FOR IMMEDIATE RELEASE

East Central HRA Site Visit Plan
Case 13–060–9005
Cunningham Children's Home

The East Central Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission, has accepted for investigation the following allegations concerning behavioral health services at Cunningham Children's Home located in Urbana, Illinois:

Complaints:

1. A recipient of services is not provided with adequate and humane care in the least restrictive environment, pursuant to an individual services plan.
2. An individual receiving services is not free from abuse.
3. The facility uses inappropriate restraints.
4. The facility impedes visitation for an individual receiving services.

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/1 et seq.), and Social Services regulations (89 IL ADC 384 and 411 et seq.).

Per its website: "Cunningham Children's Home is a safe place where children and adolescents with serious emotional and behavioral disabilities can heal, learn, and grow.

Founded in 1895, today Cunningham offers residential treatment, specialized foster care, independent living programs, and therapeutic special education to children and adolescents ages 5-21." It is a secure child care facility licensed by the Illinois Department of Children and Family Services pursuant to 89 IL ADC 411.10.

INVESTIGATIVE INFORMATION

The HRA proceeded with the investigation having received written authorization from the 16 year old youth to review his record. The HRA visited the facility, where the facility and behavioral health representatives were interviewed. Relevant practices, policies and sections of the youth's record were reviewed.

Interviews

The HRA asked how many youth are served by Cunningham Children's Home. Staff explained at this time 56 when they are full, now there are 50. The only reason there were vacancies was that they had just opened a new home on the property. All homes serve children only. There are also two transitional homes for youth ages 17-21. There are 28-30 youth in apartments. There are 26 children in foster care at Cunningham. There are 66 children who attend at Cunningham's school and 116 children who attend the public school on Cunningham grounds. Most children receiving residential services attend the Cunningham school. There are approximately 250 staff that work at Cunningham.

The HRA asked if some of the children are under Department of Children and Family Services (DCFS) guardianship. Staff responded that the children are placed there under the Department of Juvenile Justice. Some receive an individual care grant (ICG) through Screening, Assessment and Support Services (SASS), a service provided by Department of Human Services (DHS). This service provides intensive mental health evaluation for children and youth who may need hospitalization for mental health care. The SASS serves children experiencing a mental health crisis.

The HRA asked how parents are involved with their children that are being served by Cunningham. Staff explained that as part of the referral process the parents are very much involved. They participate in the assessment. Regarding how things work with parents who are separated and/or divorced and decision making, staff explained that they look at the legal documents regarding custody. They clearly try to work with both parents if they can. They also have to adhere to court orders designating who can give consent and who is the legal guardian.

When asked in this specific case who was the decision-maker for the child involved, staff explained that the mother was, but the father did have visitation. The HRA asked about Cunningham staff adhering to the court ordered visitation for the noncustodial parent. Staff explained that they normally try to arrange alternating visits between the mother and the father on weekends. They try to have visits at the facility or take the child to the parent. They have paid for parents to come visit and paid for the gas for the parents who need it to come visit. They have used specific hotel suites so that children could see siblings and family members. Cunningham staff believe that family engagement is so critical. Staff explained there are issues when they are required to supervise visits. Regarding visitation Cunningham will try to arrange visits with parents and try to engage both parents if the situation allows. They are also setting up video conferencing equipment in case parent(s) can't physically visit. (The HRA on a follow-up visit asked about the video conferencing for children and parents at a later date and it had not been set up yet.)

The HRA asked if there was a reason for either parent, whether custodial or noncustodial, to not have telephone communication with their child. Staff explained there was not. Phone calls should be connected unless the child is in a crisis. There is an area in the facility that is specifically designed for private phone calls. Occasionally there was trouble reaching the child when he was doing other activities. Neither parent made a complaint to staff or formulated a grievance regarding issues of visitation or issues of being unable to communicate with the child via the phone. Staff did explain that sometimes the father would call, but the son would not always return the call.

The HRA asked how the individual treatment plan (ITP) is developed and if it was similar to an individualized service plan. Staff explained that service plans are more driven by case components, the ITP is more clinically driven. The ITP is developed by a therapist. There are quarterly reports; educational material; special therapies; and special goals regarding relationships/emotions/sexual behavior etc. Children who live at Cunningham have both an individual treatment plan, and an individual education plan (IEP) for when they attend school.

The advantage of having both school and residential case-managers available is the daily communication with the school. The school will get that information and sometimes the educators may be coming to the residential setting so that the child does not miss school if unable to attend. Staff explained how they work together. This youth had an IEP due to emotional and behavioral goals.

Staff shared a little bit about training received regarding restraints and when they receive this training. There is therapeutic crisis intervention (TCI) at orientation even before a worker can job shadow. Orientation takes about 2 weeks. There are refreshers at team meetings. TCI is recertified yearly and it is also covered monthly. Every 4 years the entire class room portion is covered.

The HRA brought up that when they met with the young man, they observed a gash on his leg that looked pretty deep. He stated that he got it from a recent restraint for stepping outside when he was upset. Staff shared a document that a mental health professional was part of that restraint. The restraint was also reviewed by management staff. The HRA was provided information on all staff which showed they had received training on restraints.

The HRA pointed out that one of the other things that was noticed about the youth was that he was completely covered with old and new bruises of different colors and various cuts that required stitches. He admitted that most of these were self-inflicted. The HRA asked what measures were taken to prevent this young man from harming himself or others (including the staff). Staff explained that the youth never did get funding for a one on one staff person, but he was on level 1 supervision which meant he always had to be observed by staff.

Regarding the gash on the youth's leg, one staff explained the youth was a skate boarder and could have injured it or it could be that the youth may have reopened the wound. Another staff interviewed at a different time stated that the youth had already broken his nose, then the youth broke his nose again by opening a door. This was not necessarily intentional. If youth had an injury he would let staff know.

Staff interviewed separately stated the youth had re-broken his nose and that he was the only one in his room that could have broken it. He was popular on the unit because he was a relatively good skate boarder, he would make friends but he had trouble keeping them. A second staff, who was interviewed privately from the other staff, also told the HRA that the youth was a skate boarder. If he had a bruise or scab he would pick at it continuously.

The HRA explained that they had been told that the youth was sent to a hospital behavioral unit the day after the HRA visited him on 10/2/12. Per staff at Cunningham a medication wash was completed at the hospital because of self-injurious behaviors and he was restarted on medication when he returned back Cunningham. The HRA asked if his condition improved after his return. Staff explained that it did a little. He reduced some self-injury, was not scratching and cutting himself, but became more aggressive with staff.

Per the record of the DCFS involvement, the HRA inquired if this young person may have suffered from and received treatment for post traumatic stress disorder (PTSD. The response from staff was yes he did receive traditional treatment for PTSD.

The HRA asked what training is provided to staff regarding human rights particularly in the area of visitation and an unimpeded telephone conversation. Staff explained that this would be provided at orientation and at weekly team meetings. All staff have received this training. Children's rights are posted in the facility as well as the grievance policy with grievance forms made available in each unit. The grievance system had just been updated. Staff have had weekly team meetings at which rights are discussed. There are about 10 kids on each unit and they discuss the levels of interventions being used in the course of meeting.

Regarding telephone calls for this youth, staff would check the client's phone list with the custodial parent. He had access to call his father.

When asked have all staff been trained that when third-party advocacy groups or attorneys call, that it is inappropriate to ask why they are calling or what they want to discuss, a staff person admitted that because of hotline referrals and DCFS involvement that the HRA was questioned at the initial call. He just wanted to make sure it was okay for the HRA to talk to the youth. He was trying to protect the confidentiality of the youth. When asked if training regarding third party advocacy was provided to the staff that were overseeing this child, the response was not necessarily.

The HRA asked what restrictions did this child have two weeks prior to our visit. The response was typically a youth had a phone list. They don't allow children to call people off of the phone list. They would contact his mother to see if it was alright for the youth to contact someone off the list. The turnaround would be about a day.

