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HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS
Case # 12-090-9001
Bridgeway, Inc.

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving a complaint of possible rights violations at Bridgeway, Inc. The complaints alleged the following regarding a Community Integrated Living Arrangement (CILA):

1. Inadequate CILA staffing level to ensure safety of residents
2. Inappropriate admission of an individual with behavioral needs that the facility was unable to accommodate
3. Inadequate safety measures when a CILA resident with behavioral needs continued to have incidents that put other CILA residents in jeopardy

If found substantiated, the allegations would violate Community Integrated Living Arrangement (CILA) Regulations (59 Illinois Administrative Code 115), and the Mental Health and Developmental Disabilities Code (405 ILCS 5/1-100 et seq.).

Bridgeway, Inc provides services to 10 Illinois counties and 3 Iowa counties. They provide programs such as: behavioral health counseling, vocational training, substance abuse treatment, family services, community employment assistance, services to individuals with developmental disabilities and community living arrangements. The complaints concern the Bridgeway, Inc. office in Macomb which serves 12 CILA clients.

To investigate the allegations, HRA team members met and interviewed Bridgeway staff in the Macomb office, and examined pertinent documents regarding the case. The HRA did not have releases to review individual records so all records reviewed had personal information masked.

COMPLAINT STATEMENT

The complaints stem from a newspaper article regarding a CILA house member who allegedly sexually abused another resident. The article stated that an individual was charged with sexual abuse against another resident and that sexual abuse had occurred on three or four previous occasions. The HRA also received information that the same individual may have

sexually assaulted another female resident but the police were not involved. Of note, the individual named in the article was not found on the state of Illinois sex offender website.

FINDINGS

Staff Interviews (9/28/2011)

The HRA interviewed Bridgeway staff members regarding the complaints in this case. The staff began by telling the HRA that an individual who was arrested is no longer with Bridgeway. The staff explained that the individual was not charged with sexual assault and that the charges were changed to battery. A staff member initially called the police after a consumer report. The consumer who was charged was not known as a sexual offender. The arrest never went to trial because there was a plea bargain part of which discontinued contact between the involved consumers resulting in a transfer out of the facility for one consumer. Reportedly, the state's attorney instructed police to arrest the consumer.

The CILA house where the incident occurred is a Housing and Urban Development (HUD) facility which requires consumer criminal and sexual background checks. The staff explained that the Pre-Admission Screening (PAS) determines if an individual is appropriate to live at the house. The PAS agent reportedly only told Bridgeway that the individual needed to be in a house with males and nothing more. The facility had openings in a house, so they made the house all male to. The HUD application is very strict and the consumers moving into the houses can have no felonies or criminal backgrounds. All Macomb houses are HUD houses but houses within the organization that are not HUD houses process admissions in the same manner as HUD houses.

The staff explained that the newspaper article was incorrect. The staff also stated that the Office of Inspector General (OIG) was called and they would not take the case because the incident was client against client and the OIG usually only investigates abuse complaints that are staff against patients. The staff asked OIG to document that they called because there was a sexual component to the incident, and then the Bridgeway called the police. OIG called later and said that they were going to review the situation. After the incident the staff immediately began one-on-one supervision. There was no actual incident that the staff saw that made them contact the police, only information from another consumer.

The staff explained that there was a question as to whether the incident was actually consensual. Reportedly, upon return, the alleged perpetrator and victim interacted without incident with staff supervision

The Bridgeway staff explained that the bedrooms and bathrooms of the house are separated by an office and living room. The clients are not restricted in any way unless the staff is alerted that there is a problem. The staff did not immediately know about the incident until it was reported that the two consumers saw something on television that they wanted to experiment with. An incident could not be identified and the incidents descriptions kept changing kept changing and were inconsistent. The states attorney changed the charges to battery. According to the facility, it did not know about any criminal history involving the alleged perpetrator.

The staff explained that the CILA receives admission packets from the PAS agent for all new admissions. The next step is for the staff to conduct a visit with the consumer after which a trial visit is scheduled at the home and day program. The trial part of the admission is supposed to give the consumers a view as to how the new facility functions. All admission goes through a PAS agent. The PAS agent sends packets to the Illinois Department of Human Services (DHS) for approval. The PAS agent controls the movement of the consumers. Sometimes there are emergency placements if a place shuts down. The Illinois Prioritization of Urgency of Need for Services (PUNS) places consumers on a list for services. Bridgeway explained when they receive direct calls they move them to the PAS agent. Bridgeway staff stated that they have a written admitting policy. They stated that if a consumer has a history of sexual behaviors then they probably would not accept them and HUD would not accept them. The staff explained that they have never had to discharge consumers before for an incident of this nature, but they think there are a lot of others with this past in the system.

