FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
CHARLESTON TRANSITIONAL FACILITY— 17-040-9020
HUMAN RIGHTS AUTHORITY South Suburban Region

INTRODUCTION

The Illinois Guardianship & Advocacy Commission, the Human Rights Authority Division, has completed its investigation into allegations concerning Charleston Transitional Facility. The complaint stated that the facility failed to provide a resident's guardian with incidents reports and financial records as requested. The complaint stated that the facility rescinded the 30-day discharge notice and that an emergency discharge notice was given.

If substantiated, these allegations would be violations of the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/4), the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/2-102 [a]), the Illinois Administrative Code (CILA Rules) (59 Ill. Admin. Code 115.215), the Illinois Administrative Code for Medicaid Home And Community-Based Services Waiver Program (Medicaid Waiver Program) (59 Ill. Admin. Code 120.100 and 120.110) and the Illinois Probate Act (755 ILCS 5/11).

Charleston Transitional Facility provides housing, employment, vocational, counseling and advocacy services to persons with developmental disabilities and behavioral health needs. This agency also manages 12 Community Integrated Living Arrangements with a total population of about 80 residents.

METHODOLOGY

The complaint was discussed with the Regional Network Director in closed session at the South Suburban Regional Authority public meeting. A site visit was conducted at which time the Community Living Director and a Direct Services Professional were interviewed. The complaint was discussed with the resident's guardian and sections of his record were reviewed with written consent. Relevant policies and correspondence were also reviewed.

COMPLAINT STATEMENT

The complaint stated that the facility failed to provide a resident's guardian with incidents reports and financial records upon her requests. For example, it was reported that the guardian had asked the resident's previous Case Manager for receipts concerning expenditures. However, she never did receive them. It was reported that the guardian was not informed about an incident involving the resident putting his hands around a peer's neck until she was told that he would be discharged from the facility. Additionally, the complaint stated that the facility rescinded the 30-day discharge notice and issued an emergency discharge notice.

FINDINGS

Information from the record, interviews and program policy

According to the record, the resident had been a client in the facility's Community Integrated Living Arrangement (CILA) program for about ten years prior to termination of

services in 2017. An incident log, dated January 22nd, 2016 to May 19th, 2017, totaling about 25 occurrences of physical and verbal aggression towards others, property destruction and eloping behaviors was reviewed. For 2016, the incident log documented that the resident had broken a large bay window and threw a glass vase across the room in his home. He had pulled the fire alarm, redirections failed and 911 was called many times. His runaway behavior placed self and others at risk. He was transported to the hospital for an evaluation many times. His record contained corresponding incidents reports documenting that his guardian (mother) was notified in many instances.

An Incident Report dated May 17th, 2016 documented that the resident had walked out of his home without permission and was followed by a supervising staff person. The police were called because he reportedly sat down in the middle of a busy street and redirections failed. He was returned to the home by the police because he had refused to go with the staff person. Once home, he sat in the neighbor's grass and refused to follow directions from the police. He grabbed the staff person by her shirt and started pulling her hair and would not let go when the police intervened. Another Incident Report dated May 18th, 2016 documented that the resident had tried to choke the staff person assigned to provide 1:1 supervision at his day training program. Also, he reportedly choked a female staff person and slammed her against the wall. He grabbed another staff person and pulled her hair and punched other staff members. According to the incident report, the resident could not be redirected and was admitted to a psychiatric inpatient unit on that same day. His mother was reportedly notified about the two incidents above.

For 2017, the incident log documented that the resident's maladaptive behaviors had increased since that previous year. It was recorded that the resident had stolen the keys to the home's van and had tried to start the vehicle. He had punched and spat on the staff person who had prevented him from driving the van. A second incident indicated that he was inappropriate during a community outing. He reportedly had knocked items off of the shelves in a store and sat down in the middle of the floor and refused to get up. The home's supervisor was called to the store for assistance. Once home, he punched a staff person and eloped and 911 was called. He was returned to the home by the police and threw chairs around the room and hit a staff person. He was transported to the hospital for an evaluation and started destroying items upon his return to the home. A third incident documented that the neighbors had called 911 because he was looking in their window and rang their doorbell and would not leave their yard. His mother was reportedly notified about the second and third incidents above. However, there was documentation that she was informed about him stealing the keys to the van. According to the Regional Network Director, the facility was not required to complete an incident report or notify the guardian because there was no injury or aggression toward peers and the incident was witnessed by the staff.

