FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
GARDEN CENTER SERVICES- 12-040-9016
HUMAN RIGHTS AUTHORITY- South Suburban Region

[Case Summary— The Authority made corrective recommendations regarding the allegations that were accepted by the service provider. The public record on this case is recorded below; the provider's response immediately follows the report.]

INTRODUCTION

The Human Rights Authority (HRA) has completed its investigation into allegations concerning Garden Center Services. The complaint stated that the resident was given a discharge notice because she walked out of her day training center and home. Additionally, the complaint alleged that the guardian was not properly notified about the resident's elopements and hospitalizations. If substantiated, these allegations would be violations 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), 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) and the Illinois Probate Act (755 ILCS 5/11).

Located in Burbank, Garden Center Services manages eight (8) Community Integrated Living Arrangements with a population of about 47 residents. This agency also provides residential care up to 16-bed facilities as well as day training, community employment, transportation and respite services to adults with developmental disabilities.

METHODOLOGY

To pursue the investigation, the agency's Director of Operations, a Board Certified Behavioral Analyst and a Qualified Human Service Professional were interviewed. The allegations were discussed with the complainant by phone. Relevant agency policies were reviewed.

Sections of the adult resident's record and a copy of her Guardianship Order, dated August 18th, 2008, were reviewed with consent. This order appoints guardianship over the resident's personal care and finances.

COMPLAINT STATEMENT

The complaint stated that the agency issued a discharge notice because of two behavioral incidents but failed to notify the guardian about them prior to termination of services. In the first reported incident, the resident had left her day training program without authorization and walked to a nearby fire station. Once there, the resident alleged that she was having a heart attack and paramedics were called. The resident's guardian reportedly learned about the incident from emergency services personnel. In the second reported incident, the resident had walked out of her CILA home because she was angry and attempted to open cars in the neighborhood. The police were called. The resident was transported to the hospital and was placed on a behavioral health unit. It was reported that the guardian learned about the incident from the hospital's staff.

FINDINGS

According to the record, the resident was a client of Garden Center Services' day training program before she was admitted to the agency's Community Integrated Living Arrangement (CILA) program on March 16th, 2012. She was diagnosed with Mild Mental Retardation, Cerebral Palsy and visual impairment. Her history included self-injurious behaviors, somatic complaints, verbal and physical aggression toward others, and inappropriate use of emergency medical services (i.e., calling 911 and wanting to be hospitalized). The record documented that the resident had been able to deescalate with the use of behavioral interventions prior to moving into her home and interventions to help her transition to the home from a hospital's behavioral health unit were in place on the 16th. They included, but were not limited to: 1) deescalation techniques were reviewed with the home staff, 2) information about the resident was shared with the staff, and, 3) the agency's Board Certified Behavioral Analyst (BCBA) and the CILA Director would be on-call 24/7 if additional support was needed. However, her behaviors to access medical attention increased in severity and she started to exhibit new behaviors such as attempting to get hit by moving cars.

The resident's record contained a summary report written by the BCBA and other documentation detailing her many incidents of inappropriate behaviors and the staff's efforts to help her. On March 19th, 2012, the resident reportedly called 911 from her cell phone and said that strangers (unauthorized people) were in her home. It was recorded that three cars with police officers responded to her frivolous emergency call. When the agency's BCBA and CILA Director arrived at the home, they were able to calm the resident and stayed with her until about 11:30 p.m. on that same night. A protocol that included sharing information about the resident's history with emergency personnel was developed. Documentation indicated that she was provided with many reinforcements to encourage positive behavior. Her guardian, who is her grandmother, reportedly was in daily contact with her support team. However, the HRA found no mention during the record review that the guardian was informed about the incident.

On March 24th, 2012, the resident reportedly walked out of her grandmother's house during a home visit and attempts to redirect her failed. It was recorded that a community member called 911 and that the resident was admitted to a behavioral health unit. The agency held a meeting during the resident's hospital stay and procedures for managing her behaviors were reviewed and more reinforcements such as a daily community activity with a staff person of choice were added to her plan. By documentation, the resident's family agreed to the plan that included no over-night home visit for at least two weeks. Also, the plan was reviewed with the resident when she returned to the home from the hospital on March 28th, 2012.