When reviewing other behaviors of consumers for admission, the staff stated that they evaluate to see if they can deal with the behavior of the consumer. An 8 bed CILA will have more staff so they can deal with behaviors better. They base admission on staff skill level, and also on the people residing in the house.

There were no other reports of similar incidents from other consumers at the home as per staff. The parents of consumers were called the next day. The facility informed parents that an incident occurred but they would not give details about the incident. The staff explained that they had to protect the consumers. A staff member explained there was also no real reaction from the consumers other than they were confused by the one-on-one aide being there. The staff explained that they believe they had done everything they could to make the process as transparent as possible.

The Bridgeway staff explained that the behavior plan is onsite. If there are changes to the plan, they are explained to the staff. Instructions usually involve using Crisis Prevention Intervention (CPI) or calling police. The facility tries not to admit people into the CILA homes that will put other people at risk. If the staff thinks someone is dangerous, then they will not admit them. The staff believes that general behaviors of the people in the house are safely manageable. The consumers will become mad but they are redirectable. Consumers also have a place were they can go to be alone. The staff also explained that this was the consumer's first known sexually aggressive allegation.

The Bridgeway staff explained safety measures that are in place for behavioral situations. The staff follows the support plans for the individuals for their safety measures. For example, if consumers are having behaviors in the community, staff will talk to the team regarding what should be done. The staff uses a strong interdisciplinary process and also the staff is well trained. If staff needs to leave for some reason, they have back-up.

If staff are having problems with a consumer, there is an on-call system managed by 6 or 7 Bridgeway employees who take shifts of being on-call. Staff explained that on-call staff have been called in due to situations in the past. The on-call staff consists of administrators and managers. All staff members are on the on-call list is medication trained. If staff cannot contact

the on-call staff member, they will call another staff member on the list. There is a separate on-call list for medical issues.

Consumers also have a direct way to contact someone if there is an incident. The Consumers also know to call police in certain situations. During staff meetings consumers are asked questions about whom to call. The staff explained that there are posters are up with contact numbers. Consumers also know the hierarchy of staff and who reports to whom in the organization.

The staff explained that when someone is admitted to Bridgeway, they receive a consumer centered plan within 30 days. Now, if there is an issue listed in the consumer's previous plan, staff will formally fill out a sheet of possible issues before the 30 days.

The staff explained that no consumers currently are under direct site supervision or one-on-one supervision. The Human Rights Committee review the consumers' behavior support plans and approve the plans. The Human Rights Committee also reviews all updates to the plans confidentially in letter form to improve timeliness. The Human Rights Committee did not discuss the incident.

The CILA house is an 8-bed house. They have 1 staff member overnight and 2 or 3 staff members during busy hours (4-9pm). The staff explained that there are 2 staff members working in the morning; one staff member gives medications and another helps consumers with preparing for the day. The ratio of staff to consumer depends on what consumers are specifically doing during the shift. The overnight staff to consumer ratio is 1 to 8 at the least and the rest of the shifts the ratio is 1 to 4.

Phones are accessible to the consumers, with one phone in the office and one phone in the common area. With the phone in the office, staff stated that the consumer can close the door if they want privacy. Consumers know they can call OIG and the police if there is an incident. They are told this at meetings with the consumers and then annually. Also, all residents in that house are ambulatory. The staff believes that there has never been a problem with staffing other than someone calling in, and if that happens, someone else covers the shift.

The Bridgeway staff said that the Bureau of Quality Management, Bureau of Accreditation, Licensure and Certification (BALC), and the Commission on Accreditation of Rehabilitation Facilities (CARF) were contacted regarding the complaint. Bridgeway staff stated that they consider these to be the facility's quality assurance system.

The staff explained that consumers can take classes based on their treatment plan. The facility has done independent studies with people who have sexual issues, and they have had classes with couples who need to have sexual components discussed. The classes are always available if necessary. Staff will sometimes request a class for a consumer but the guardian will not agree to the class. They will discuss the classes with the guardian at the consumer's staffing. The facility has a class called Circles. The staff explained that the Circles program discusses the different levels of closeness with individuals and how to interact with the different levels of relationships. The program also deals with good touch and bad touch. The facility has staff who

have taught the program and they also have an individual who will come to the facility to teach the program. The facility also can buy the program on DVD as training.