According to the incident log, the resident went on a home visit due to behavioral issues from January 21st through February 21st, 2017. He was admitted to a short-term stabilization home on February 21st and the facility's staff and the stabilization team had weekly meetings and the home staff were trained on his behavioral plan. Upon returning to the facility, the resident walked out of his home without permission on May 2nd and the neighbors called the police while the staff were trying to redirect him. He was transported to the hospital for an evaluation and choked a nurse and his mother was notified. An Incident Report dated May 12th, 2017 documented that the resident had tried to choke his 1:1 staff person at his day training. He reportedly placed her in a headlock and chased another staff person who had tried to help her. It

was recorded that 911 was called because redirections failed and his residential staff and his mother were notified. He was transported to the hospital for an evaluation and was returned to his home on that same day.

An Incident Report dated May 17th, 2017 indicated that the resident was kicking, hitting and spitting on an employee at his day training program. He knocked items off of the desk and tore pictures and other items off of the wall. According to the Incident Report, the resident might be suspended from his day training program, and his mother was notified on that same day. Also, it was recorded that the Illinois Department of Human Services, the Division of Developmental Disabilities' Special Support Team and a behavioral analyst would be informed and retraining and a determination about the effectiveness of his behavioral plan would be requested. An Incident Report dated May 18th, 2017 indicated that the resident became angrier because the staff had blocked the door to prevent him from leaving the home. Three staff members tried to redirect him, according to his behavioral plan, for more than one hour without success. The Community Living Director was called to the home for assistance. Once there, the resident kept saying "call the cops" and began destroying items in the home. He reportedly knocked a lamp off of the shelving unit and the glass shattered all over the floor. He threw a large shelving unit across the living room floor and knocked items off of the shelving unit in the television room. According to the incident report, the staff called 911 for assistance, and the resident was happy to see the police when they arrived to the home. He was transported to the hospital and his mother was notified on that same night.

A letter dated May 25th, 2017 addressed to the resident's co-guardians (his parents) stated that the facility could no longer provide residential and developmental training services due to extreme physical aggression, elopement, property destruction, verbal aggression, and constant use of 911/emergency services. According to the letter, the resident's program had been changed many times since he was admitted to the facility in 2007. His medications had been adjusted and staff trainings were done. He was moved to smaller home and had his own bedroom. However, his maladaptive behaviors became more frequent and severe and were addressed by the Interdisciplinary Team (IDT) more than 50 times since 2011. His behavioral plan with input from five Board Certified Behavioral Analysts (BCBA) was adjusted more than 15 times. His case was reviewed by the Department's Clinical Administration Review Team in 2012 and Special Support Team in 2015 and 2016 with "failed results." He was admitted to the Department's Special Support Housing program in 2017 and was transported to the hospital due to elopement, choking staff members and severe property destruction soon after returning to the facility. The staff, neighbors and other concerned individuals had called 911 more than 20 times during the past year. He had slammed his behavioral analyst against a wall and three male employees had to subdue him. He had choked multiple employees, pulled hair from a staff person's head, and exhibited aggression toward the police requiring him to be subdued. According to the letter, all services would be immediately terminated due to imminent danger to self or others effective on May 25th. The letter documented that appeal information was included.

A letter dated September 22nd, 2017 addressed to the resident's co-guardians from the Illinois Department of Human Services (IDHS) stated that the resident's discharge from the facility's residential and developmental training program was upheld by the Department. The letter documented that the IDHS had reviewed information detailing that the resident's maladaptive behaviors had escalated since he was admitted to the agency in 2007. It stated that the agency had utilized various programmatic interventions to decrease his inappropriate

behaviors and had limited success. According to the letter, the Department had made a determination that the agency could not provide the appropriate services necessary to meet the resident's needs. Another letter dated December 1st, 2017 addressed to the resident's co-guardians from the facility stated that the resident was discharged from the facility's residential and developmental training program effective on that same day. According to the letter, the resident's banking account would be closed, and any remaining money and other personal items would be mailed to his guardians.

According to the facility's Community Living Director, who serves as the supervisor for the home, the resident's mother was very involved with him. She said that she had a good relationship with his mother. The facility's protocol is to notify the guardian about incidents and that she had called the guardian one night at 11:00 p.m. She said that the resident was escorted to the bank to deposit his $60.00, which is allotted for personal allowance monthly from his social security benefits, in his checking account. The Regional Network Director told the HRA that financial records are provided to guardians every three months. He said that the resident's mother had requested copies of incidents reports and financial records after he was discharged from the facility. The facility provided the HRA with an email from his mother, dated May 25th, 2017, requesting copies of incidents reports for the year of 2015 through May 19th 2017. Also, a note, dated November 27th, 2017, recorded that the resident's mother was provided with copies of all financial information, receipts for expenditures, and incident/injury reports that was included in the record reviewed by the HRA. His record lacked any other requests for records from his mother.