The HRA asked does the agency have a behavior treatment committee and a human rights committee and were the restraints used in this case discussed by these committees. The response was they do have both committees. This case may or may not be discussed. The child had a DCFS hotline call against him and until the investigation is completed there would not be much discussion.

The HRA was provided a tour of the portion of the facility that the youth resided in. It was a locked unit. Client rights were posted as well as the chore assignments. There was a board that listed the behaviorist and the caseworkers' names. Youth could write their names under workers' names, if they wanted to spend individualized time with those workers. There was posted information about how to file a client grievance.

The HRA observed the seclusion room. In order for staff to put a youth in seclusion the staff would have to hold a panel down with their hand to keep the door locked. If the staff person removed their hand, the door was unlocked and the youth could exit. The seclusion room had a window where the staff would observe the youth.

There was an observation room. There were rooms to play video games. Video conferencing areas had not been set up yet. There was a dining area where the youths would have breakfast, dinner, evening snacks and all weekend meals. Each youth would receive a choice of two healthy snacks. Lunch was served at the school cafeteria.

The HRA also toured a section of the facility for females and found the same set up in this unit. Once again, rights information and grievance information was posted. Third party advocacy information was posted on the bottom of the of the rights information.

Record reviews

On 8/2/11 the youth was admitted to Cunningham Children's Home. It was documented by the youth's signature that client rights were explained to him. The parent and the youth had signed informed consent for services and treatment. Consent was given by both for mental health treatment. Consent was also given in writing by the parent for Cunningham to seek medical treatment for the youth at various medical providers. The intake form documented:"… the youth takes the following psychotropic medications: Seroquel, Depakote, Abilify, and Celexa." It was also documented that the youth has had a history of several psychiatric hospitalizations over the last four years resulting from auditory and visual hallucinations, suicidal ideation, and homicidal ideation. "His mood is very unstable and can be volatile. He has been extremely physically aggressive and destructive in the home environment. He has been aggressive with family and with peers at school. He has a history of being cruel to animals. He is overly sensitive and tends to misperceive others which results in his reaction being exaggerated and often triggering anger and aggression. He experiences a great deal of anxiety and is fearful of various different things…."

The *Admission Note* documented: "Clinical and diagnostic information that the presenting problems are suicidal ideation/gestures, psychotic symptoms, aggressive behavior, mood disorder, homicidal ideation/gestures, sexual behavior problems, anxiety/PTSD, medical and health issues (including psychotropic medication): Seroquel, Depakote, Abilify, asthma, and seasonal allergies."

In the *Admission Note* section of diagnostic impression at time of admission: "DSM IV Axis (symptom criteria)296.64 Bipolar I disorder – most recent episode mixed with psychotic features and 300.2 generalized anxiety disorder".

In the section marked precautions or special programming that will be required: "**Aggressive behavior** - staff will use TCI verbal techniques to help de-escalate the youth before he becomes aggressive. If he becomes aggressive, TCI restraint techniques may be used, or

seclusion may be necessary. Staff are trained in both of these techniques. Staff will be proactive with the youth by keeping him engaged in the program, which will hopefully keep the number of aggressive incidents to a minimum.

Mood disorder – staff will work with the youth on being aware of his moods and learning how to manage mood swings. His mood swings will be monitored by the consulting psychiatrist, and medication will be monitored/adjusted necessary.

Homicidal ideation and gestures– staff will closely monitor the youth regarding homicidal comments/gestures. Qualified mental health professional (QMHP) staff and/or SASS will be notified if necessary.

Sexual behavior problems – Staff will closely supervise the youth and ensure he is not alone with other youth. He will be placed on the appropriate supervision level. Staff will notify supervisors/therapist if the youth engages in sexually problematic behaviors. If necessary, a safety plan will be instituted.

Anxiety/PTSD – Staff will work with the youth on developing and utilizing coping skills to manage anxiety and trauma symptoms. The youth will participate in individual and group therapy to address anxiety/PTSD issues. The youth's medication will be monitored by the psychiatrist on a monthly basis, and concerns will be reported at these appointments.

Suicidal ideation/gestures – Staff will monitor the youth closely for any self – harm comments or gestures. If the youth engages in such behaviors, appropriate protocols will followed (e.g. notifying a QMHP for assessment removing unsafe items from his person/room, written safety contracts). SASS will be notified if necessary.

Other (e.g. medications, etc.) – psychotropic medications will be monitored and/or adjusted by the consulting psychiatrist for Cunningham children's home; asthma; seasonal allergies (Flonase, singular)"

On 9/1/11 a mental health assessment was completed for the youth. On 9/6/11 a psychiatric evaluation was completed by a psychiatrist.

In the *Family Involvement Guidelines* booklet, in section 4. it states: "In all cases unless specifically indicated otherwise by the treatment or service plan, parent-child contact is encouraged. This can occur at the agency, in our local community, or in the parent's home, depending on the needs of the child. Cunningham Children's Home views family visitation as a right that children have and will not reduce or limit family contact as a form of discipline or punishment. Children will never have to earn time with their family…."

The *Phone Call/Visit Parameters* document stated that both parents are to have unsupervised contact, but for the father visits must be previously arranged.

In the record was consent from the youth's custodial parent for restrictive behavior management intervention (BTP) which included restraint and/or seclusion only to be used when the youth poses a physical risk of harm to himself or others. Restraint and seclusion would only be conducted by staff and who have been trained in these techniques. It also stated that the parent would be notified any time their child is involved in an incident in which restraint and/or seclusion has occurred.

The record included the *Behavior Treatment Plan* (BTP). The rationale for the plan was to use needed close supervision due to his emotional dysregulation and unsafe behaviors. The

BTP goals were to improve anger management skills and avoid self injury. The conditions that restraint would be used in the plan were danger to self (self – harm behaviors), and danger to others (physical aggression). The conditions that seclusion would be used were danger to self (self – harm behaviors), and danger to others (physical aggression). It listed how to contact the parent. The youth was medically assessed for the BTP.

Some of the techniques and interventions to be used for de – escalation include:

- Relationships; offering choices; coping skills;
- TCI – managing environment, proximity, prompting, caring gestures, hurdle help, redirection, directive statement, time away;
- Collaborative problem-solving –
  A: must be addressed
  B: negotiate a solution
  C: ignore for now.
- Reinforcement: feedback system, rewarding alternative behaviors, modeling, individualized motivational systems, planned ignoring, primary/secondary /reinforcers, and privileges.

Discipline to be used with this youth in the BTP, include:

- Taking away privileges, such as game room time, or off-campus time.
- Restriction would include confinement to the bedroom, no one on one time with staff, and no activity time with peers.
- Withholding allowance for restitution if the youth was destructive when escalated his allowance can be used to pay for damages.
- Early bedtime, if his behaviors affect his points he may be on a lower-level resulting in an earlier bedtime.

The HRA reviewed 15 unusual incident reports. All the reports included physically aggressive acts or behavior of the youth. The youth was restrained in 11 of the reports for physically aggressive acts or behavior. The reports document that the youth was put in seclusion 2 times. In 5 of the reports the youth was given extended restriction or removal. The restraints used in 3 of the reports document the youth being injured as a result of the restraints. The record documented that all of the staff involved in the restraints were TCI certified. The documentation of the youth being injured on these reports occurred on the following dates:

- **4/2/12** – The youth was punching a window, staff asked the youth to stop. Then the youth attempted to strike the window with his head. Staff used close proximity to prevent the youth of hitting his head. The youth then attempted to leave the facility. The staff used proximity to prevent the youth from leaving. Staff initiated a TCI two-person restraint of the youth in the course of rolling the youth to his stomach the youth bit a staff member's left arm. The staff held the youth's nose shut and pulled out of the bite. They continued the restraint. Upon the arrival of the third staff member, the youth was moved to a supine restraint. The youth was released according to TCI procedure. The youth suffered rug burns to his left elbow during the restraint. Interventions used to avoid the restraint were active listening and empathy. The restraint was supervised by a QMHP. The rug burns were treated with an antibiotic ointment and bandages. The restraint was reviewed by the coordinator and associate director and was approved.