Conversation with two PAS agent organizations

The HRA discussed the admission process with two PAS organizations that deal with Bridgeway consumers. The first PAS agency stated that when an individual is looking for services, they offer the consumers the choice of the different types of facilities within their region. Sometimes a lack of vacancy in the location that the consumer desires will limit their choices. As far as the information that they share with the provider, the first step is that the PAS agency has the consumer sign a release so that they can share their information. The PAS agency will then give the facility a PAS packet which has assessments, psychological assessments, Inventory for Client and Agency Planning (ICAP), psychiatric information, medical information, progress notes, and any other information they receive. The PAS agency stated that they would share if the consumer being placed is a sex offender. They also stated that, in general, if someone coming from an agency was sexually aggressive, they would also share that information. The PAS agent said that there is a chance that if the individual was coming from home, they would not know that information. The PAS agent said they do not perform background checks for HUD consumers and that is the provider's responsibility. The PAS agency stated that criminal records would be passed along to the provider. If the PAS agent knew that a consumer had a criminal record, they would receive a release for the record. Generally, that information would be in the consumer's record and they would receive it from the previous provider. The PAS agent said that the information could be hidden but that does not really happen often.

The second PAS agent organization stated that currently the state is only funding crisis situations and often, in those cases, they receive very little information. The staff member stated that in the perfect situation, if it is not a crisis, they send the provider a packet with an Individual Service Plan (ISP), ICAP, psychological assessment, behavioral programming, and medication. These are provided in a packet with a cover letter that describes the situation with the individual. If the individual was a sex offender, that information would probably be in the service plan. If the person was found guilty of a crime, the agency would have to contact the CILA provider. Sometimes, if someone has a record for assault, the PAS agency is not given that information. If they know about it, and it is relevant and current, they would inform the provider. If the assault occurred many years ago and was not repetitive or relevant, they may not inform them. The staff member the HRA spoke to said that they have seen incidents follow a consumer around for 20 years when it was a one time occurrence. Overall, the agency has to advocate for everyone, including the individuals currently in the CILA houses, so they would pass along information that would keep them safe. The agency stated that it does not do HUD background checks or any background checks on consumers.

FINDINGS (Including record review, mandates, and conclusion)

Complaint #1 - Inadequate CILA staffing level to ensure safety of residents

The HRA reviewed a document titled "Residential Staff Hours by Residence" that is

stated to be "FY 2012" but is dated 7/1/11. The document states that the Bridgeway residences have 39 total beds. According to the document, the Grant residence, which is the residence named in the newspaper article, has 8 beds and is afforded 220 staff hours per week. According to the comments section, there is one staff member at the house from 11pm to 9am all week, with an additional staff member at the house between 6:30am and 9am (making two staff members between 6:30am and 9am) on Monday and Friday. Also on Monday through Friday, there is one staff member at the house between 3pm and 11pm, one staff member at the house between 3pm and 9pm, and on Monday through Thursday there is a third staff member at the house between 4pm and 8pm (making it two total staff members between 3pm and 9pm and an additional staff member between 4pm and 8pm). On Saturday and Sunday there is staff at the house between 8am and 4pm and 10am and 8pm. The Washington residence has a similar schedule, with variations on staffing, and overnight coverage for the weekends.

The HRA reviewed two different masked Consumer Centered Plans (CCP) which stated that the individuals live on Grant Street and need 24 hour supervision.

The HRA also reviewed a Bridgeway Policy titled "Staffing Assurance." The purpose of the policy is "To assure that staffing levels are assessed and maintained based on the needs of the persons we serve and the staff turnover or absences does not have a negative impact on the health and safety of consumers and staff or on the delivery of quality services and supports." The policy ensures that there is an adequate number of personnel to "Meet the established outcomes" of recipients, to "Ensure the health and safety" of recipients, to deal with unplanned absences and to meet organizational performance expectations. The policy procedure reads "Each program area has a budgeted level of staff to provide services to the consumer/stakeholders and this level reflects the basic policy criteria referenced above. Based on the number of persons served in each program area, their specific needs, and the level of financial support for the program, a staffing budget specifying the number of Full Time Equivalent (FTE) staff is developed and approved by the Personnel Review Committee/Senior Management. For some services, staff 'pools' are developed to increase the efficiency of the hiring process. Vacancies may or may not be filled based on the needs of the program. When consumer levels increase, additional staff may be hired to ensure safety and outcome expectations. When staff absences occur, the supervisor will assign staff to carry out essential duties to ensure the health and safety of consumers. The health and safety of our consumers and staff are paramount in ensuring an adequate number of personnel."

The HRA also reviewed an incident report which read that a recipient saw "… another consumer physically attacking a consumer that's help-less, immediately became upset, he physically attacked the consumer who has been physically attacking everyone in the entire house, staff tried to intervene but [illegible handwriting] was only one staff on the shift, trying to hold back 2 grown men." In the section that asked if the incident was preventable, it reads "It wasn't, having or allowing someone to live in the same house w/non-verbal & non-violent consumers poses a threat to the other consumers, it makes the consumers feared for their lives therefore, resulting in other consumers to become easily upset and defensive." The follow up action taken reads "Talked to [recipient] about appropriate actions. [Recipient] was proud of what he did but informed him that there are other ways of dealing with situations." This occurred at 1:20pm on 11/28/2010, which was a Sunday. According to the schedule above, there

are supposed to be two staff members in the house at that time on Saturdays and Sundays, and this passage indicates that there is only one which does not follow the facility's own staffing schedule.