The facility's Community Living Director told the HRA that the resident had 1:1 staff supervision at his home and day training program. His behavioral interventions included redirections, positive reinforcements and a two-person hold. She said that he would target pregnant staff members and female staff were afraid of him. Three male staff were assigned to the home and two female staff were present on most days. The resident weighed between 230 and 250 pounds and calling the police was a "trigger" for him. She reported that the staff tried to prevent him from eloping from the home by placing him in a physical hold. She said that the stabilization home consisted of all male staff members who are more muscular than his home staff, and that he responded better with requests from men. According to the Community Living Director, the guardian did not want the resident to be hospitalized because she did not want his medications to be increased. She took the resident home with her before he was discharged from the facility and did not want him to return to his residential placement even though she was appealing the discharge decision.

A Direct Services Professional (DSP), who has worked in the home for two years, told the investigation team that the resident did not have a roommate as requested by his mother. He was compliant with medication; he would elope from the home almost every night and would go to the neighbors' houses sometimes. She reported that he had tried to hit her in her face one day when she had pursued him after he walked out of the home without permission. She said that it took about three hours for him to calm down and that she was retrained on his behavioral plan many times. This included redirections, to offer positive incentives and to physically hold him. She said that the resident is strong and was placed in a physical hold at least twice. She explained that a staff person would stand on each side of the resident and hold his hands to prevent him from eloping. He usually did not comply with requests from female staff members in the home. He liked going to the hospital and would exhibit more aggression when the police were called to the home.

The resident's mother told the HRA that the resident did extremely well during his stay at the short-term stabilization home in April and May of 2017. She said that the agency had agreed to follow the plan developed by the stabilization team upon his return to the facility. This plan included the use of physical intervention (holding his hands) to prevent him from eloping from the home and that calling 911 was not an option. She said that he had eloped from the home on the second night after he had returned from the stabilization home because the staff did not follow the plan. She took the resident to her home for a short stay and was planning on bringing him back to his residential placement. She said that the facility had agreed during a telephone conference with her and the SST earlier on that same week that he could return to the home in about one week after additional training was done. However, the facility sent a letter, dated May 25th, 2017, stating that the resident was being immediately discharged from services. She said that the Regional Network Director told her during a phone call that he could not return to his residential and developmental training program. The facility decided to rescind the 30-day discharge notice and to terminate services under emergency circumstances. The HRA notes that only an emergency discharge notice was found in his record.

CTF's "Incident/Injury/Medication Reports" policy includes procedures for the staff to follow upon witnessing, discovering, or notification of an incident, injury or significant medical occurrence. For example, the policy states that the direct care staff will seek medical treatment, notify the agency's nursing staff per protocol, document the incident/injury on the report form and notify the Community Living Director or Supervisor. It states that Community Living Director or Supervisor is responsible for notifying the guardian or person of choice if applicable about such occurrences.

The facility's "Individual Money Management" policy states that individuals served by the facility will be allowed to participate in the management of their financial affairs. It states that the facility will manage the individual's funds upon the individual's or guardian's written consent. The facility's staff will provide assistance, supervision, and monitoring of the individual's funds and will provide a summary of the individual's account to the person and/or guardian every three months.

CTF's "Admission /Discharge" policy states that the facility may suspend or discharge an individual as follows: 1) the person desires to stop participating, 2) the person **is** to be transferred to a program offered by another agency and the transfer has been agreed upon by the individual or guardian, the transferring agency and the receiving agency; 3) the person's attainment of the exit criteria, physical disability or medical condition cannot be met by the agency, 4) the person's maladaptive behavior places self or others in serious danger, and, 5) the person is relocated to an area not serviced by the agency or funding has been terminated. The policy states that an Interdisciplinary meeting will be held: 1) to determine if criteria for discharge or suspension has been met prior to the discharge or suspension, 2) to recommend alternative services and programming, and, 3) to determine the criteria that the person might be readmitted to the agency's program. The meeting notes will be placed in the person's chart. A 10-day written notice will be provided to the person or guardian prior to the discharge or suspension from the facility's day training program and at least 30 days in advance from the facility's residential program, except in cases of documented danger to self or others. The policy directs that the Department's appeal rights should be included with the discharge or suspension notice.

CONCLUSION

According to Section 110/4 of the Mental Health and Developmental Disabilities Confidentiality Act,

> The parent or guardian shall be entitled, upon request, to inspect and copy a recipient's record. Whenever access or modification is requested, the request and any other action taken thereon shall be noted in the recipient's record.

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

> A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. The plan shall be formulated and periodically reviewed with the participation of the resident to the extent feasible and the resident's guardian, if appropriate.

