworker showed correspondence dated 8/10/10 from the CILA Director to the Illinois Department of Human Services North Suburban Network which stated that (referring to DHS) "As we discussed my next step was to see if [client] would consent to a voluntary discharge from our CILA program." The Director goes on to say in this correspondence that the client signed the voluntary consent.

At the site visit, Clearbrook staff stated that the client had been in and out of the hospital since she was transferred to Clearbrook in July of 2009. She had numerous hospitalizations during that time for wound care, catheter related complications and infections. Her family is not overtly supportive. She has a brother in Rockford who has expressed a desire to have her live closer to him, but communications with him are difficult and intermittent. It was stated that the client had not been happy with her current services and wanted to move to a setting with more medical care. Agency personnel reported that she had been very consistent in her expressions about this. Her

community caseworker had been trying to find alternate living arrangements without success. The client had been discussed with CART (Clinical and Administrative Review Team) twice and the state is aware of the situation. The considerations offered from the CART meeting held on April 20, 2010, were that if it is determined by a physician and PAS screen that 24 hour nursing supports are needed, agency staff were to consider Clearbrook Commons, so that the client could maintain her relationship with Clearbrook, until placement in Rockford is identified. Clearbrook Commons is an Intermediate Care Facility. The Director stated that the client was denied admission into Clearbrook Commons due to behavioral concerns. The Director stated that he had been in consistent contact with DHS regarding discharge recommendations. The Director emphasized that it was the client's medical needs that were the primary concern in discharging her. His medical staff – and a consulting physician – had all said that they were unable to adequately take care of her medical needs and that the agency was putting her at risk if she was accepted back to Clearbrook after being discharged from the nursing home facility. The medical concerns included:

1. Open wound needing sufficient care
2. Decreased upper body strength – especially left arm
3. Limited ability to perform transfers because of decreased strength and pain.
4. Maladaptive behaviors – Urinary Cather problems.
5. 20 pounds weight gain.
6. Need for intensive PT and skilled nursing care.

The Director stated that he was directed by DHS to have the client sign a voluntary discharge. When asked if the letter that the client signed was a standard form, the HRA was told that the letter was developed specifically for this client.

The Coordinator explained that she and a QSP, Qualified Support Professional – who no longer works for the agency – went to see the client while she was in the nursing home. They explained the letter to her and the client said that she wanted to leave Clearbrook "Because the CILA cannot meet my needs". It was stated that the client is deaf, she can read lips, uses her voice and uses sign language. It was stated that the QSP was fluent in sign language and could interpret for her. It was stated that the client kept repeating that the CILA could not meet her needs. It was also stated that they had to wear a gown, mask and gloves because of the concern of visitors transmitting some additional infection to the client. When interviewing the client, the HRA asked her if Clearbrook staff were wearing the masks when they were talking to her and she said they did not have the infection control masks on.

The Director emphasized that the reason for the discharge was because they were unable to meet her medical needs. The STAR (Service Termination Approval Request) document that he sent to the CAU Worker showed that the client was discharged because she was admitted to a nursing facility. (The STAR form is sent to the CAU Worker, who is to sign-off and submit the form to DHS.) The CAU Worker told the HRA that she received the form but she did not sign it and did not send it to DHS because she did not agree to the discharge.

Clearbrook's Discharge Criteria Policy states that the interdisciplinary team shall consider recommending termination of the client's placement only if: 1) The medical needs of the individual cannot be met by the CILA Program; or 2) the behavior of the 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.

The policy goes on to say that "A voluntary discharge occurs at the request of the client or guardian. The procedure is as follows: 1) when a discharge is contemplated either by the facility or the family/guardian, a CST meeting shall be held with all interested parties, including the client. 2) a

complete review of all related materials shall be presented. 3) a written report by the CST shall be developed. This report shall be given to the client, family/guardian and various state agencies and shall include the discharge plan based on CST recommendations. 4) a discharge date shall be mutually arrived at based on client, family and agency needs.

Conclusion

Pursuant to the Illinois Administrative Code, Section 115.215 *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. For individuals enrolled in the Department's Medicaid DD Waiver, termination of services is subject to review according to 59 Ill. Adm. Code 120.

The HRA concludes that Clearbrook violated the client's rights when it did not follow its own policy by ensuring that a CST meeting was held regarding the discharge and no discharge plan was developed.

Recommendation:

The facility must follow its own policy regarding a voluntary discharge and conduct a discharge meeting for all discharges.

RESPONSE

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

CLEARBROOK

4/18/11

Julie Sas
Guardianship and Advocacy Commission
9511 Harrison Street, W-300
Des Plaines, Il 60016-1565

RE: #11-100-9005

Dear Julie Sas;

Regarding [redacted] # 11-100-9005; Clearbrook will follow our own policy regarding voluntary discharges by conducting a discharge planning meeting for all voluntary discharges.
As discussed in a previous letter to you the agency is planning for [redacted] return to our CILA program.
Please let me know if you need additional information and/or have questions.

Sincerely,

Sam Tenuto
Director of Community Living Services
Arlington Heights, Il 60005
847-385-5010
stenuto@clearbrook.org