On April 12th, 2012, the resident reportedly eloped from her day training building and walked four blocks to a fire station. It was recorded that the resident threatened the staff person, who followed her, when she attempted to intervene. She reportedly persuaded the fire station employees that she needed medical care and they called an ambulance. The CILA Director, the guardian and the resident's aunt reportedly arrived on the scene, but there was no written indication concerning guardian or family notification found in the record. However, the complaint alleged that emergency personnel had called the guardian. By documentation, the resident was not transported to the hospital because paramedics determined that she did not require emergency medical care. She was allowed to spend time with her aunt for stabilization purposes before returning to her day training program on that same day.

An incident report, dated April 18th, 2012, stated that the resident became upset and took her guardian's keys to prevent her from leaving the CILA home. The staff provided redirection and she eventually threw the keys across the room and walked out of the home. She then tried to get her neighbors across the street to call the police because she wanted to go to the hospital. She reportedly stood in the street and put her arms around the staff person so that both of them would get hit by a car. When a car pulled up, she asked the people inside of the vehicle to call the police and yelled profanity at the staff person. She also said "I'm going to [expletive] kill you" when the staff person attempted to intervene. According to the report, the resident punched the staff person on her arm one time and in her stomach twice. The resident reportedly was able to calm down and return to the home with the assistance of a second staff person.

An incident report, dated April 19th, 2012, stated that the resident had refused medication, and a worker from the community prescreening agency came to the home to see her. The resident told the worker that she was having stomach problems and refused again. She then announced that she was leaving and walked across the street to a neighbor's house and knocked on the door. However, her neighbor did not respond or open their door. She yelled profanity at the staff person, who pursued her down the street, and was spitting at her. She reportedly said that she did not care if she got hit by a car and approached three cars and community workers called the police. It was recorded that the police called for an ambulance to transport the resident to the hospital, although they were informed that it would be better if she was allowed to walk to the hospital escorted by the staff.

The BCBA wrote that the resident's referral to the Illinois Crisis Prevention Network (Support Service Team) was still active in April 2012. This is a network of highly trained professionals, who have partnered with the Department, to work with individuals with severe behaviors and are struggling to maintain in their current home or placement. Her history and medication regimen reportedly were reviewed by the Support Service Team (SST) at the time. It was also recorded that recommendations for future treatment planning were shared with the hospital, the guardian and her psychiatrist. Also, the BCBA documented in the record that the resident required during her stay in the CILA home as follows: 1) deescalation with the assistance of more than one staff member about one to six times daily, 2) support from many administrative staff members and other personnel to return to her home at the end of her day training program on the average of three days every week, and, 3) physical management procedures to minimize and prevent serious injury to self or others about one to three times every

week. She wrote that the resident hit at least four staff members with a closed fist causing injuries. She was physically violent toward peers at her day training program. She also reportedly tried to harm herself with a pair of scissors and threatened to use weapons to harm others.

An email dated May 2nd, 2012 from Garden Services' Executive Director addressed to representatives with the Illinois Department of Human Services Office of Developmental Disabilities stated that the resident had been accepted into the agency's CILA program because of the BCBA's relationship with her while working with the Support Service Team (SST). According to the correspondence, the resident would not be returning to her CILA home because the agency cannot keep her safe. It referenced the resident's inappropriate behaviors such as running into traffic and that the agency's BCBA had reached out to the SST for help. It stated that the community prescreening agency and the hospital were informed about the agency's decision and that the resident needed a more secured setting.

A letter dated May 4th, 2012 addressed to the guardian stated that the agency could no longer provide CILA and Developmental Training services because the resident's behaviors placed her and others at serious risk. The letter documented that the agency planned to terminate all services, but there was no effective date of the action mentioned in the letter. It stated that the resident had the right to appeal the decision within ten (10) working days after receiving the notice. The letter also included the Illinois Department of Human Services' address and a statement that appeal information could be found on the Department's website.