- **9/12/12** – The youth have been involved in negative interaction with a peer in the courtyard. He was asked to return to the unit to cool down. When staff explained to him why he was asked to come in, he began to escalate. There was increased volume posturing and threats to staff. The youth became physically aggressive toward staff and two staff members began closing routes and directing youth toward a quiet room. When the youth realized what was going on he swung at staff. The youth was taken down and maneuvered into the position for prone restraint. The interventions used included a directive statement, the youth being offered choices, positive attention, and life space interview. When taken inside, staff emphasized that the youth wasn't in trouble. When he began to escalate, the youth was given the choice of the time away room or the youth's room. When he escalated, he was directed to supervised time away. The outcome was the youth came out of the restraint and was able to walk to the quiet room for supervised time away after showing staff compliance. The youth had minor abrasions/lacerations to the knee and was given basic first aid by staff. The restraint was supervised by a QMHP. The restraint was reviewed and approved by the coordinator and associate director.
- **11/29/12** – The youth was becoming hyper and prompted to stop throwing a ball at a peer or it would be taken. He threw the ball at a staff person and was upset because he could not have it back, but avoided an incident. He then found it unfair when he was told to stop swearing and shoved and kicked a staff person when he was given the option of the quiet room or his own room. The youth was hyper, aggressive, confronting and challenging toward staff. The youth threw a book at a staff person after being told he needed to go to the quiet room. Two staff persons went and restrained the youth. A third staff person came to assist when the youth was on the ground. The youth struggled at first and swore at staff. The interventions that were used included a directive statement, environmental management, proximity, choices, prompting, and life space interview. The youth had three staffs' attention and he was prompted with the option of the quiet room or his room. He was also told he needed to calm down and was able to transition to the quiet room. The youth had rug burns on the right side of his face from the restraint. No medical intervention required. The restraint was supervised by a QMHP. It was documented that the client was taken down on his back, but not with staff in proper position due to staff losing footing during the struggle. The youth complained of his leg being squished so staff moved away some to relieve pressure. The restraint was not approved by the coordinator because the prone restraint was not appropriately performed per TCI standards as reflected in the report and the youth had visible rug burns on the right side of his face due to the restraint. The associate director approved the restraint. The notes document while adjustments had to be made to TCI, the interventions were still warranted given the youth's aggressive behaviors.

One of the restraints on **8/2/12 was not approved** by the director because the youth was aggressive, but he was reacting to being in the restriction. The extended restriction was not warranted due to a compliance issue with the youth. Further action to correct the issue was identified as the milieu coordinator reviewed/clarified with staff that going hands-on is not warranted for compliance issues.

The HRA reviewed the tracking of restraints by worker. There was no pattern of restraints being applied more often by a specific worker.

There were individualized treatment/transition plans, and staffings, completed with the youth and his parent. The record showed numerous notes by the QMHP documenting that much care was provided to the youth.

Other trips to the Cunningham nurse, convenient care or the emergency room were documented in the record as follows:

- **10/27/11** – hand pain.
- **11/15/11** – hand pain.
- **12/12/11** – contusion of hand.
- **12/21/11** - broken nose.
- **1/15/12** – rectal bleeding resulting from self injurious behaviors.
- **3/15/12-** for dental trauma and abrasion.
- **6/15/12** – An abrasion noted on the left side of forehead/face, due to injury during restraint, right shoulder reddened, no swelling, skin intact. The youth is able to move shoulder up and down, hesitant to do full range of motion. Area on top of forearm covered with large band aide, due to self injury, being reopened during restraint.
- **7/9/12** – the youth stated he was in the hallway at school and hit his nose on the door. (No UIR)
- **7/9/12**- The youth is put on level one supervision where he must be within staff's sight at all times.
- **7/20/12** – glass shards in both arms cuts on hands glass and injury on left hand from youth punching window.
- **8/3/12** – concussion and minor head injury. The youth stated he fell down the night before at the back of his head. He had dizzy spells. Nursing notes document the youth had been complaining of dizziness and blackouts since the restraint that had occurred the day before when he hit his head.
- **8/21/12** – the youth had a possibly broken hand.
- **8/27/12** – the youth had sprained his hand (by punching a tree.)
- **8/29/12** – the youth ingested glass (Nursing notes at Cunningham document that youth claimed to have swallowed part of a broken light bulb.) The parent was notified.
- **9/4/12** – the youth had blood in his stool as a result of self injurious behaviors and was referred to see his primary care physician.
- **9/19/12** –the youth had a contusion of hand because he had punched lockers, doors and a window. Glass shards were in the wound.
- **9/20/12** –Swallowed glass.
- **9/25/12** – The youth went to the ER for swallowing glass.
- **10/1/12** – self mutilating behavior and deliberate self cutting.
- **10/2/12** – the youth inflicted the 2 inch linear laceration to his arm is approximately 1/4 wide. The two sutures are intact that the youth had inflicted the day before. The parent was notified.
- **10/3/12** – client bit right forearm. The parent was notified.
- **11/7/12** – client sustained injury to his right wrist area after attempting to grab a Frisbee.
- **11/25/12** – possibly swallowed glass
- **11/26/12** – (Nursing notes at Cunningham document that youth claimed to have swallowed part of a broken light bulb.) The parent was notified.

- **12/19/12** – the youth had to have three sutures removed from his right forearm.

The HRA reviewed the 688 pages of contact notes documenting staff contacts with the youth or on his behalf. Regarding visitation issues it was documented:

- **9/12/12** – DCFS worker contacts case management and advises that a safety plan be developed to protect other children he may come in contact with on home visits.
- **9/13/12**– Cunningham staff learn that the youth had been indicated by DCFS.
- **9/19/12** –Visit with father is cancelled due to ongoing DCFS investigation and the need for a safety plan for visits.
- **9/25/12** – Case-Manager advises mother not to visit the youth at hospital for swallowing glass because it may reinforce negative attention seeking behaviors.
- **9/26/12** – The youth claims he swallowed glass because his home visit was cancelled.
- **10/3/12** – At a staffing a parent voiced that he thought his son was struggling because his home visits were unstable. Staff explained that the youth had a home visit every other weekend. This was due to the youth's self-harm, allegations of sexual abuse and the ongoing DCFS investigation.

In the notes it was documented that staff really tried to work with the youth concerning self injurious behaviors. Various therapies were tried with the youth. One successful form of therapy that Cunningham provided the youth was pet therapy. Per the notes of staff on 11/21/12 from 3:30 PM – 3:40 PM: "The youth attended pet therapy along with the therapy dog and its owner with a focus on his emotions specifically utilizing coping skills to manage his emotions connected with his feelings of anger, sadness, anxiety, and frustration. During the session the therapist asked the youth to explain to both himself and the volunteer what he believed that pet therapy could do for him or specifically what he wanted to work on. The youth stated that he sometimes has very hyper behaviors and other times it's very angry at other people. I processed with the youth that the dog can play a role in helping him with things he needed to work on the youth first aid he was not sure that as we continued talking was able to discuss possible ways the dog could help you to manage his emotions. The youth stated that petting the dog and the dog could help him feel better about himself as the dog was very happy to see him. He also stated that just getting to come to this session and be away from his unit would also help you to do better as he get away from peers treatment. I explained to the youth that dogs were good listeners and listen as he talked about getting things off his chest. The youth agreed and stated that he knew the dog could not talk back so that would be helpful sometimes he did not want others opinions. The dog's owner also explained to the youth if he was hyper or upset the dog would not be willing to be near him and that could also be a motivator for the use calm down. The youth stated that he never wanted to scare the dog. The youth made slight progress on his goal area and he was able to identify many ways that the dog in his pet therapy session use as a positive coping skills for him now and in the future he received a grade of 5/5 continue to attend pet therapy on a weekly basis to address his goal areas as appropriate."

