EQUIP FOR EQUALITY
A SPECIAL REPORT
from the Abuse Investigation Unit

Northern Illinois Academy Report

Advancing the Human & Civil Rights of People with Disabilities in Illinois.

NORTHERN ILLINOIS ACADEMY REPORT

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NORTHERN ILLINOIS ACADEMY

Part I: Background and Final Recommendation

Equip for Equality (EFE) conducted a comprehensive review of Northern Illinois Academy's (NIA) program beginning in late January 2021, pursuant to its contract with the Department of Children and Family Services (DCFS). While these activities were focused on current conditions, this report must not be read in a vacuum.

Specifically, EFE's November and December 2019 review of NIA noted concerns regarding lack of meaningful programming, unsafe restraint practices, problems with de-briefing, failure to identify / report incidents of restraints and seclusion, inaccurate reporting of incidents, complaints regarding time youth spend in their rooms, restricting residents from communication devices, and significant program failures in the Blackhawk unit, all of which EFE reported to NIA management at the time. Shortly after this, in January 2020 the Centers for Medicare and Medicaid Services (CMS) terminated NIA's certification as a psychiatric residential treatment facility (PRTF), citing NIA's dangerous restraint techniques and lack of staff training, and NIA remains decertified. In addition, DCFS' Corrective Action Plan from March 12, 2020, which followed DCFS' intensive monitoring activities and recommended a lift of the bed hold then in place, noted improvements in the following areas of concern: improper restraint techniques, failure to debrief post-restraint, undocumented injuries, under-reporting to the hotline, and failure to implement de-escalation techniques. In lifting the hold, DCFS also noted NIA's commitment to continued improvement in these areas. Finally, EFE's Fall / Winter 2020 review of conditions at NIA revealed many of the same significant areas of concern, including unsafe and abusive restraint practices (at times resulting in physical injuries), inadequate discipline in response to staff abuse, failure to report abuse to the hotline, failure to identify / report incidents of seclusion, lack of meaningful programming, high elopement activity, and inadequate supervision.[1]

Unfortunately, and as detailed in this report, EFE's comprehensive review revealed that these significant areas of concern continue to exist at NIA despite the vast resources the State and other entities have expended to help this facility over the past year and one-half to improve services and ensure the safety of the vulnerable children in its care. The continuing systemic problems at NIA lead EFE to the conclusion that NIA and its parent company are not willing to invest sufficient resources into this facility to effect lasting change to resolve the existing treatment and safety issues. As a result, EFE recommends that the State proceed with a phased closure of this facility. If the State follows this recommendation, the involved agencies must develop a contingency plan to act swiftly in the event of a sudden closure. EFE is willing to participate in the development such a plan, which must at minimum include independent

[1] It is also worth noting that NIA is part of a network of Sequel Youth and Family Services, a for-profit company. This company has announced closures of 12 facilities since 2019 amid decreasing enrollment that followed pressure from state regulators and disability rights groups, and national media attention for abuse. Presently, the States of California, Maryland, Minnesota, Oregon, and Washington no longer send their youth to Sequel facilities.

monitors to ensure safety during the closure process as well as experts to assist with developing appropriate and safe transition plans.

If the State decides to continue funding child services at NIA, it must expend significantly more resources over the next year (at minimum) to ensure that the youth in its care are safe and receive therapeutic services designed to assist them to improve and return to a more integrated setting. The findings below include detailed recommendations should the State wish to invest these resources in NIA.

As part of the State's response to these issues, regardless of whether NIA is to remain open, EFE encourages the State to educate parents and guardians to ensure informed decision-making about where their youth can best be served, including information regarding home and community-based services through Medicaid and Medicaid Waivers, the Family Support Program, the Family First Prevention Act, and school funding, both before admission to NIA, as well as part of discharge planning from NIA. As part of this education, EFE also encourages the State to present parents and guardians with service models that will help prevent out of state placements.