A second email dated May 7th, 2012 from the agency's Executive Director addressed to a representative with the Department was reviewed. In the correspondence, the agency's Executive Director said that he had never taken this kind of action before but he believed that it was in the best interest of the resident. It stated that the agency had "enhanced" its staff to work with the resident. Also, they reportedly had many staff trainings to implement the behavioral interventions that had worked with the resident when the BCBA was a member on the SST.

When the complaint was discussed with the agency's staff, they said that the resident had lived with her guardian (grandmother) before being placed in their CILA program. The HRA was informed that the guardian was very involved with the resident. She had a fairly good relationship with her three housemates. She was not compliant with medication. She initially was verbally threatening but subsequently became physically violent towards others. We were informed that sometimes two staff members were assigned to monitor the resident. The BCBA confirmed that fire personnel called the guardian concerning the incident on April 12th, 2012 that was previously mentioned in the report. On questioning, the Director of Operations said that the resident's guardian was frequently notified about the individual's behaviors by phone. However, the record does not support the staff person's assertion. She said that the agency usually does not provide incident reports to guardians and that any request would be reviewed on a case-by-case basis. The Director of Operations could not think of any reason why the agency would not provide an incident report to those appropriate upon their request.

According to the BCBA, the agency made a determination that they did not have the resources to meet the resident's needs. The Director of Operations explained that the staff were

concerned about the resident's safety because she would approach moving cars and strangers. The hospital was reportedly informed that the resident would not be allowed to return to her CILA program upon her discharge from the hospital. The Qualified Human Service Professional (QHSP) told the HRA that discharge letter dated May 4th, 2012 was sent to the guardian by regular mail. He said that the discharge decision was also discussed with the guardian by phone. However, there was no evidence of this found in the record nor was supporting documentation provided as requested. The Director of Operations said that the resident was discharged under emergency circumstances. However, the QHSP reported that the resident was discharged from the agency on June 4th, 2012, which represents a regular discharge. The investigation team was informed that the guardian did not mention that she would appeal the agency's decision to terminate services. The guardian told the HRA that she had mailed the appeal information on May 10th, 2012.

The agency's "Incident/Injury Reporting" policy states that the agency is committed to fully protecting its program participants. It states that the staff should document, follow up and complete a "General Event Report" concerning participants' significant incidents and injuries. The nursing staff shall inform the Direct Support Professional or the person who makes the call about the agency's procedures. The participant's physician shall be notified about injuries or incidents that may require care from a physician. According to the policy, the participant's guardian or family member may be notified about significant events, and the QHSP or administrator on duty will usually provide this information by phone.

The agency's "Discharge Procedure/Termination" policy states that a program participant has the right to remain in his or her CILA unless the participant voluntarily withdraws or meets one of the following conditions: 1) the individual's medical needs cannot be met in their current program, 2) the individual's behavior represents a serious danger to self or others, 3) the individual is being transferred to another program as agreed by all parities, or, 4) the individual no longer benefits from CILA services. Additionally, the policy states that the Qualified Mental Retardation Professional will convene a meeting with the Community Support Team in a timely manner: 1) to discuss the reasons for termination of services, 2) to review current service provision, 3) to make recommendations for alternative service provision, if requested, 4) to complete and sign the discharge packet, 5) to obtain information such as the receiving agency's address, if possible, 6) to obtain consent for follow up services, if requested, 7) to attach the Interdisciplinary Team (IDT) meeting minutes to the discharge packet, and, 8) to forward the discharge packet with the IDT's recommendations to the agency's Intake/Discharge Committee Coordinator for discharge approval. It states that the agency's committee may approve, disapprove or make recommendations concerning the discharge decision. The agency's Executive Director and/or its Board of Directors will have the final decision regarding the discharge.

CONCLUSION

The Illinois Probate Act Section 5/11a-17 states that the personal guardian shall make provisions for the ward's support, care, comfort, health, education and maintenance.