The HRA reviewed the Department of Human Services Rule 115 which reads "d) Based on their needs, individuals shall receive supervision and supportive services which may range from continuous to intermittent" (59 Admin. Code 115.200). The HRA saw no evidence of a specific staff to consumer ratio in Rule 115.

Complaint #1 Conclusion:

Due to the fact that the HRA reviewed evidence that the facility was not following its own staffing model, and there was a situation documented in an incident report where one individual was staffed at a house when there should have been two, the HRA finds this complaint **substantiated** and offers the following **recommendation:**

- Follow the staffing model that was created by the facility for each CILA house.

The HRA also offers the following **suggestion**:

- In reviewing the incident report, the HRA did not see follow up regarding the staff member's request that there was not enough staff in the CILA. The HRA suggests that when a direct care staff person, who works with the individuals daily and is a part of the incident, makes a recommendation, there at least be some follow up or discussion as part of the recommendation made. The HRA also suggests reviewing the living situation based on the staff comments of an aggressive consumer living with "non-verbal, non-violent" consumers.

Complaint #2 - Inappropriate admission of an individual with behavioral needs that the facility was unable to accommodate

The HRA reviewed the facility "Admission, Transitioning, and Intake" policy. The policy states that when a vacancy occurs, Bridgeway contacts "area Service Coordination offices and collateral providers for referrals. If an individual is referred for services but is not involved with Service Coordination, Bridgeway forwards the referral to the appropriate service coordination unit for screening." The admission policy then states "The Service Coordination agency completes various assessments to determine eligibility. The individual and their family/guardian are informed of the available CILA providers in the area they wish to live. The individual determines the provider they are interested in by meeting staff from the agency and visiting the service sites. This also gives the providers an opportunity to screen the individual, by meeting them, and reviewing referral information and documents provided by the Service Coordination agency … Through this screening process, the individual is allowed a choice between providers, and the providers have the opportunity to become acquainted the person to see if they are able to meet their interests and needs. To help the individual make a good choice, a variety of activities are planned with the individual, including one or more visits to both the residential and day services sites." The policy also states that once an individual has chosen

Bridgeway, and it has been determined that Bridgeway can meet the individual's needs, a service plan is developed. The plan is submitted to the DHS to determine a CILA rate for the individual and upon approval of the CILA rate and acceptance by Bridgeway, a transition plan is developed for the individual. The policy reads "This plan involves input from the individual and his/her guardian as well as the Service Coordinator and any programmatic staff (previous facility as well as Bridgeway)." The final step of the policy reads "If the individual is approved for CILA placement, into a HUD residence, a HUD application (if appropriate) must be processed prior to move in. If the individual is not approved, rationale is provided and alternative service recommendations are made."

The HRA also reviewed a document titled "Community Integrated Living Arrangements Admission and Termination Criteria." The document illustrated admission criteria such as the individual must be 18 years of age, must be developmentally disabled or have a related condition, must need an array of services in a supervised living arrangement, must agree to participate in the development and implementation of a Consumer Centered Planning Process (CCP), must give informed consent, must be approved for services by the Department of Human Services, and must meet HUD eligibility if appropriate. The admission criteria proceeds to state that "People who meet the eligibility criteria will be accepted in the program regardless of accessibility, behavioral or medical issues, provided the financial resources are available so that Bridgeway is able to meet their needs for health and safety, appropriate programming and supervision." The policy also reads "Bridgeway has a no decline policy regarding CILA admissions, however if there is an inability to accommodate a particular type or level of disability, Bridgeway will work collaboratively with the person and their Service Coordination agency to find another provider."

The HRA also reviewed the McLean County Circuit Clerk website and saw that the perpetrator had prior dispositions in the category of criminal misdemeanors.

The HRA reviewed the Bridgeway policy guide on Consumer Centered Plan Development, Review and Modification. The policy reads "Prior to the development of the Consumer Centered Plan, a Mental Health Assessment and/or Developmental Disability Assessment will be completed to ensure that relevant medical history, psychological and social information, and information related to previous direct services and supports are utilized in the plan development."