Part II: Comprehensive Review Activities

EFE's review of NIA included approximately 1,600 staff hours, conducing an on-going assessment in several areas through a variety of methods. Activities included on-site monitoring at NIA on five different days from February 3, 2021 through February 10, 2021, with visits to all the units and the therapeutic day school. EFE also conducted interviews with approximately 23 staff, 19 youth served by NIA (past and present), 19 guardians and family members, and 7 stakeholders. EFE also examined various materials as part of the review, including but not limited to 15 individual charts, restraint and seclusion records, reports, personnel records, video surveillance, policies, training materials, spreadsheets, staffing records, and police records. NIA provided requested information through a file sharing program which was helpful in providing EFE access to necessary information. NIA's cooperation in these efforts has been appreciated.

Part III: Interviews with Youth, Guardians and Stakeholders.

Before review of EFE's list of concerns / recommendations should the facility remain open, it is important for the State to hear from the youth, their families / guardians, and the stakeholders involved with these youth.

A. Reports from Youth Served at NIA

- As part of its review, EFE interviewed several youth in NIA's care. Below are some things that they shared, which are reflective of the concerns noted below:
    - One youth shared that staff members "don't really listen to what you say" and "they just blame your feelings or actions on something else."

- Another youth shared that she wishes NIA would hire real nurses, and that the "nurses never believe us." She also shared that youth were required to go to their bedroom 5-6 times a day in response to a behavior or crisis on the unit.

- A youth who left NIA in February 2021, and resided on Bears and Bulls shared the following complaints:
  - Staff frequently shoved youth and slammed them to the ground and on their beds.
  - Staff block youth to keep them in their bedrooms,
  - Youth are frequently not supervised, resulting in youth engaging in inappropriate activities undetected. He reported often waking up from a nap in the afternoon and finding himself alone on the unit, noting that he would have to knock on the door of Cubs to alert a staff member. He further shared that staff would not take them off the unit in response to fire alarms.
  - Staff would take away personal property as punishment for failing to listen, including pictures of family members.
  - The food was horrible and he was hospitalized for food poisoning while there. He also reported other youth experienced food poisoning at NIA.
  - A lot of youth contracted COVID-19 at NIA and had to isolate in their bedrooms with plastic coverings on their bedroom door.
  - The youth named a staff member who was fired, returned after 90 days, and was fired again, and said it was not uncommon for staff to be rehired around 90 days after having been terminated.
  - Youth are scared to report concerns because "higher ups" do not believe them, and they are afraid of retaliation as staff say that if they tell "it will happen again." When asked if he ever filed a grievance, the youth said, "they took that down several months ago."
  - The youth was very familiar with the Five Second Rule, and shared that youth are required to stay in their bedrooms for one-two hours during shift change, and that during this time they would observe staff being on their cell phones.
  - The youth only receive one 5-minute call per day and are allowed one 15-minute call each week.
  - Good staff leave due to lack of support from management.

- Another youth shared during an in-person interview that he was happy to see a staff member fired for slamming him to the floor, noting it was not the first time it had happened with this staff member. This youth was also familiar with the Five Second Rule and did not like that he had to stay in his room when others acted out. He would also like to go outside more, and was concerned about arbitrary enforcement of rules, resulting in personal items being taken away. This youth also mentioned he was on precautions (he did not have access to his shoes or a change of clothes) due to being a significant safety threat to others, and EFE staff noted that he was not receiving any enhanced staffing.

- This youth shared multiple concerns, including:
    - She would like to be able to spend a lot more time outside, but outside time is very limited.
    - She does not feel "safe," which she mentioned repeatedly, due to residents being aggressive towards her, which she relayed caused her to be aggressive towards them.
    - She really wants to return home to her family but does not think NIA is helping her achieve her goals. She noted that she needs help "learning how to handle her frustration" to progress.
    - Staff recently dragged her from school to the unit, and she has seen staff drag other youth. She also shared that as part of this incident, staff picked her up and forced her to her room, and that she had pain under her left arm but that she had not seen a nurse. She did not seem hopeful that seeing a nurse would be helpful.
    - After EFEF's interview with the youth, she tried to leave the unit and a supervisor brought her back to her bedroom. Staff then placed a chair in front of the youth's door, blocking her in the room. This lasted for 20 minutes, when staff accompanied the youth to the therapeutic day school.

