FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
PROGRESSIVE CAREERS and HOUSING, INC. — 13-040-9011
HUMAN RIGHTS AUTHORITY– South Suburban Region

[Case Summary— The Authority did not substantiate the complaint, but we made suggestions that were accepted by the service provider. The public record on this case is recorded below; the provider requested that its response be part of the report.]

INTRODUCTION

The Human Rights Authority (HRA) has completed its investigation into an allegation concerning Progressive Careers and Housing, Inc. The complaint alleged that a resident grabbed a large knife from the kitchen drawer and threatened a staff person with the dangerous object and that the safety of other residents was also compromised. If substantiated, this allegation would be a violation of the Illinois Administrative Code (CILA Rules) (59 Ill. Admin. Code 115.200 [d] and 115.300 [6] [A]) and the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/2-102 [a]).

Progressive Careers and Housing provides residential and vocational services to adults with developmental disabilities throughout the state of Illinois. The agency manages twenty-one (21) Community Integrated Living Arrangements, nine (9) 16-bed intermediate care facilities and two vocational centers that serve about 387 clients.

METHODOLOGY

To pursue the investigation the complaint was discussed with the agency's Vice President of Corporate Affairs and Compliance, a Qualified Intellectual Disabilities Professional/the House Manager and a Behavioral Analyst during closed session at the South Suburban Regional Authority public meeting. A site visit was done at which time the House Manager and a Direct Services Professional were interviewed. The resident was interviewed privately at the home. Sections of the resident's record were reviewed with her guardian's written consent. Relevant policies were also reviewed.

FINDINGS
Information from the record, interviews and program policy

The resident's "Individual Services Plan," dated May 28th, 2013, stated that she was placed in the agency' Community Integrated Living Arrangement (CILA) program in 2011 and

requires 24-hour supervision. She was diagnosed with Schizoaffective Disorder, Mild Mental Retardation and some physical problems. She is very independent in most areas of activities of daily living. Her mental health seems to cycle and her behavior sometimes is extremely inappropriate for months at a time. The resident's behavioral plan, dated May 6th, 2013, targeted physical aggression and agitated behaviors such as hitting, cursing and threatening to harm others. Her behavioral plan reportedly was reviewed by the agency's Behavior Management Committee (BMC) and documented that any restriction would be reviewed by the provider's Human Rights Committee, (HRC), the resident and her guardian.

The HRA reviewed fourteen incident reports from January to June 4th, 2013 of which eleven of the incidents were considered to be moderate to serious and one of them was life threatening and the focus of the investigation. Two incident reports documented that the resident had threatened a Direct Services Professional (DSP) with a knife on June 4th, 2013. The agency's Behavioral Analyst and a direct services trainee reportedly had witnessed the incident. An incident report written by the DSP, who reportedly was threatened, stated that the resident was angry upon returning to the home because her lunch had been stolen at her workshop. The Behavioral Analyst was called to the home to assist with the resident's inappropriate behaviors. The resident was described as being belligerent toward the staff person. She then tried to throw a chair at the staff person and went to the kitchen and grabbed a "butcher knife" and "held it up" at her. According to the incident report, the police were called to the home, and the Behavioral Analyst took the resident outside for a walk.

A second incident report written by the direct services trainee stated that the Behavioral Analyst took the chair from the resident when she tried to hit the DSP with the object. Then, the resident reportedly tried to cut the DSP with the knife. Corresponding documentation indicated that the agency's HRC's Chairperson and the guardian were notified about the incident on June 4th. An email addressed to the Chairperson above from the Director of Behavioral and Clinical Services stated that an emergency restriction on knives in the home was requested on that same day. According to the email, the knives needed to be locked in the medicine closet to prevent harm to staff and others.

An HRC's emergency restriction notice, dated June 4th, repeated information previously mentioned in the report such as the resident was verbally aggressive toward the residential staff because of an incident that had occurred at her community day program. According to the notice, the Qualified Intellectual Disabilities Professional (QIDP), who also serves as the House Manager, had engaged the resident in an activity prior to the incident. However, the resident became verbally aggressive again shortly after the House Manager left the home, and the Behavioral Analyst was called to the home. Once there, the resident reportedly picked up a chair as if she was going to throw it at the staff [person], and the Behavioral Analyst took the chair from her. Then, she asked "where is that knife" and proceeded to the drawer that contained the residents' silverware and grabbed a large knife and threatened to cut the staff [person]. She reportedly put the knife back in the drawer when the staff [person] picked up the phone and said that she was going to call 911. A report was filed with the police upon their arrival at the home. On June 5th, an email addressed to the House Manager from the Director of Behavioral and Clinical Services stated that the Chairperson gave consent to implement the restriction on an emergency basis. The House Manager was directed to send to the residents' guardians completed

forms to obtain their consent for the restriction. The notice was signed by the Chairperson on July 15th, 2013.