One of the PAS agencies interviewed about this case sent the pre-admission screening policy that the agency is to follow as directed by the Illinois Department of Human Services (DHS). This policy can be found on the DHS website. In the section of the document titled "Role of the PAS Agencies," it reads "The role of the PAS agency is to ensure compliance with applicable Federal and State laws, arrange for and conduct assessments, make necessary determinations regarding eligibility for services, educate individuals and families, and make referrals and provide linkage to appropriate and needed services. The PAS process will prevent inappropriate admissions to long term care facilities (nursing facilities and Intermediate Care Facilities serving persons with Developmental Disabilities [ICFDDs]) and inappropriate enrollments in waiver programs." The policy does not directly state that it is the PAS agencies' responsibility to share information regarding criminal background with the provider, but the role

seems to indicate that the PAS agency has responsibility in preventing inappropriate admissions into facilities, and providing information such as criminal backgrounds could be considered part of that responsibility. Also, on the list of assessments that must be obtained by the PAS agent, in the Behavior Therapy Assessment section, it states that the assessment must include a "Summary of the data that describes the individual's maladaptive behaviors, frequency of the behaviors, severity of the behaviors, and antecedents of the behaviors" and also "Assessment of the environmental events that are correlated with the occurrence of behavior problems."

The DHS Rule 115, states "5) Admission to programming … B) Admission policies and procedures shall be set forth in writing and be available for review" (59 Il Admin Code 115.320).

Due to the fact that there is no evidence to confirm that the facility admitted a consumer it was unable to accommodate and admission policies are consistent with CILA requirements, the HRA finds this complaint **unsubstantiated** but offers the following **suggestions:**

- Much of the responsibility for the consumer's information that would determine if they would be admitted into the facility was placed on PAS agencies by the Bridgeway staff, yet the staff seems to have the final determination in whether the individual can reside in a Bridgeway facility and also, it seems as though the facility is responsible for the background check for the HUD housing. The HRA also determined that there are opportunities for important information to be missed. The HRA did successfully find that the individual has a criminal record in another county through a quick internet search. Since the facility feels as though information was kept from them, the HRA suggests that the facility take more responsibility in their own collection of information upon admission and rely less on information being provided by others.

Complaint #3 - Inadequate safety measures when a CILA resident with behavioral needs continued to have incidents that put other CILA residents in jeopardy

Because the HRA did not have releases for the individual who was identified as the perpetrator in the newspaper article, the HRA could not review the perpetrator's records to review whether safety measures were put in place regarding the resident or whether the resident had multiple incidents that put other CILA residents in jeopardy. The HRA did review Bridgeway policy relating to aspects of recipient's behavioral needs as well as masked records of individuals, which included CCPs and incident reports.

The HRA reviewed the Bridgeway policy guide on Consumer Centered Plan Development, Review and Modification. The policy reads "The CCP will be reviewed on a regular basis, at least semi-annually, and will be revised, as appropriate, in order to remain meaningful to the person served and based on his/her satisfaction and changing needs." The policy also states "When services are provided to persons with a serious mental illness who are criminal offenders, Bridgeway will coordinate services with the criminal justice system to help ensure compliance with governmental and legal authorities. Service planning will encompass the following: a. Information will be provided to the consumer concerning the relationship between the criminal justice system and our organization. b. A detailed criminal history of the consumer will be obtained as part of the Mental Health Assessment process."

Another document, titled "Behavior Management Guidelines" reads "After a thorough evaluation of the consumer, a Consumer Centered Plan or Behavior Plan is developed and if maladaptive behaviors are present such as temper outbursts, stealing, self-abuse, etc., a behavioral approach may be incorporated into the Service Plan with clinical review and oversight by the Qualified Support Professional and the consumer's/guardian's informed consent." The document proceeds to illustrate that nonrestrictive interventions are utilized first with emphasis on positive reinforcement. If positive reinforcement is not effective, then the facility resorts to more restrictive interventions. The policy states that "The rules delineate specific problem behaviors that, if they occur, have clearly defined consequences. The following behaviors may result in a suspension from services; fighting, destruction of property, stealing, illegal drug or alcohol possession, consumption, or intoxication; verbal threats, swearing, yelling or vulgar talk, weapons possession or sexual harassment. Repeated violations of these program rules can result in prolonged or extended periods of suspension from service as determined by the Interdisciplinary Treatment Team." The policy also reads "Clinical direct care staff receives training in Behavior Management and certified instructors provide Non-Violent Crisis Intervention training at regular intervals throughout the year. Direct service staff attend this training when first available following their employment. Additionally, Behavior Management Guidelines are reviewed during the initial orientation process for new staff with periodic reviews through the Bridgeway Folder In-services Process."

The HRA reviewed a Consumer Centered Planning Overview which indicated that there were admission assessments, as well as annual assessments that covered the same assessments as on the admission. The HRA also saw that there is another group of similar assessments that are completed within a year of the previous, admission assessments.

The HRA also reviewed the Bridgeway policy regarding reporting and investigating allegations of consumer abuse, neglect, and incidents of death, which reads "Bridgeway has established both administrative and organizational policies and procedures pertaining to the identification, reporting and investigation of unusual/critical incidents in order to promote the safety and well-being of staff, consumers, and others as well as to meet or exceed the standards recommended or required by professional, regulatory and governmental entities … Bridgeway actively advocates for all consumers to ensure they are safe in all environments, especially when suspicion or concerns of abuse or neglect surface from staff, family members or the community."