- A youth who has been at NIA for many years stated that her favorite time is when she goes to bed, because it is quiet and peaceful then. She said waking hours are "chaos," that she does not feel safe at times, and that she feels better when things are calm and predictable. She shared that the food is terrible and that she makes bad choices at times because she is "lonely." The facility used to have a therapy dog, which really helped her cope, and after the animal left, she expressed her desire for a therapy dog but has been told she cannot have one at NIA. She expressed that she "would like to start a new life and go somewhere else" but did not know what she needed to accomplish to leave NIA.

- Another youth complained of a specific staff member who was threatening and abusive (which EFE reported to DCFS), and that another staff is particularly arbitrary about taking away personal property. He used to make complaints about conditions at NIA but stopped after nothing happened in response. He was also very familiar with the Five Second Rule and shared that if they did not go to their rooms in response they would be written up for non-compliance, which could then impact their status level. This youth also reported the practice of staff using large chairs to block youth in their bedrooms.

B. Reports from Guardians and Family Members

- As part of its review, EFE interviewed several guardians and family members of the youth in NIA's care. Below are some things that they shared, which are reflective of the concerns noted below:

    - One guardian / family member shared the following concerns:

- They felt NIA's use of medication increased since the removal of supine restraints.
- Not being informed of incidents, restraints, injuries, and not receiving related paperwork after requesting it.
- Lack of individualized treatment.
- Mistakenly being provided other youths' confidential information.
- The level system is too complex and not appropriate for youth who do not have the capacity to understand it.

- Another guardian / family member reported that their youth has had at least 5 different therapists at NIA. Other concerns included ill-fitting clothing, and poor hygiene practices, including untrimmed fingernails, overgrown hair, poor oral care, and overall lack of cleanliness.

- This guardian / family member shared the following concerns:
  - Inadequate supervision leading to youth engaging in sexual activity with each other at NIA, risking pregnancy and transmission of sexually transmitted diseases. Relatedly, the guardian / family member was also concerned about criminal activity in the past few years, including a staff member arrested for assault and an 18-year-old resident arrested for raping a 13-year-old youth during a field trip.
  - Not being informed of incidents, including elopements and the youth's significant allegations against staff.
  - NIA is not helpful in discharge planning / sharing documents to assist with discharge planning**.**

- A professional guardian / caseworker shared that a hospital called her out of concern that the youth's staff was not with him at the hospital, and that they could not connect with anyone at NIA. She also shared that the youth has been digressing rather than improving since his placement, and that she is concerned about whether he is receiving a balanced diet and sufficient exercise.

- A mother of a youth no longer at NIA reported the following:
  - Communication from NIA was poor.
  - Her child had a significant accidental injury while at NIA, and was complaining of pain, but NIA did not take him for needed medical assessments until the family kept pushing the issue. The orthopedic surgeon suspected a break in his collar bone, and recommended PT and a follow-up MRI, but neither occurred before his discharge from NIA, although there was time to act on the doctor's orders.
  - NIA transports for family visits were often significantly late (1-2 hours with no notice to family), and on one occasion late last year a staff was driving so recklessly that another staff had to take over. In addition, a youth on the van had to urinate, but because the transport was so late, staff required him to use a bottle in the van.

- It was her understanding that FSP funding for her child had stopped (or stopped at NIA) and that he could go to Arkansas with 7 other kids from NIA. She chose to bring him home rather than send him out-of-state but received no information about discharge services or home and community-based services.