"…The youth learned about the focus of his emotions specifically displaying constructive and safe expressions of his feelings in order to interact appropriately with others and keep himself safe. The therapist began the discussion with the use in regards to the dog's body language and how dog reacts when it feels various motions...."

Notes regarding pet therapy document that the youth was able to participate in 3 more sessions of pet therapy. In all three sessions he scored a grade of 5/5. In the following sessions

he learned about peoples' body language. He was able to discuss the importance of body language for himself in order to interact with others appropriately. In another session he made comments that having an adult that he cares about him is also helpful. In another session the youth briefly discussed that he had been struggling, but did a fantastic job working with the therapy dog.

The HRA reviewed the *Human Rights Committee Minutes* for the 7/11/12 meeting. Phone procedures were discussed. "There was discussion regarding that certain staff are not necessarily using the 'restrictions of rights' form to document some restrictions (e.g, in the monthly parole meetings). The intent of the policy is that the restrictions are documented in the record, not necessarily the format in which they are documented. "It was agreed that restrictions are documented on contact notes would suffice. Language reflecting this possibility will be added to the procedure…."

"…We discussed the documentation piece which references to the 'restrictions of rights' form which is not currently used in the Community Services program. Director of Quality Improvement will review the Rule 384 language the Director of Community Service to determine the parameters/requirements of this type of documentation. Depending on the direction of this review, it is possible we may separate these procedures in the two program areas…."

Policy Reviews

The HRA reviewed the following policies and procedures at Cunningham children's home:

- *Clients Rights (No Date)*
- *Restriction of Rights to Receive and/or Send Mail (2/8/13)*
- *Restriction of Rights Related to Phone Use (8/7/12)*
- *The Agency Behavior Treatment Plan (4/14/10)*
- *Mandated Reporting (no date)*
- *Acknowledgement of Mandated Reporter Status (1/2009)*
- *Business Ethics and Conduct (3/1/90)*
- *Code of Ethics (4/1/03)*
- *Client Rights (3/25/09)*
- *Residential Transition and Discharge Protocol (No Date)*
- *Room Cleaning Expectation (No Date)*
- *Expectations for Chores (No Date)*
- *Daily Incentive Program Update (No Date)*
- *Cunningham Training Catalog (No Date)*

The HRA reviewed the *Clients Rights (No Date)* #9 which states: " You have the right to private and uncensored communication (mail, phone and visits.) These rights may be limited to protect you and others from harm."

Regarding the *Restriction of Rights Related to Phone Use (8/7/12)* policy in procedures part 3,: "Use of the telephone may be recently restricted by the program director and/or designee

of me in order to protect the client or others from harm, including harassment or intimidation, provided that notice of such restriction is given to all clients admission."

In part 5,: "Cunningham may not restrict ingoing or outgoing phone calls involving: … Guardianship and Advocacy Commission…."

In part 6.,: "Any restrictions on telephone use that occurs during the course of placements must be documented in the case record. Cunningham has developed the restrictions of rights form to document restrictions."

The HRA reviewed the *Mandated Reporting* (no date) policy. It explained that all staff, interns and volunteers at Cunningham are mandated reporters. "By law, (staff) must report all suspected cases of abuse and neglect involving any young person know to you in your professional capacity…."

The HRA reviewed the *Acknowledgement of Mandated Reporter Status (1/2009)* completed by each employee that provided services to the youth. It states: "I will become a mandated reporter under the Abused and Neglected Child Reporting Act [325 ILCS 5/4]. This means that I am required to report or cause a report to be made to the child abuse hotline…."

Cunningham Training Catalog (No Date) documented that staff participate in a 28 hour TCI course over a 4 day period at orientation. The content is "Using the Cornell University Model, participants are certified in the philosophy, behavior management techniques, and physical skills necessary to deter and--when necessary--respond to aggressive, explosive behavior. (The training) emphasizes use of less restrictive measures whenever possible, and careful attention to safety…." There was also a 5 hour TCI recertification class given yearly to staff in the fall and 2-3 hour TCI refresher class in the spring.

The *Cunningham Training Catalog* included a 2 hour Behavior Management and Licensing course and a 1 hour Seclusion Training course for new staff. There were numerous other courses provided to staff listed in the catalog. The HRA did not observe any training on human rights in the training catalog.

The HRA reviewed *The Agency Behavior Treatment Plan (4/14/10)* pg5. "The mission of CCH is to offer emotional, physical, social, education and spiritual support to children, child/youth and families by providing a safe, nurturing, therapeutic environment in which individuals may experience personal growth and healing." It covered the policy on which staff are qualified to apply restraints and when they are necessary and how to provide services according to each individual's behavior plan.

CONCLUSION

Complaints:

1. **A recipient of services is not provided with adequate and humane care in the least restrictive environment pursuant to an individual services plan.**
2. **An individual receiving services is not free from abuse.**

The youth sustained substantial injuries which required medical attention at a minimum of 24 times while he was at Cunningham mostly from self-harm. During the time that he sustained most of these injuries he was on a level 1 supervision, which meant that he must be

observed by staff at all times. Based on the evidence it appears that he was not being observed by staff at all times. The Mental Health Code defines adequate and humane care in section 405 ILCS 5/1-101.2, as: "Services reasonably calculated to result in a significant improvement of the condition of a recipient of services confined in an inpatient mental health facility so that he or she may be released or services reasonably calculated to prevent further decline in the clinical condition of a recipient of services so that he or she does not present an imminent danger to self or others."

The Code further states in 5/2-112**:"** Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect." This is reiterated in Social Service regulations 89 IL ADC 411.300 for Client Rights and Confidentiality which state: "a) The legal rights of children and youth shall be protected in accordance with Chapter 2 of the Mental Health and Developmental Disabilities Code [405 ILCS 5]…" and part f) of this section states: "Every child and youth shall be free from all forms of abuse and neglect, including physical, emotional, medical, etc."

In one instance when the youth was attempting to self-harm, he had taken apart a piece of furniture in order to use the nails from the furniture to injure himself. This injury required sutures. In the record, there were several incidents where the youth broke light bulbs and ate the glass from the light bulbs to intentionally self injure. It is very difficult for the HRA to understand how this could happen if he was being observed by staff continuously.

Regarding issues of the abuse at Cunningham the HRA reviewed quite a few unusual incidents reports regarding restraints and injuries--instances that could imply possible abuse. What was of concern was there was no report when the youth allegedly re-broke his nose by opening a door to his room on 7/9/12. Per interview with staff the youth approached the staff and claimed that he broke it while opening his door. Once again it raises the question as to why was he not observed by staff at the time and why did such an event not raise any suspicion among the staff members. All staff interviewed seemed to have accepted that the youth broke his nose by simply opening a door without any question. Per social service regulations 89 IL ADC 411.500 it states: "The following reports or documents shall be forwarded to the Department as specified: …d) Unusual Incident Reports: The secure child care facility shall state in the child's or youth's record and shall report to the parents, attorney and/or Guardian ad Litem, and the Department any unusual incidents or serious occurrences involving children and youth. These incidents and occurrences shall be reported in writing, or if made verbally, confirmed in writing within 48 hours after the occurrence. These incidents and occurrences include serious accident or injury requiring extensive medical care or hospitalization...."

The record documents there are three instances during which the youth was restrained and was hurt when restrained by staff. In all three instances there were justifiable reasons to restrain the youth, but the youth incurred injuries from struggling with staff quite aggressively. However per social service regulations in 89 IL ADC 384.50 h): "Manual restraint shall not consist of, the use of excessive or unnecessary force, or any other action that produces pain, covers the head or any part of the face, or in any way restricts normal circulation and respiration of the child."