The HRA reviewed 12 Behavior Incident Reports that occurred between 8/2010 and 7/2011. On the report forms, there is a question which states "How was the incident preventable?" and also a section asking if follow up action was taken. In all of the reviewed reports, there was a follow up action taken. Some examples of follow up action read "Talked to [recipient]. He said he was sorry he just got upset. Reminded him of appropriate action to take when he gets upset. He kept saying he was sorry and that was alright." Another reads "[Recipient] gets upset very easily. Talked to [recipient] about not paying attention when other consumers are having behaviors and how to handle frustration." Another reads "Talked to [recipient] seems to be having a little trouble adjusting to the new consumers that have moved in. They are higher functioning than [recipient] is used to being the highest functioning." All of the follow up action taken involved directly speaking with the recipient regarding the incident.

Another incident indicated that it would also be discussed with the IDT (interdisciplinary team). The incident reads "Talked to staff about incident. Talked to [recipient]. Jealousy of housemates seems cause of behaviors. Keeping knife in office for now until discussion with IDT." (The incident with the knife was non-violent but rather the recipient was going to attempt to open a door with a pocket knife and staff stopped him from using the knife out of safety which upset the recipient).

In the section asking if the incident was preventable, it sometimes was written "unknown" or "it wasn't" but some reports have opinions from the staff regarding the incident. One example reads "It wasn't, another consumer upset" indicating that the recipient gets upset when other consumer becomes upset. Another reads that "It [the incident] came out of nowhere." Another incident explains that the incident was preventable by "Using social stories with [recipient] for different occasions may help prevent behaviors in the future." The follow up action, in that incident reads "Talked to [recipient]. He apologized. Talked to staff about 'Social Stories' idea. Idea seems reasonable. Will discuss with team at next staffing." As indicated in complaint #1, there was an incident in which a staff recommendation seemed to be ignored in the follow up actions taken by the facility.

The HRA reviewed 3 individual's masked records. The records were marked #1, #2, and #3. The HRA reviewed these in accordance with the third complaint. As a part of those records, the HRA reviewed Behavior Data Collection forms which tracked individual's behaviors over the span of a year, the individuals' CCPs, the individuals' behavior plans, and the individual program plans.

Masked Record #1

This individual's behavior data collection form spans from October 2010 through August 2011. The behaviors tracked deal with physical aggression, pushing others in wheelchairs, shoving others, throwing items, hitting others, and screaming while holding ears. Over the time frame specified, screaming while holding ears was the behavior that occurred most frequently at 28 times in January 2011, 32 times in March 2011, and 31 times in May 2011. The individual's CCP states that "Due to increased agitation [individual] Risperdal was increased to 1-1 mg tab 2x daily. The team continues to work with [individual] on behavioral approaches."

The individual's behavior support plan includes approaches to the behaviors such as "Staff are to make sure that [individual] and others are safe," "CPI techniques may be used to prevent injury to self or others," and "Tell [individual] that it is not appropriate to hit other consumers."

The Nursing Input form reads "Staff is trained in CPI for verbal and physical techniques to use when needed. Staff track physical aggression and verbal outbursts and staff look for triggers in environment that may be causing agitation (such as noise)."

Masked Record #2

Another individual, marked as #2, has a statement in his individual program plan that reads "[recipient] has some difficulty dealing with his frustration and anger while he is at the center. [Recipient] can become very upset when others around him are arguing or when he is assigned or asked to perform a different task for the day. Once [recipient] has been assigned to a task, he feels that it is now his job and anyone else performing that task can cause him distress. [Recipient] will work with his trainer to role-play some various situations that will help him to better cope with frustration and anger, and will help him to perform his job tasks with fewer disruptions for talking or upsets."

In reviewing the behavior data collection form for consumer #2, which spans October 2010 through August 2011, the HRA saw that the individual had behaviors in April 2011 that consisted of 19 incidents of pouting, 6 incidents of raising fist, and 2 incidents of rushing towards others with raised fist/hand. In May the in consumer with 21 incidents of pouting and 3 incidents of raising fist. In June 2011, the individual had 20 incidents of pouting, 8 incidents of raising fist, and 5 incidents of rushing towards others with raised first/hand. The worst month was August of 2011 when the individual had 28 incidents of pouting and 22 incidents of raising fist.