- The mother of a youth that NIA left at a hospital and refused to take back earlier this year, shared the following:
  - NIA took him to the ER for psychiatric hospitalization without telling his mother, and then discharged him. NIA stated he could not return due to aggressive behavior.
  - The day of this hospitalization, the youth reported physical abuse by two staff members on the Wolves Unit, and the hospital found bruising on the youth's body. Her understanding of the incident leading to this report of abuse and hospitalization is that two staff came into his room while he was napping (at an authorized time) and yelled at him to get out of bed. The youth reported that this escalated into staff pressing his head against the bed (with his cheek pressing against Legos already on his bed). The youth further reported that one of these two staff later returned to his room and hit him in the ribs. It is unknown whether NIA reported these allegations to DCFS, but it has been otherwise reported.
  - The mother was not familiar with the "calm room" and when she asked her son about it, he reported that they would push him into the calm room and force him to stay there. He became agitated and upset when talking about this topic.
  - The youth was placed at NIA after his behaviors increased with the changes COVID-19 brought to his school schedule. After his placement, she heard inappropriate staff statements while talking on the phone with her son and/or when present at the facility. For instance, on one phone call when her son said: "I'm going to tell my mom how you are treating me," she heard a staff person mocking the youth's words back to him. During an in-person visit, she overheard a staff tell her son, "come on baby I don't have all damn day." Another time, she observed a staff member (involved in the abuse allegation noted above) say to her son: "Shut up, shut up, shut up." Although she wrote to NIA about this last incident, she never received a response, even after inquiring further.
  - The mother reported that she believed her son had been restrained twice, but, when she asked him, he reported it had been about 10 times. This was very surprising information to her.
  - Although he liked his therapist at NIA, the youth shared with his mother that he did not tell his therapist about staff mistreatment because he was afraid.

- The mother of another youth recently discharged to a hospital without notice, reported the following concerns:

- NIA suddenly discharged the youth after placing her at the hospital. Although no new placement had been arranged as of the interview, it is likely she will be placed on the East Coast.
- The youth had a plan to elope from NIA in August, was picked up by two women, and was sex trafficked. She was missing for two days. Police found her at a hotel two days later. After the youth returned to NIA, the mother had to insist that her daughter was taken to the hospital for a rape kit. At the hospital she tested positive for marijuana and a vaginal bacterial infection. Despite being on 1:1 supervision, the youth eloped again a few days later, and police located her within the hour. The mother does not know if NIA called the DCFS hotline regarding this incident, though EFE did last month. The mother further reported that NIA staff told her they only follow youth to the end of the property.
- In November, her child started to become violent and destructive, which was not a behavior she had before arriving at NIA less than a year ago. She reported her daughter seems "numb" now.
- Even though this youth has been subject to multiple restraints at NIA, the facility did not inform the mother about the use of these restrictive procedures.
- The mother did not request assistance with obtaining home and community-based services at this time and seemed concerned about whether the State would offer sufficient services to help her daughter safely return home.

- Another guardian / family member shared her concerns that NIA is not responsive to requests, does not provide documentation when asked, and does not contact her when significant incidents occur.

- One mother, whose child was transferred from Illinois to Arkansas based on her understanding that the youth lost her FSP funding at NIA late last year, reported that the Arkansas facility is worse than NIA. This mother reported that the therapist at NIA did a good job, but the overall environment was not positive, there was too much idle time, and she felt like kids ran the place. She also reported concerns about the youth having sex there.

- A couple of family members complained that there is no privacy in the family meeting room at NIA, which is a conference room with a window / glass wall in the area where people enter NIA.

- Another family member reported she would never send her youth back to NIA, noting the following concerns:
  - There are a few good therapists, but the staff are the problem along with the new director. The prior director was more responsive. There are a few good staff, just not enough of them.

        - A NIA staff member sexually assaulted the youth, which resulted in a criminal investigation, and she did not feel that NIA timely removed the staff from the facility.
        - The child sustained a black eye during a hold. This family member felt that incident could have been avoided if they had given her time to calm down.

    - A mother whose youth is no longer at NIA had multiple concerns with her child's care at NIA, including:
        - The child was injured many times at NIA and every time she came home, she had new bruises and scars. She was afraid to shower at NIA, other youth abused her, and staff would hold her down. She has scars around her eyes from physical altercations with other youth.
        - The mother reports that her child remains afraid to talk about what happened at NIA.
        - NIA did not communicate with her regarding injuries or restraints, and staff were not responsive to her concerns.
        - Hygiene was poor and personal property routinely went missing.

    - Another family member is actively working to remove his youth from NIA due to serious safety concerns. He felt that NIA used to provide good services, but that this changed with the current management. They are unresponsive and do not alert the family member of incidents despite his frequent requests that he be notified. Staff did not keep his youth safe from another youth known to target her, resulting in injuries. NIA is chronically understaffed and cannot retain staff because of how they are treated. His youth has had multiple therapists.