The youth incurred multiple injuries from self abuse after he was supposed to be observed at all times on level 1 supervision. The services at Cunningham should have resulted in a significant improvement of the condition of the youth; the HRA contends that services should have prevented further decline in the youth's condition so he was not a danger to himself or

others. It would appear that services did not follow the youth's behavior plan and the agencies policies, if he was to have constant observation. A broken nose injury was not documented by staff on an unusual incident report. The youth had been injured three times when he was restrained by staff and there were multiple reports of self injury in spite of the high level of staff supervision. Based on the evidence in the record the complaint **a recipient of services is not provided with adequate and humane care in the least restrictive environment, pursuant to an individual services plan is substantiated.**

Per the documentation, there was no evidence that any staff person had any intent of abusing this youth. **An individual receiving services is not free from abuse is not substantiated because there was no evidence that staff intended to abuse the youth.**

The HRA makes the following recommendations:

1. **Follow the Mental Health Code and Social Service regulations in providing adequate and humane care, pursuant to individual services plans.**
2. **Follow policy/practice requirements and complete incident reports for injuries.**
3. **Ensure staff are truly observing a youth continuously on level 1 supervision to prevent a youth from self-harm, harming a peer, and staff.**
4. **Complete restriction of rights forms for restraint use as the internal human rights committee documented that staff were not always completing these forms.**

Complaint 3. The facility uses inappropriate restraints.

Per Social Service regulations 89 IL ADC 384.50 Behavior Management Requirements for the Use of Manual Restraints, it states: "Each application of manual restraint may be used only as a therapeutic measure when a child presents a threat of physical harm to self or others. Such threat shall include any dangerous behavior reasonably expected to lead to physical harm to self or others. Manual restraint shall not be used until after other less restrictive procedures or measures have been explored and found to be inappropriate…."

All the restraints reviewed by the HRA were employed by staff that had been certified as having successful completion of TCI. All restraints were observed and later reviewed by a QMHP. All restraints were reviewed by the administrator's designee and approved or disapproved pursuant to 89 IL ADC 384.50 social service regulations section j) which states: "j) Manual restraint shall be employed only by persons who are certified as having successfully completed a competency based training program presenting the specific procedures to be used. This certification must be renewed through a competency based assessment at least every 12 months…."

"k) Application of manual restraint requires direct authorization, supervision and management by the mental health professional…"

"…The mental health professional must review the restraint episode immediately upon conclusion of the restraint to ensure that the restraint continued and concluded in a manner that is consistent with the model and the child's interest. Each use of manual restraint shall be reported as soon as practicable and a written record forwarded within 24 hours to the administrator of the facility or designee, the assigned caseworker in the facility, and the social work supervisor. If the use of manual restraint results in an injury requiring emergency medical treatment by medical

personnel or exceeds 60 consecutive minutes, the senior agency administrator shall be contacted immediately."

The restraint on **8/2/12 was not approved** by the director because the youth was aggressive, but he was reacting to being in the restriction. The further action to correct the issue was identified with staff that the restraint is not warranted for compliance issues. Per sections b) and g) of 89 IL ADC 384.50 "b) Manual restraint shall not be used as discipline for rule infractions or as a convenience for staff."

"g) Manual restraint shall be administered in such a manner as to avoid provoking further and escalating incidents of the behavior in the child." It appears that in this case the agency took action to correct the disapproved restraint.

Per the record the youth received rug burns and lacerations in 3 separate incidents involving restraints. The record documents restraints that were applied and the youth sustained injuries related to the restraint application. Social service regulations 89 IL ADC 384.50 h) state: "Manual restraint shall not consist of, or be accompanied by, the use of mechanical restraints, the use of excessive or unnecessary force, or any other action that produces pain, covers the head or any part of the face, or in any way restricts normal circulation and respiration of the child. Manual restraints that include neck holds or a staff member lying across the torso of a client are prohibited." **The facility uses inappropriate restraints is substantiated in that restraint was used for non-compliance; however, the facility has corrected and the HRA makes no related recommendations. The HRA cannot substantiate an abuse complaint in that it cannot state for sure that the injuries sustained during restraint episodes were definitely caused by staff. However the HRA is very concerned about the frequency of injury when restraints are used with this youth.**

The HRA makes the following suggestions:

1. **Ensure that TCI techniques are properly applied when considering restraint use.**
2. **When injuries occur during restraint episodes, document the cause.**
3. **Conduct a debriefing of restraint use with the recipient and staff. Discuss with each how the injury might have been avoided.**
4. **Consider behavior management committee reviews of restraint incidents.**

Complaint 4. The facility impedes visitation for an individual receiving services.

Based on the interviews with staff it did not appear that all staff had been trained when third-party advocacy groups or attorneys call that it is inappropriate to ask why they are calling or what they want to discuss. Social Service regulations 89 IL ADC 411.300 2) for Client Rights and Confidentiality state: "Their (child's) right to contact protection and advocacy agencies such as the Guardianship and Advocacy Commission and Equip for Equality, Inc., their attorney, Guardian ad Litem, foster parents, and/or parents. Staff shall offer to assist children and youth in contacting these groups or individuals, and shall give each child or youth the address and telephone number of the Guardianship and Advocacy Commission and Equip for Equality, Inc…. "

In the record on 9/12/12 a DCFS investigator contacts case management and advises that a safety plan should be developed to protect other children the youth may come in contact with

on home visits. Cunningham staff learned that the youth had been indicated by DCFS on 9/13/12. On 9/19/12 a visit with the father is cancelled due to an ongoing DCFS investigation and the need for a safety plan for visits. On 9/25/12 the case-manager advises his mother not to visit the youth at hospital for swallowing glass because it may reinforce negative attention seeking behaviors. The youth claims he swallowed glass because his home visit was cancelled. Per Cunningham's *Family Involvement Guidelines*, in section 4., it states: "In all cases unless specifically indicated otherwise by the treatment or service plan, parent-child contact is encouraged. This can occur at the agency, in our local community, or in the parent's home, depending on the needs of the child. Cunningham Children's Home views family visitation as a right that children have and will not reduce or limit family contact as a form of discipline or punishment. Children will never have to earn time with their family…."

When the HRA reviewed the *Human Rights Committee Minutes* for the 7/11/12 meeting, there was discussion that some staff are not necessarily using the 'restrictions of rights' form to document some restrictions. Per the record of the youth there was no rights restriction in the record when the youth was prevented him from going on a visit to be with his father. Pursuant to Social Service regulations 89 IL ADC 411.300 "e) Justification for restriction of client rights under the statutes cited in subsections (a) and (b) of this Section shall be documented in the client file. In addition, the child or youth affected by such restriction, the parents, attorney, Guardian ad Litem, the Guardianship and Advocacy Commission, and any agency designated by the client pursuant to subsection (c)(2) of this Section shall be notified of the restriction."

The Mental Health Code in 405 ILCS 5/2-103 states: "Except as provided in this Section, a recipient who resides in a mental health or developmental disabilities facility shall be permitted unimpeded, private, and uncensored communication with persons of his choice by mail, telephone and visitation." It is reiterated again in Social Service Regulations in 89 IL ADC 411.320 b) concerning visits: "Visitors shall be identified on visiting lists approved by the secure child care facility director. The child's or youth's caseworker shall provide, in writing, any names of persons restricted from visiting the child or youth."

In section i) it states: "The denial of visitation must be based on documented security concerns related to conduct of children, youth or visitors during visits or that involve issues related to safeguarding the children or youth from visitor abuse. The denial of visitation must be documented in the child's or youth's record and reported to the caseworker."