The individual's CCP states that "Over the past year [individual] has been in good health and has had fewer behavioral issues noted on his tracking sheets. Staff has noticed that [individual] has been able to walk away more often from situations that have caused him to be upset in the past." In another part of the CCP it reads "Staff assists [individual] with accessing health care services. He currently has a behavior support plan. Over the past year staff have noticed a decline in behaviors, and continue to work with [individual] on conflict resolution and coping skills." The nursing input notes read "[Individual] still has had issues with crying up to 2 times, pouting up to 9 times, raising fist towards peers or staff up to 6 times and rushing towards peers or staff with raised fist up to 6 times in a months time. He also punches hand in a threatening manner approximately 405 times a month and leaves hand red often. He has also hit self when upset in the past year. Staff has had to intervene with verbal de-escalation techniques and physical blocks and moves in the past year to keep staff, peers and [individual] safe." In the recommendations section it reads "Nursing would recommend due to verbal aggression and physical aggression it would be beneficial for him to see [physician] for medication management or recommendations for non medicated interventions when he is verbally or physically agitated. Staff needs to continue to track and monitor verbal and physical aggression along with items mentioned above. He has hit staff in the past year and does still charge at staff with fist raised and he may be able to have better anger control with a medication addition. The team needs to agree that his aggression is still present (both verbal and physical) and appointment with the psychiatrist may benefit him if we a find a medication that assists with anger control or to get other suggestions or interventions for verbal and physical aggression from psychiatrist."

The individual's behavior support plan has approaches for his behaviors, for example, the approach to raising fist and rushing towards staff reads "Staff will ask [individual] to stop and take a minute to get control of himself. [Individual] will be asked to go to a room/outside where he can calm down. [Individual] may return soon as he feels he is ready to do so. Staff will check on him every 5 minutes until he is ready to re-join the group. If punches are thrown staff will use CPI to prevent injury to themselves or others."

Masked Records #3

The HRA also reviewed 3 Behavior Data Collection Forms which tracks an individual's behaviors. The forms that the HRA reviewed covered a years worth of behavior tracking. On the data collection form for #3, which span October 2010 though August 2011, the individual's behaviors were "Inappropriate touching," "Pushing others to get in Front of Line," "Monopolizing conversation," and "Invading others' personal space." The behaviors appeared to be inconsistent throughout the year, with the worse of it being in January 2011 and February 2011. In January 2011 the individual had 22 incidents involving monopolizing conversation and 6 incidents of invading other's personal space. In February 2011 there were 18 incidents of pushing others to get in front of the line, 39 of monopolizing conversation, and 25 incidents of invading others personal space. After those two months, the incidents lessened.

The CCP for individual #3 reads "It has been reported by staff that [individual] has had an increase in verbal aggression within the past 6 months. The team added this to his BSP [Behavior Support Plan] and agreed to try behavioral approaches before any medication change." In a nursing input sheet for the individual's consumer centered planning meeting it reads "Nursing staff would like to have self abusive behaviors (scratches to self) added to behavioral support plan or staff have to complete incident report daily when they note scratches. Verbal aggression needs to also be added again to plan due to increase in his behavior in the past few months. Multiple staff have redirected and observed this behavior and an issue we need to readdress."

The behavior support plan for individual #3 has approaches to dealing with the individual's behaviors, for example with inappropriate touching, the approach states "Staff will give [individual] non-verbal cue such as a hand on his shoulder as a reminder to stop the behavior and correct himself." For verbal aggression, the approach states to "Remind [individual] of appropriate social skills," "Redirect [individual] to another activity," and "Encourage [individual] to use relaxation techniques."

The HRA would also like to reference a section from a previous report that was written by the HRA which illustrates the facility's reaction to a consumer's behaviors. The HRA had obtained a release for this consumer's records. Report 11-090-9019 reads "The HRA reviewed IDT team meeting notes on the consumer who was named in the complaint as being too aggressive to live with others. The IDT team met on 8/6/2010 to discuss a situation in which the consumer hit a young girl and her mother while at a fast food restaurant. The consumer also hit a staff member who tried to intervene in the situation. As stated in the document, the IDT team discussed the fact that the consumer has had an increase in behaviors at the day program over the last month and a half and an increase at home over the last month and a half. The team discussed the possibilities of what could be causing the problem and decided that it was more behavioral than psychiatric. The team also discussed that the consumer was anxious prior to leaving the day of the incident. The team decided that if the consumer '… shows signs of any agitation during the day then he needs to stay at home/work and will not be permitted to go on any outing, especially outings where the event/place could be crowded. The team also decided that [Consumer] should avoid going on outings where the situation could increase agitation, anxiety

or paranoia.' The notes go on to say 'Team also decided that they will monitor [Consumers] behaviors and agitation over the next few weeks. If there is not an increase in behaviors then a consult with [Consumer's Physician], about increased anxiety, would be needed.'"