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

According to termination criteria under the CILA Rules, Section 115.215 of the Illinois Administrative Code,

> (a) The community support team shall consider recommending termination of services to an individual only if: 1) The medical needs of the individual cannot be met by the CILA program; or 2) The behavior of an individual places the individual or others in serious danger; or 3) The individual is to be transferred to a program offered by another agency and the transfer has been agreed upon by the individual, the individual's guardian, the transferring agency and the receiving agency; or 4) The individual no longer benefits from CILA services.
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> (b) Termination of services shall occur only if the termination recommendation has been approved by the Department.

Section 120.100 of the Medicaid Waiver Program Notice of action states,

> (d) Individuals requesting or receiving program services have the right to a written notice of disposition of the request, or reduction, suspension, denial or termination of services. Such notice must be mailed at least 10 calendar days prior to the effective date of the action, except, in an emergency…Notices shall contain the following information: 1) A clear statement of the action to be taken; 2) A clear statement of the reason for the action; 3) A specific policy reference which supports such action; and 4) A complete statement of the individual's right to appeal, including the provider's grievance process, Department review and Department of Public Aid hearing.

Section 120.110 of the Medicaid Waiver Program under Appeals and fair hearings states,

> (i) (1) Services may be suspended, terminated or educed before the final administrative decision only if all of the following conditions are met: A) The physical safety of the individual or others is imminently imperiled; B) Appropriate services are not available at the provider agency; C) The provider agency has documented attempts to identify and ameliorate the probable causes of maladaptive behaviors and to seek training or technical assistance to meet the individual's needs; and D) The PAS agent has: i) Reviewed the individual's record; ii) Gathered the necessary clinical information; iii) Reviewed the action of the provider; iv) Met with the individual; and v) Determined that a delay in termination, suspension or reduction in services would imminently imperil the physical safety of the individual or others and has documented that fact in the individual's record …. Services to the individual may be terminated, suspended or reduced and the notice of action shall be given in accordance with Section 120.110 (d), but in no case later than 48 hours after the termination, suspension of reduction in services.

The Authority cannot substantiate the complaint stating that the facility failed to provide a resident's guardian with incident reports and financial records as requested. Documentation and the staff interviewed indicated that the guardian was very involved in the resident's care. A case note, dated November 27th, 2017, documented that the resident's mother was provided with copies of all financial information, receipts for expenditures, and incident/injury reports that were included in the record reviewed by the HRA. His record lacked any other requests for records from his mother. It included a detailed time-line of occurrences and incidents reports concerning his significant maladaptive behaviors. However, there was no specific mention that the resident had put his hands around a peer's neck as stated in the complaint. Documentation indicated that his guardian was informed about all incidents mentioned in the report with the exception of him punching and spitting on the staff person after he had allegedly stolen the keys to the home's van. According to the Regional Network Director, the facility was not required to complete an incident report or notify the guardian because the incident did not involve injuries or aggression and was witnessed by the staff. This violates the facility policy that directs the staff to follow upon witnessing, discovering, or notification of an incident, injury or significant medical occurrence. The Authority finds no clear violations of Section 110/4 of the Mental Health and Developmental Disabilities Confidentiality Act and the Illinois Probate Act, Section 5/11a-17. Also, no violations of the facility's policies on Individual Money Management were found.

The Authority cannot substantiate the complaint stating that the facility rescinded the 30-day discharge notice and an emergency discharge notice was given. The resident's record indicated that he was discharged from the facility under emergency circumstances under Section 120.100 (d). His discharge from the facility's services was upheld upon an informal review by the Department. The notice contained a written statement of the guardian's right to appeal the termination decision, but there was no specific mention of the agency's policy which supports such action found on the document as required by the Section. The record and the notice

supports that additional interventions were explored and that the agency sought assistance from the Department's Clinical Administration Review Team and its Special Support Team before the impending discharge occurred pursuant to Section 120.110 (i) (1). The discharge notice indicated that the prescreening agency was informed that the resident would not be returning to his to CILA program. However, the HRA is unclear whether or not the PAS agent was provided with all necessary information to review the termination decision as required by the Section or that the facility held an IDT before terminating per their policy.

RECOMMENDATIONS

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

2. The facility shall follow its policy and complete incidents reports upon witnessing, discovering, or notification of an incident, injury or significant medical occurrence. Also, the guardian shall be notified about all occurrences.

SUGGESTIONS

1. Clearly document that the PAS agent has reviewed the termination decision as required under the Administrative Code Section 120.110 (i) (1).

2. Ensure that all documentation surrounding a discharge is maintained in consumer records, including a 30 day notice even if rescinded.