Clearly there were issues of safety concerning the youth going on visitation however there may have been a way for the youth to go on a home visit to see his father by setting up a safety plan with the parent so he could go. However since the visit was cancelled, the youth reacted by swallowing glass. Then, staff advised his mother not to visit the youth in the hospital. There was no rights restriction notice in the file to document that the youth and his family were given their right to contact third party agencies to advocate for the youth. When the HRA attempted to call the youth, the phone call was impeded. Based on the evidence, **Complaint 4. The facility impedes visitation for an individual receiving services is substantiated.**

The HRA makes the following recommendations:

1. **Follow the Mental Health Code and Social Service regulations regarding an individual's right to unimpeded, private, and uncensored communication with persons of his/her choice by mail, telephone and visitation,**
2. **Complete rights restriction notices and issue them to anyone designated (405 ILCS 5/2-201) and (89 IL ADC 411.300) whenever a visitation or any right**

under the Code is restricted and be sure that all rights-related policies may amplify or expand but not restrict or limit these rights (405 ILCS 5/2-202),

3. **Require Human Rights training to be provided to every employee at Cunningham, including the leadership at Cunningham.**

The HRA takes this opportunity to make the following suggestions:

1. Social Service regulations in 384.45 l) Behavior Intervention Requirements for the Use of Discipline state: "No child shall be deprived of visits or weekly telephone contacts with family, attorneys or their legal assistants, assigned caseworkers or other persons who have established a parenting bond unless otherwise indicated for clinical or safety reasons (as documented in the record by way of guardian signature)." On 9/25/12 the case-manager advised the youth's mother not to visit the youth at hospital for swallowing glass because it may reinforce negative attention seeking behaviors. **The HRA strongly suggests that visitation should never be impeded as a form of discipline. It is the youth's right to visit family members or have the family members visit him. There was evidence that this incident of swallowing glass might have been related to the youth being prevented from visiting his family. Staff should follow Cunningham's *Family Involvement Guidelines*, which states that;"…Cunningham Children's Home views family visitation as a right that children have and will not reduce or limit family contact as a form of discipline or punishment. Children will never have to earn time with their family…."**
2. During the tour the HRA observed a board that listed the behaviorists' and the caseworkers' names. Youth could write their names under workers if they wanted to spend time with those individuals. **The HRA suggests that since this may be a violation of privacy for youths seeking treatment that a system should be in place, for youths to make private requests to see workers for treatment.**

The HRA commends Cunningham Children's Home for providing pet therapy for the youth because it was a therapy that really worked for the youth. In the notes it was documented that the youth scored a grade of 5/5 for every session. Per the Paws for People website http://www.pawsforpeople.org/who-we-are/benefits-of-pet-therapy/ there has been documented evidence that pet therapy has been able to do the following:

- "lifts spirits and lessens depression
- decreases feelings of isolation and alienation
- encourages communication
- provides comfort
- increases socialization
- reduces boredom
- lowers anxiety
- helps children overcome speech and emotional disorders
- creates motivation for the client to recover faster
- reduces loneliness
- helps children focus better
- improves literacy skills
- provides non-stressful, non-judgmental environment
- increases self-confidence, reduces self-consciousness…."

The HRA appreciates the full cooperation of Cunningham Children's Home during the investigation.

RESPONSE

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

REGIONAL HUMAN RIGHTS AUTHORITY

HRA CASE NO. 13-060-9005

SERVICE PROVIDER: Cunningham Children's Home

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 recommendation/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.

Pat A. Ege Patricia A. Ege
NAME

Vice President of Program Services
TITLE

August 29, 2013
DATE

CUNNINGHAM
Children's Home

Cunningham Children's Home
1301 North Cunningham Ave. – Urbana, IL 61802
Tel: (217) 367-3728 - Fax: (217) 367-2896
www.cunninghamhome.org

August 29, 2013
Human Rights Authority
East Central Regional Office
2125 South First Street
Champaign, IL 61820

Re: Human Rights Authority Case #13-060-9005

Dear Ms. Auth:

Cunningham Children's Home is submitting our agency's response with action items in regard to recommendations and suggestions provided to us in HRA Case #13-060-9005. Cunningham Children's Home is committed to providing high quality services to all of our clients. An important component of our services is the protection and advocacy of client rights.

We appreciate the time and effort spent on the investigation as well as the recommendations and suggestions that will further improve our agency's practices. Please do not hesitate to contact me by phone at (217)367-3728 or via e-mail (pege@cunninghamhome.org) if you require any additional information.

Sincerely,

P. A. Ege

Patricia A. Ege, M.S. Ed, LCSW
Vice President of Program Services
Cunningham Children's Home

Cunningham Children's Home
Human Rights Authority Response
Case No: 13-060-9005

Before we provide our response and related action items, we would like to begin by clarifying two items that appear in the HRA report.

1) The report includes references to Cunningham Children's Home being a "secure" child care facility. In addition, key sections from the licensing standards for secure child care facilities (89 IL ADC 411) are also included throughout the report. Cunningham Children's Home is not licensed as a secure child care facility. We are instead licensed under 89 IL ADC 404 which is licensing standards for child care institutions and maternity centers. We also want to clarify related language in the report that refers to a "locked unit". Cunningham Children's Home is not considered a locked facility as the doors utilized in the residential units are delayed egress (doors unlock after 15 seconds).

2) The information describing the clients served by our main campus residential program requires some clarification (page 2).

- The majority of clients are wards of the Illinois Department of Children and Family Services (DCFS) and are referred/placed by that agency.
- We do not serve youth whose placements are funded by the Department of Juvenile Justice (DJJ) in the main campus residential program (although we do serve DJJ youth in some of our other programs).
- Youth who receive an Individual Care Grant (ICG) are funded by the Department of Human Services (DHS). Screening, Assessment and Support Services (SASS) is unrelated to the placement of these youth.
- In addition, Cunningham also serves some youth whose placements are funded by the youth's home school district and the Illinois State Board of Education (ISBE).

Complaints and Associated Recommendations or Suggestions:

1. **A recipient of services is not provided with adequate and humane care in the least restrictive environment pursuant to an individual services plan.**

   RECOMMENDATIONS:

   a. **Follow the Mental Health Code and Social Service regulations in providing adequate and humane care, pursuant to individual services plans.**
   c. **Ensure staff are truly observing a youth continuously on level 1 supervision to prevent a youth from self-harm, harming a peer and staff.**

   Note: Our response to recommendations 1a. and 1c. reference related information. As a result, we have combined the response for these two items into a single narrative.

One of the issues identified in relation to these findings is that staff did not consistently follow the youth's plan for Level I supervision which is described in this report as "constant observation." Information about Level I supervision appears to have come from a contact note dated 07/09/12. We would like to clarify that description of Level I supervision provided in the contact note was not complete/accurate. While the note indicates that the client "would need to be within staff sight at all times," the context for the implementation of this supervision level was related to the client's inappropriate boundaries with peers (which is described in the note) vs. self-harm behaviors. Level I supervision is geared toward constant staff supervision during a time a client is with his/her peers and is designed largely to protect others from harm. Level I supervision does not mean the client could not have been alone in his room or in the bathroom. In an e-mail informing the treatment team of this client's supervision level, the supervisor wrote "As we talked about in team [client] is now on Supervision level 1. This means that he needs to have staff with him at all times, unless he is in his room or the bathroom. If he is with other kids then there needs to be a staff for [client] and a staff for the other kids."

We did recognize that this client had a high rate of self-injury and in some cases (5 of the incidents noted in the report), the client did engage in self-harm while in his room alone. As part of our concern with the client's number of self-injury incidents, we re-located him to the observation room of the unit on October 2, 2012. The observation room has a window which allowed our staff to better monitor his behavior and ensure his safety. At the time this move was made, members of the treatment team were informed via e-mail that client was to have extremely limited belongings in his room as he had broken plastic objects and other items to use as a means of harming himself.