In staffing notes, dated 12/3/10, the IDT met to discuss an increase in behaviors by the consumer. During that meeting, it was agreed by the team that if the consumer uses his 'hobbies' (which is not defined in the IDT) as weapons, then staff will take them away until safety can be assured. The team also discussed a reward program which dictates that if the consumer has no behaviors for 3 days, he will earn a 'treat.' If the consumer has no behaviors for 5 days, then he will earn an outing into the community. The team also stated that while at a specified location, the consumer will earn a treat of his choice for everyday that he does not have a behavior. The IDT team discussed that they should consult with the consumer's psychiatrist because the behavioral interventions that they have been trying have been ineffective. They talked about moving the time that the consumer is taking his anxiety medication to help him deal with some of his behaviors.

The HRA reviewed the consumer's current behavior support plan dated 12/3/10. The plan illustrates a frequent behavior by the consumer, such as hitting people, along with the cause of the behavior and then an approach of different options to try and deal with the behavior. An example of something that may be done as an option to deal with hitting would be reminding the consumer that he should not do the behavior and suggest alternatives to the behavior. Some of the approaches for the behavior list what to do if the behaviors happen in the community. In regard to the complaint that the Office of Inspector General (OIG) was not contacted in these situations, the HRA did not see any evidence that the OIG was contacted regarding the behaviors at the fast food restaurant or other incidents discussed in the IDT meeting. On the behavioral plan, it does state that if the consumer reports that a staff member hit him; staff is not to ask him if he has told the truth but immediately notify a supervisor so that OIG guidelines can be followed. Also, on the ISP, there is documentation that hitting people occurred 3 times in the month of May, 19 times in the month of April and 7 times in the month of March. The documentation does not state that the hitting is directed toward staff or other consumers.

In reviewing the documentation on the consumers (the 3 masked records and the record with the release), the HRA saw no indication that there was a sexual assault against a female resident in any of their files.

The Mental Health and Developmental Disabilities Code states that "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" (405 ILCS 5/2-102) and that "Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect" (405 ILCS 5/2-112). The Illinois Administrative Code regarding Standards and Licensure Requirements for Community-Integrate Living Arrangements states "Every individual receiving CILA services has the right to be free from abuse and neglect" (59 Il Admin Code 115.250).

Complaint #3 Conclusion:

According to the masked records reviewed, and previous reports, the HRA finds evidence of the facility taking action to assist consumers who have behavioral needs such as tracking behaviors, discussing the issues with the team and developing behavioral approaches. The HRA also found no evidence of inadequate safety measures within the facility policies. Due to this, the HRA finds the complaints **unsubstantiated**.

RESPONSE

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

BRIDGEWAY

April 24, 2012

Meri Tucker, Chairperson
Regional Human Rights Authority
5407 North University, Suite 7
Peoria, IL 61614

Re: Human Rights Authority Case #12-090-9001

Dear Ms. Tucker:

Bridgeway is responding to the Human Rights Authority Report of Findings in the above referenced case involving a complaint of possible rights violations. Bridgeway has reviewed the extensive report and is responding to the one substantiated finding that had one recommendation. We have also reviewed the "suggestions" contained within the report and we will take them under advisement but we will not formally respond to them.

We appreciate the diligent work of the Human Rights Authority and we share your goal of ensuring that the rights of persons with disabilities are preserved. We will continue our mission of serving the "sickest and the poorest" always striving for excellence and always endeavoring to create solutions in partnership with the people we serve.

Sincerely,

Sandra L. Wood

Sandra L. Wood
Senior Vice President

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☐ RT 164 W. Frontage Rd., Oquawka, IL 61469 • (309) 867-2626 • (309) 867-2025 • FAX (309) 867-2216

SERVICE PROVIDER'S WRITTEN RESPONSE	RESPONSIBLE PERSON(S)	DATE
<u>Complaint: Inadequate CILA staffing level to ensure safety of residents</u> <u>Bridgeway Response/Plan of Action:</u> **Maintaining the health and safety of the consumers we serve is always of the highest priority. The CILA staffing plan that is reviewed and established each year and revised as needed, is a best practice plan that is implemented on a regular basis. Due to staff turnover and challenges with recruiting and hiring staff plus the changing needs of the consumers and occupancy of the residences, the staffing plan may be altered under the guidance of the Director. The residences are always staffed with at least one DSP trained staff per shift and there are generally 2 staff on duty during morning and evening medication times. Bridgeway maintains an emergency on call system 24/7 comprised of managers and Community Support Specialist staff (QIDP's). This team of professionals is used as back up staff to ensure adequate staff coverage at all times within the CILA residences.** **Regarding HRA Case No. 12-090-9001** **Bridgeway, Inc.** **James H. Starnes** **CEO/Executive Director** Sandra L. Wood **Sandra L. Wood** **Senior Vice President** **Authorized Representative** **April 24, 2012**	**Tonya Beckner, Director of Rehabilitation and Residential Services – Macomb** **Wendy Skrypkun, Director of Rehabilitation and Residential Services - Pekin** **Sandy Wood, Senior Vice President**	**Current and Ongoing**