When the complaint was discussed with the agency's staff during closed session at the HRA's public meeting, the Behavioral Analyst informed the HRA that the resident is compliant with medication. She said that the resident was agitated upon her arrival at the home on the incident day because of a problem with a peer at her day training program. She said that the resident "taunted" a staff person with a knife in the kitchen. The resident's housemates were in the home when the incident occurred, but they were not in the kitchen area. The resident's guardian reportedly was notified. The staff interviewed reported that all sharp knives and objects are now locked in the closet that contains the residents' medicine and medical supplies. According to the Behavioral Analyst, she had previously recommended that the residential staff should keep the resident busy because she only becomes aggressive when she is not engaged in activities. She said that the DSP, who was threatened with the knife, is still working in the same home even though she recommended that the staff person should be assigned to another home. There was no written indication that the resident's behavior or treatment plan was reviewed or revised given the fact that the incident was serious enough for the police to be called. We also found no indication that she was evaluated.

At the site visit, the DSP explained that the home has five bedrooms and that the resident has seven housemates. She said that the resident had gone on an outing with her day training staff and that someone had eaten her lunch on the incident day. The Behavioral Analyst was waiting for the resident when she arrived at the home because she was upset. According to the DSP, she was cooking dinner when the resident started calling her expletives, and she did not say anything to her leading up to the incident. The resident reportedly took a butcher knife from a drawer in the kitchen and threatened her with the object. The Behavioral Analyst took the knife from the resident and escorted her outside for a walk. The direct services trainee called the police. The resident's housemates also witnessed the incident, but they reportedly did not seem scared and stayed in their chairs. According to the DSP, the resident "takes things out on the staff" when something happens at her workshop. She usually displays verbal aggression, but she had never threatened the staff with a knife prior to the incident. She said that the resident subsequently apologized and that her behavior escalated because other staff members were present. According to the DSP, she would have redirected the resident to go to her room to music and called the police if she had been working alone in the home.

The DSP further reported that sharp knives are kept in a room located in the back of the home since the incident. This room reportedly is used as an office and a storage area, and the door is never locked. She said that another direct care staff person told her that the sharp knives had been placed in the office for safekeeping. Upon request, the investigation team was escorted to the office, and we observed six knives in a black bucket on the top shelf of a shelving unit. However, the butcher knife reportedly used in the incident was not found in the bucket. On questioning, we were informed that the dishwasher does not work and that sharp knives are hand washed when they used for preparing meals. There reportedly is no staff person responsible for accounting for the sharp knives and that the home lacks written procedures concerning this issue. The HRA was informed that the resident has some of her belongings in the office where the knives are kept and that she goes in the office to get her items.

The House Manager said that resident's clothing is stored in the office, according to the seasons, but she does not go in the office. She escorted the investigation team to the medication closet located in front of the home where the butcher knife was allegedly being safeguarded. The investigation team noticed that the medication closet was locked and that the knife used in the incident was missing when she unlocked the closet. The House Manager said that the nurse might have moved the knife from the closet. We asked the staff person to call the nurse who reportedly said that she saw the knife in the medicine closet on August 5th, 2013, which is the day that she started working in the home. The House Manager then speculated that the knife might have been used to cut meat during a cookout on the Labor Day Holiday. And, she reportedly called the staff person, who was on duty on the holiday above, but there was no answer. On questioning, the House Manager confirmed that the agency does not have written procedures about safeguarding sharp knives and objects in the home.

The resident told the HRA that she went for a walk with the Behavioral Analyst after she had threatened the staff person with a knife. She said that the staff person involved in the incident is not very nice to her and her housemates. According to the resident, the staff person tells her to go to her room, and she does not want her to work in the home anymore. She asked the investigation team why the staff person cannot work in another home.

CONCLUSION

The Illinois Administrative CILA Rules Section 115.200 (d) states,

> Based on their needs, individuals shall receive supervision and supportive services which may range from continuous to intermittent. CILAs shall be designed to promote optimal independence in daily living, economic self-sufficiency and integration into the community through the interdisciplinary process.

Section 115.300 (6) (A), the agency shall ensure that living arrangements shall be safe and clean within common areas and within apartments over which the agency has control.

> Section 115.320 (c) states that,
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> 1) Services shall be provided in the setting most appropriate to the needs of and reflecting the preferences of the individual.
>
> 3) The agency is required to ensure a process for periodic review of behavior intervention and human rights issues involved in the individual's treatment and/or habilitation.