On multiple occasions, this client broke light bulbs in his room/observation room (by throwing objects at the bulbs) and ingested glass. We consulted with our Maintenance Department to problem-solve alternative light bulbs, bulb shields or other options that might be used to reduce the risk of breakage and/or pose less risk if swallowed. As an initial step, the night light can lights (which contained the bulbs being broken) were removed from the client's bedroom. Once the client was moved to the observation room and broke that light bulb, our Maintenance staff installed a Plexiglas shield over the light fixture which resolved the issue. We are now in the process of installing Plexiglas over all of the main campus residential bedroom can lights to reduce the risk of similar incidents in the future.

This report also notes that it is difficult to understand the high number of self-harm incidents that occurred if the client was under staff supervision. When we reviewed the incidents noted in the report, we found that the client often was, in fact, with staff when an injury was reported. Some of the challenges to preventing injury included:

- In some cases, the client's behavior was explosive and unpredictable and occurred with limited opportunity for staff intervention (while walking with staff, client unexpectedly punched a window which caused cuts to his hand);

- In some cases, a single staff person was with client, but staff were unable to immediately intervene physically due to being alone.
  Note: Our staffing ratios meet or exceed licensing standards (Rule 404) and do not include funding for additional staff to be added for individual client needs. Staff do utilize push-to-talk phones or other communication systems (overhead paging) to request immediate assistance when needed.

- In at least one case, client had a potential weapon (e.g., glass from a window he'd broken). See additional information below related to risk assessment process and intervention.

Related to some of these dynamics, we would like to clarify a few basic tenets about Therapeutic Crisis Intervention (TCI). TCI provides many types of approaches and interventions that our staff use to avoid the necessity of a restraint. TCI also advises on situations which may prohibit the use of restraint. Staff are trained to use the least restrictive intervention(s) necessary to de-escalate the client. Often, staff will try multiple interventions they believe might be appropriate/effective before determining that the client's risk of harm warrants use of restraint. Staff members must consider each of the following elements prior to performing a restraint:

- Determine if the client is an imminent danger to self or others.

- Use professional judgment (dynamic risk assessment) which indicates a restraint is necessary (based on imminent danger) AND can be executed safely. The safe implementation of a restraint requires consideration of the following:
  - Are there at least two staff available to perform a prone restraint (or three staff if implementing a supine restraint)?
  - Is the environment safe? This question involves considering the location (e.g., in public), the emotional status of other clients who might be present (e.g., who may impede the restraint) and the physical environment (e.g., clear of dangerous items such as glass).
  - Does the client have a weapon that could be used to harm himself or others? TCI recommends that staff NOT physically intervene when a client has a weapon. This scenario elevates the risk of injury to both the client and staff. At times, based on the staff's assessment of the situation, a decision may be made to physically intervene as the best way to protect the child from injury. In addition, we continue to use verbal strategies throughout any such incident and, when necessary, may call the police.

While we believe it is important to provide some additional information and context to comments in the report and resulting findings (narrative above), we also take these recommendations seriously and are committed to the following:

1) Beginning with the current quarter, we will be implementing a quality assurance review for youth with a high number of injuries (regardless of cause). We currently aggregate client injury data for quarterly Safety Committee reports and will begin to look for patterns/trends for individual youth with a high number of injuries. The review process will be completed by the QI Department and follow-up will be done with the Director of Residential/Clinical Services for any required follow-up and/or action planning.

2) We agree that we need to evaluate the definition of our supervision levels and whether our current practices and protocols are meeting the needs of youth who engage in self-harm. For example, we may need increase the frequency of room checks, have youth leave their bedroom doors open or take other measures to improve supervision.

b. Follow policy/practice requirements and complete incident reports for injuries.

We agree that an Unusual Incident Report (UIR) should have been completed for the client re-injuring his nose on 07/09/12. There is no indication from available documentation (nursing notes, daily shift logs, etc.) that the client's nose was re-fractured, but nursing documentation reflects that the client reported to residential staff that he "hit nose with door at school". This incident occurred at the school and completion of the UIR would have been the responsibility of our school staff (Note: The school was not included in this investigation). Nonetheless, our residential staff should have followed up with the school and provided information in daily logs or other appropriate documentation.

It is our goal that an UIR be completed for all unusual incidents. UIR data is important to charting individual client progress, understanding program trends and identifying risk management issues. We include specific UIR categories for reporting injuries and provide training to staff during orientation on the appropriate completion of UIRs. We have developed and continue to refine checks and balances to ensure that UIRs are completed. We also receive feedback from our DCFS monitors on the fidelity of our UIR reporting. In general, this feedback has been very positive (albeit the review is focused only on our DCFS ward population). We understand the importance of these requirements and will continue to provide ongoing staff training and support around this issue.

d. **Complete restriction of rights forms for restraint use as the internal human rights committee documented that staff were not always completing these forms.**

As part of some recent changes to Medicaid Community Mental Health Services Program (59 Ill. Adm. Code 132), our restriction of rights procedures and forms are currently under review. Revisions that fully meet these requirements as well as those that are part of the Mental Health and Developmental Disabilities Code will be completed no later than September 30, 2013. Training around the new procedures and forms will be completed with all residential/group home program staff by October 31, 2013.

Note: This recommendation specifically references restraints. Restraints are documented on the Unusual Incident Report (UIR) form vs. a Restriction of Rights form. The UIR is appropriately disseminated to all persons specified under 405 ILCS 5/2-201. We have developed checks and balances to ensure that UIRs are completed when significant events occur. We will continue to provide staff training as well as refine these systems for ensuring that all restraints are appropriately documented.

2. **The facility uses inappropriate restraints.**

SUGGESTIONS:

a. **Ensure that TCI techniques are properly applied when considering restraint use.**

As noted in the Guardianship and Advocacy Commission report, all program staff working in the residential program are trained in Therapeutic Crisis Intervention (TCI). Training is initially provided in orientation and every employee is re-certified annually. In addition, all staff also participate in "refresher" trainings once a year that address topics identified by supervisors in practice and through our quality improvement processes (e.g., Safety and Behavior Treatment Committees). Certainly, a key aspect of TCI training and re-certification is the appropriate application of each restraint technique.

As part of our commitment to proper implementation of all aspects of TCI, we currently have 11 staff members who are trained as TCI instructors (which includes the milieu coordinator for each main campus residential unit). Three (3) additional staff will become certified by the end of September, 2013 and one additional staff member will be certified in March, 2014. Our goal is to maintain 12-15 TCI instructors at Cunningham to ensure that staff receive in-the-moment training and feedback regarding TCI techniques (interventions geared toward de-escalation as well as restraints) and have ongoing access to this expertise.

Although it is never our intent that a child should be injured during the course of a restraint, it is possible for injury to occur despite the use of proper technique. During a TCI restraint, especially with a prone restraint, a client may self harm by rubbing his/her face on the floor (some surfaces in the residential treatment center are carpet). In order to prevent client injury, staff are trained not to put weight on the head, neck or back. At times, it may be appropriate for staff to put their hands above the head to reduce head banging behavior (i.e., client striking head against floor). As noted in the report, this client struggled aggressively with staff during the restraints reviewed. Due to this level of aggression, the hold on the body would likely have been less effective and there would likely be increased risk of harm if staff had tried to limit the movement of his head.

Note: During the past year, Cunningham Children's Home approved and trained staff on the use of the supine restraint which does not require as many steps to complete and would reduce the likelihood of a client experiencing rug burns.

b. When injuries occur during restraint episodes, document the cause.

Our goal in the documentation of any unusual incident involving our clients is to capture all pertinent information related to the incident. To that end, our unusual incident report (UIR) form includes multiple client injury types that our consistent with our licensing agency's incident reporting requirements (Accidental Injury/Wound Requiring Medical Attention, Self-Inflicted Injury/Wound Requiring Medical Attention and Restraint Involves Injury to a Child). In addition, other incident types may also capture information about the cause of client injury (e.g., Physical Assault of Child). In addition to multiple categories for UIRs involving injury, we also request that staff specify information on the UIR related to client injuries, including a description of the injury, how it occurred and information about any medical care provided. As part of orientation training, all program staff complete training on the appropriate completion of the UIR form.