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

> 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 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 educed 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.

The Authority does not substantiate the complaint stating that a resident was given a discharge notice because she walked out of her day training center and home. The resident's record documented many instances of her inappropriate behaviors and that interventions to redirect her had failed. It was recorded that the resident had attempted to get hit by moving cars. She went door-to-door asking neighbors, who lived near her home and day training program, to call 911. She had attempted to enter cars while they were in motion. She was physically violent towards others, etc. In a letter dated May 4th, 2012, the guardian was informed about the agency's decision to terminate all services because the resident's behaviors placed self and others in serious harm. There was no effective date of the action found on the notice. The QSP said that the guardian also was informed about the discharge decision by phone, but this was not found in the resident's record.

The staff interviewed gave conflicting information concerning whether the resident's discharge was an emergency, which requires 48 hours notice or a regular discharge and requires a 10-day notice under Section 120.100 (d). The notice contained a written statement of the guardian's right to appeal the termination decision, but there was no specific mention of the agency's policy which supports such action found on the document as required by the Section. The record supports that additional interventions were explored and that the agency sought assistance from the SST before the impending discharge occurred pursuant to Section 120.110 (i) (1). The agency's Director of Operations reported that the prescreening agency was informed that the resident would not be returning to her to CILA program. However, there was no clear evidence that the PAS agent was provided with all necessary information to review the termination decision as required by the Section.

The Authority cannot substantiate the complaint stating that the guardian was not properly notified about the resident's elopements and hospitalizations. The record and the staff interviewed indicated that the guardian was very involved in the resident's care. However, the HRA found no clear written evidence that the agency notified the guardian about the incident on March 19th, 2012 or that she had been hospitalized on April 19th, 2012. Her record also lacked a

general or incident report concerning all of her significant behavioral episodes. This violates the Code's Section 5/2-102 (a), the Illinois Probate Act Section 5/11a-17 and program policy.

RECOMMENDATIONS

1. Garden Center Services shall follow the Administrative Code requirements regarding termination notices and include a statement about the agency's policy which supports such action under Section 120.100 (d).

2. Follow the Administrative Code Section 120.110 (i) (1) and document that the PAS agent has reviewed the termination decision.

3. The agency shall follow the Illinois Probate Act, Section 5/11a-17 and the Code's Section 5/2-102 (a) by ensuring that guardians are informed about behavioral incidents and especially significant events.

4. Follow the agency policy and ensure that reports are completed regarding all significant incidents.

SUGGESTIONS

1. Consider utilizing resources such as the Clinical Administrative Review Team (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. Include date of effective action on discharge notices.

3. Document all contacts with guardians or family members.

4. Revise the agency's "Incident/Injury Reporting" policy to state that guardians shall be informed about significant events.

RESPONSE

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

5/6/13

To Whom it May Concern,

The following is in response to HRA No. 12-040-9016:

1) Garden Center Services' policy now includes the following verbage ensuring it is in compliance with Section 120.100 (d) of the Administrative Code:
    a. 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:
        i. A clear statement of the action to be taken
        ii. A clear statement of the reason for the action
        iii. A specific policy reference which supports such action
        iv. A complete statement of the individual's right o appeal, including the provider's grievance process, Department review and Department of Public Aid hearing
2) Garden Center Service's policy clearly states the inclusion of Administrative Code Section 120.110 (i) (l):
    a. (i) (l) Services may be suspended, terminated or educed 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 probably causes of the maladaptive behaviors and to seek training or technical assistance to meet the individual's needs
        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
            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 or reduction in services.

3) The agency has retrained all QHSPs and behavioral supports staff to ensure that all guardians are informed about behavioral events, especially significant and the notification is appropriately documented.
4) The agency has retrained all QHSPs and behavioral support staff to ensure that all significant incidents are documented appropriately.

Documentation for the policy updates and the trainings are attached. Please let me know if there is any further information you may need.

Sincerely,

Cindy Haworth
Director of Operations