Section 5/2-102 (a) of the 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.

Section 5/2-112 of the Code states that every recipient of services in a mental health facility shall be free from abuse and neglect.

Section 5/2-201 of the Code states that whenever any rights of a recipient of services are restricted, the recipient shall be promptly given a notice of the restriction.

Section 5/3-211 of the Code states that a recipient suspected of being the perpetrator of abuse shall be immediately evaluated to ensure the safety of the recipient and others.

Although a resident did grab a large knife from the kitchen drawer and threatened a staff person, the right for safety of other residents was not compromised. Based on the record and the staff interviewed, three staff members were present in the home when the incident occurred on June 4th, 2013. The Behavioral Analyst reportedly was trying to calm the resident when she grabbed the knife from a drawer in the kitchen. The resident's record documented that she is sometimes very aggressive and that her behavioral plan had been approved by the agency's BMC. The agency immediately took steps to protect the safety of everyone in the home and followed up with its human rights committee. The provider's HRC's Chairperson gave emergency consent to lock up sharp knives in the home on that next day, and she signed the restriction notice on July 15th, 2013. This meets the requirements under Sections 115.200 (d), 115.300 (6) (A) and 115.320 (c) of the CILA Rules, and Sections 5/2-102 (a) and 5/2-201 of the Code.

The Authority understands that CILAs are designed to promote a family like-setting and that sharp knives are needed for food preparation. The staff initially reported that sharp knives are now locked in a closet. However, the HRA observed during a visit to the home that sharp knives are stored in a room that reportedly is never locked and accessible to residents. The DSP said that the resident goes in the room in question to retrieve her personal items, although the House Manager denies this. We are concerned because the large knife used in the incident could not be located during our visit.

SUGGESTIONS

1. The Authority suggests that the agency's human rights committee should periodically review the need to continue the restriction pursuant to Sections 115.320 (c) (3) and 5/2-201 and be certain that knives are more secure and that the missing knife used in the incident is located.

2. Consider reviewing the resident's behavioral plan sooner to determine if there is a need to address the knives.

3. Consider following up with the Behavioral Analyst's recommendation and recipient comment about the identified DSP working at another location.

4. Conduct evaluations and treatment plan reviews subsequent to serious behavioral incidents.

RESPONSE

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

Tradename for
Progressive Housing, Inc.

Progressive Careers & Housing

Integrated Training and Residential Services for
Individuals with Intellectual and Developmental Disabilities

To: Judith Rauls, Chairperson - Regional Human Rights Authority

From: John Mirecki (Sr. VP Compliance / Corporate Affairs)

CC: Geraldine Boatman – HRA Coordinator

Date: 12/18/13

Re: HRA CASE NO. 13-040-9011

This letter is in response to the report of findings report dated 11/20/13. The end of the report had four suggestions. The following is our response to those;

1. The Authority suggest that the agency's human rights committee should periodically review the need to continue the restriction pursuant to Section 115.320 © (3) and 5/2-201 and be certain that knives are more secure and that the missing knife used in the incident is located. (RESPONSE) Progressive Careers & Housing does hold regular scheduled HRC Committee meetings. This Committee does review all resident restrictions on a quarterly basis on a as needed basis. All individual in our facilities have an annual as well as a six month review of their individual plans which included restrictions. Individuals that are Behavior Management Plans additionally have quarterly reviews by the agency Psychologist and Psychiatrist. The knife at the CILA was located by the nurse it was in the locked medication closet but hidden in the bottom of a cart. The agency is in the process of developing a written procedure for safeguarding sharp knives and object which includes periodic checks of these items in the CILA's.

2. Consider reviewing the resident's behavioral plan sooner to determine if there is a need to address the knives. (RESPONSE) The individuals Behavior Plans are reviewed by the Interdisciplinary Team / Clinical Team (QIDP, Behavior Analyst, Nurse (RN), and Psychologist). The QIDP as well as the Behavior Analyst review monthly completed reviews of observations, and data analysis to ensure appropriateness of the individual Behavior Plans. If ever a new or significant behavior occurs modifications are made to the individual's behavior plans.

3. Consider following up with the Behavioral Analyst's recommendation and recipient comment about the identified DSP working at another location. (RESPONSE) In this case the DSP was moved to another CILA location. Since that move the DSP is no

longer employed with this agency. All recommendation made by agency staff will be forwarded to the CILA Director and Management Team for their review and direction.