Cunningham has also developed a process for supervisory review of each UIR. For incidents involving restraint and seclusion, two supervisory-level staff review the UIR. The goal of these review processes is to ensure thorough documentation of each incident, evaluate staff interventions (provide feedback when necessary) and ensure that incidents involving restraint and seclusion were both necessary and conducted appropriately. Data related to client injuries is routinely aggregated and analyzed as part of an ongoing agenda item for our Safety Committee.

Despite the form requirements, training and review mechanisms, we do recognize that occasionally the information provided on the UIR form does not sufficiently document the cause of injury. This has been an issue we have internally identified through our Behavior Treatment Committee reviews as well as reports created for the Safety Committee. As part of recommendations from our

Behavior Treatment Committee, the Assistant Director of Residential/Clinical Services (a new position developed/hired in May, 2013) is currently developing a training document for supervisors to improve the quality and consistency of the supervisory review process. Part of our goal is to ensure that supervisors are conducting more timely and appropriate follow-up when information from a UIR is either incomplete, inconsistent or lacks clarity. It is also important to note that the Assistant Director of Residential/Clinical Services is also often involved in the review of restraints and seclusions and has a key task of providing more immediate follow-up coaching and support for staff.

c. Conduct a debriefing of restraint use with the recipient and staff. Discuss with each how the injury might have been avoided.

As noted in response b) above, we have recently hired an Assistant Director of Residential/Clinical Services. One of the primary job tasks of this position is implementation of a consistent debriefing process for both staff and youth. Our Assistant Director of Residential/Clinical Services will be completing the TCI Instructor training in September, 2013. The basic TCI Instructors training incorporates debriefing concepts and in addition, several of our existing TCI Instructors have participated in a specific debriefing training module offered by Cornell University.

Our Assistant Director of Residential/Clinical Services will be designing our debriefing protocol based on the Cornell model which includes a review of every incident to a) assess the emotional and physical well-being of all staff and clients involved in an incident and b) identify what could have be done differently either to prevent the incident completely or to have impacted the outcome in a more positive way. In some cases, debriefing may focus on what went well / was done correctly that we can use in the future. Our goal for implementation of the debriefing protocol within the residential program is October 31, 2013.

To provide additional support to our direct care staff in the evenings and on weekends, Cunningham added two supervisory positions in the fall of 2012. These staff will be critical to our implementation of the debriefing protocol. Both of these staff are also TCI instructors.

d. Consider behavior management committee reviews of restraint incidents.

The Behavior Treatment Committee already reviews restraint incidents as part of each meeting. DCFS Rule 384, Behavior Treatment in Residential Child Care Facilities requires that facilities with more than 25 clients review at least 13% of all interventions used. Our Behavior Treatment Committee meets quarterly and reviews a random sample of incidents involving restraint and/or seclusion.

As part of our response to this recommendation and ongoing commitment to the safety of our clients, we will begin intentionally selecting some restraint and/or

seclusion incidents which involve client injury to assess factors which may have contributed to the injury, other de-escalation efforts that could have been used as well as what post-crisis debriefing occurred. Note: As described above, post-crisis debriefing will be implemented in the near future.

3. **The facility impedes visitation for an individual receiving services.**

RECOMMENDATIONS:

a. **Follow the Mental Health Code and Social Services regulations regarding an individual's right to unimpeded, private and uncensored communication with persons of his/her choice by mail, telephone and visitation.**

As noted throughout the Guardianship and Advocacy Commission report, there is documentation that Cunningham Children's Home has a number of policies, procedures and other documents that support our commitment to this basic client right. Among these documents are our Client Rights Statement, Family Involvement Guidelines, Restriction of Rights to Receive and/or Send Mail and Restriction of Rights Related to Phone Use. Client Rights posters are present in each unit and the grievance procedure was recently updated to create a more user-friendly process for clients and/or parents/guardians to file a grievance.

That being said, we recognize that additional staff training specific to client rights would further our goal of supporting our clients' rights, including unimpeded, private and uncensored communication. In accordance with recommendation c. under this section, Cunningham Children's Home will be developing a Client Rights training that will provided to agency staff. Training will be provided to current agency staff as well as integrated into the initial orientation for new employees.

We will also ensure that when visitation is restricted based on clinical contraindication (client's risk of harm, harassment or intimidation to himself/herself or others), it is appropriately documented on a restriction of rights form.

b. **Complete restriction notices and issue them to anyone designated (405 ILCS 5/2-201) and (89 IL ADC 411.300) whenever a visitation or any right under the Code is restricted and be sure that all rights-related policies may amplify or expand, but not restrict or limit these rights (405 ILCS 5/2-202).**

Note: As noted in the introductory/clarifying comments of our response, Cunningham Children's Home is not licensed under Rule 411 Licensing Standards for Secure Child Care Facilities. There is not an analogous section of Rule 404 Licensing Standards for Child Care Institutions and Maternity Centers.

As part of some recent changes to Medicaid Community Mental Health Services Program (59 Ill. Adm. Code 132), our restriction of rights procedures and forms are currently under review. Revisions that fully meet these requirements as well as those that are part of the Mental Health and Developmental Disabilities Code will be completed no later than September 30, 2013. Training around the new procedures and forms will be completed with all residential/group home program staff by October 31, 2013.

c. **Require Human Rights training to be provided to every employee at Cunningham, including the leadership at Cunningham.**

We agree with this recommendation. Training regarding client rights is currently under development and our goal will be to launch this training by January 1, 2014. Training will encompass client rights included in the Mental Health and Developmental Disabilities Code (405 ILCS 5) as well as rights contained in Medicaid Community Mental Health Services Program (59 Ill. Adm. Code 132), Mental Health and Development Disabilities Confidentiality Act (74 ILCS 110), HIPAA, DCFS Rule/Procedure and Council on Accreditation (COA) standards.

Suggestions:

a. **Social Service regulations in 384.45 1) Behavior Intervention Requirements for the Use of Discipline state: "No child shall be deprived of visits or weekly telephone contacts with family, attorneys or their legal assistants, assigned caseworkers or other persons who have established a parenting bond unless otherwise indicated for clinical or safety reasons (as documented in the record by way of guardian signature)." On 9/25/12, the case manager advised the youth's mother not to visit the youth at hospital for swallowing glass because it may reinforce negative attention seeking behaviors. The HRA strongly suggests that visitation should never be impeded as a form of discipline...**

Cunningham agrees that a parent/guardian should never be discouraged from visiting their child. Human Rights training (response 3c) will address the right to unimpeded communication (including visits) as well as the related issue cited above from Social Service regulation 384. Although we believe it is important to inform the parent of clinical concerns related to their child, this should never prevent visitation. The message should have been more about advising the parent on how to reduce the likelihood of reinforcing the behavior during the visit.

As a more immediate response, our Director of Residential/Clinical Services has discussed this issue with each of our three Associate Directors (who provide clinical oversight to our 6 residential units). Each Associate Director is tasked with providing follow-up to each team that visitation should never be canceled, discouraged or otherwise impeded as a form of discipline.

b. **During the tour the HRA observed a board that listed the behaviorists' and the caseworkers' names. Youth could write their names under workers if they wanted to spend time with those individuals. The HRA suggests that since this may be a violation of privacy for youths seeking treatment that a system should be in place, for youths to make private requests to see workers for treatment.**

Clients do have an opportunity to request time with their case manager or therapist privately.

We have found from a milieu management perspective that the process of a client adding their name to the board when they would like to meet with their case manager or therapist is very effective. The client does not provide any information on the board about the reason for wanting to meet with their assigned workers. Risk of violating privacy seems minimal.