4. Conduct evaluations and treatment plan reviews subsequent to serious behavioral incidents. (RESPONSE) When an incident or behavior occur all staff are required to complete a behavior reporting form of these behaviors or incidents. This form requires them to report how they intervened and if the intervention resulted in a successful result or not. This report and information is then reviewed by the Behavior Analyst. All serious incidents or behaviors will require an emergency special IDT team meeting to review the incident, and discuss recommendations and or changes that may be warranted or required.

If you have any questions or concerns please notify me.

John Mirecki. Sr. VP Compliance / Corporate Affairs

Office: 708-283-1530 / Fax: 708-283-2470

SOUTH SUBURBAN REGIONAL HUMAN RIGHTS AUTHORITY

HRA CASE NO. 13-040-9011

PROGRESSIVE CAREERS & HOUSING

Pursuant to Section 23 of the Guardianship and Advocacy Act (20 ILCS 3955/1 *et seq.*), we have received the Human Rights Authority report of findings.

IMPORTANT NOTE

Human Rights Authority reports may be made a part of the public record. Reports voted public, along with any response you have provided and indicated you wish to be included in a public document, will be posted on the Illinois Guardianship and Advocacy Commission Web Site. (Due to technical requirements, your response may be in a verbatim retyped format.) Reports are also provided to complainants and may be forwarded to regulatory agencies for their review.

We ask that the following action be taken:

X We request that our response to any recommendations/s, plus any comments and /or objections be included as part of the public record.

____ We do not wish to include our response in the public record.

____ No response is included.

John Mirecki
NAME

Sr. Vice President Compliance
TITLE

12-18-13
DATE

STATE OF ILLINOIS
Pat Quinn
Governor

GUARDIANSHIP & ADVOCACY COMMISSION

Dr. Mary L. Milano, Director

HUMAN RIGHTS AUTHORITY
LEGAL ADVOCACY SERVICE
OFFICE OF STATE GUARDIAN

November 20th, 2013

John Mirecki
Vice President of Corporate Affairs and Compliance
Progressive Careers and Housing
3615 Park Drive, Suite 100
Olympia Fields, IL 60461

RE: HRA No. 13-040-9011

Dear Mr. Mirecki:

The South Suburban Regional Human Rights Authority of the Illinois Guardianship and Advocacy Commission has completed its investigation of the case listed above. The report of findings for the investigation is enclosed.

Please be aware that the Authority may vote to make any of its findings a part of the public record. You may comment on and/or object to the findings and have these comments and/or objections included in any public document. If you wish your comments and/or objections to be included in any publicly released report, you should so indicate. Otherwise the report may be made public without them. Please provide any comments and/or objections within 30 days of receipt of this document.

Please note that any report made a part of the public record may be posted on the Commission's Web Site, along with any response you provide if you have decided that your response will be included with the public document.

Please contact HRA Coordinator, Geraldine Boatman at (708) 338-7509 if you have questions. Thank you again for your cooperation.

Yours truly,

Judith Rauls

Judith Rauls, Chairperson
Regional Human Rights Authority

JR/gb
cc: Jon Burnet, HRA Supervisor

WEST SUBURBAN REGIONAL OFFICE
♦ P. O. Box 7009 ♦ Hines, IL 60141-7009
♦ Telephone (708) 338-7500 ♦ Fax (708) 338-7505
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At the site visit, the DSP explained that the home has five bedrooms and that the resident has seven housemates. She said that the resident had gone on an outing with her day training staff and that someone had eaten her lunch on the incident day. The Behavioral Analyst was waiting for the resident when she arrived at the home because she was upset. According to the DSP, she was cooking dinner when the resident started calling her expletives, and she did not say anything to her leading up to the incident. The resident reportedly took a butcher knife from a drawer in the kitchen and threatened her with the object. The Behavioral Analyst took the knife from the resident and escorted her outside for a walk. The direct services trainee called the police. The resident's housemates also witnessed the incident, but they reportedly did not seem scared and stayed in their chairs. According to the DSP, the resident "takes things out on the staff" when something happens at her workshop. She usually displays verbal aggression, but she had never threatened the staff with a knife prior to the incident. She said that the resident subsequently apologized and that her behavior escalated because other staff members were present. According to the DSP, she would have redirected the resident to go to her room to music and called the police if she had been working alone in the home.

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SUGGESTIONS

1. The Authority suggests that the agency's human rights committee should periodically review the need to continue the restriction pursuant to Sections 115.320 (c) (3) and 5/2-201 and be certain that knives are more secure and that the missing knife used in the incident is located.

2. Consider reviewing the resident's behavioral plan sooner to determine if there is a need to address the knives.

3. Consider following up with the Behavioral Analyst's recommendation and recipient comment about the identified DSP working at another location.

4. Conduct evaluations and treatment plan reviews subsequent to serious behavioral incidents.