C. Reports from Third Party Professionals and Law Enforcement

- As part of its review, EFE interviewed several third-party professionals as well as local law enforcement. Below are some things that they shared, which are reflective of the concerns noted in the problem list:

    - One out-of-state child protective services professional shared her concern that NIA's use of medication has increased since NIA's stated policy of discontinuing supine restraints.

    - An Illinois Independent Service Coordination (ISC) agency will no longer place children at NIA because they do not see good therapeutic results. For children already there, this ISC agency is aware of multiple families unhappy with the services at NIA.

    - An Illinois Screening, Assessment and Support Services (SASS) worker reported as follows:

- NIA used to be a good facility, that would timely submit paperwork and be responsive to requests and concerns. There was a significant decline starting 12 to 18 months ago, after the departure of a clinical director.
- NIA is no longer responsive to her concerns in that management and staff do not respond to phone calls or e-mails, do not provide required records or communications about incidents / hospitalizations, and do not meet their responsibility to report allegations to the DCFS hotline (the example given included a staff member inappropriately touching a child).
- There is high staff turnover and understaffing.
- She also shared that staff were untruthful, reporting that they provided certain services or had taken actions on a child's behalf, and were caught in a lie, and she is concerned that children are being over-medicated. One of her youth was being targeted by a roommate, and NIA committed to changing room assignments in response. This did not happen, and her youth was subsequently attacked several more times.
- This SASS worker will not refer a child to NIA again. She is also taking steps to find new placements for the children on her caseload because NIA is "detrimental to their health."

- The local police department shared that it is very concerned about the safety of children at NIA, and had the following specific complaints:
  - Frequent and concerning elopements that have included children with exposed skin and no shoes in winter weather (including one child who eloped on two separate cold evenings in mid-March 2021 with no clothes on) and children in heavy traffic areas, including on an interstate highway, and sometimes without staff in pursuit. Also, in some of these situations, the police department learned of the elopement from members of the public as opposed to NIA, with NIA staff falsely claiming they called 911. These elopement issues are of particular concern due to the location of the facility and the fact that a staff member from NIA died in 2013 after being struck by a vehicle while trying to secure a NIA youth who was in traffic.
  - Multiple reports from youth who elope that they would rather go to the hospital or jail than return to NIA, and that they are mistreated at NIA, combined with police observations of inappropriate staff conduct towards youth and staff exhibiting a lack of interest in the youth they serve.
  - Staff failure to use de-escalation techniques and, at times, egging-on a youth by their own conduct and words. Staff do not appear to be well trained to appropriately interact with these youth, and NIA is reactive as opposed to proactive with the youth.
  - NIA cites DCFS rules preventing them from locking doors, as the reason elopements, without taking responsibility for staffing issues and staff interactions with youth.
  - NIA management has encouraged injured staff to file a police report to have the youth arrested and charged criminally, where it did not appear that the staff would have otherwise made a criminal complaint.
  - The police have received reports of understaffing and high overtime.

- The police have met with NIA on multiple occasions to address concerns, but the meetings have not been productive. NIA management has recently been unresponsive to requests to discuss concerning events.
- NIA dumping youth at the hospital and refusing to take them back.
- Youth making multiple suicide attempts.
- NIA declining SASS' offer to evaluate students at the facility, and instead taking them to the hospital.
- SASS' concern that youth are being re-traumatized due to the chaos at NIA.

Part IV: Findings and Recommendations

EFE verified many of the above reported concerns through extensive document review and on-site visits. In addition, DCFS and ISBE staff who conducted monitoring at the facility following EFE's on-site activities also observed similar concerns during their in-person monitoring. For instance, DCFS shared that its monitors observed: under-staffing, which was worsened following code calls, leading to chaotic units and unchecked escalation of behaviors; lack of structured activities on a consistent basis (which also contributed to behavior problems on the units); and the need for skills development for unit staff. ISBE monitors observed the following concerning circumstances: outdated calendar for unit activities, staff inattention to duties (cell phone usage, eyes closed for an extended period of time, and general disinterest) and two staff who appeared to be sleeping, staff using inappropriate language, staff being reactive rather than proactive, staff sitting in a chair to block youth from leaving their rooms, inconsistent use of Ukeru de-escalation techniques, the ease with which youth leave the facility without staff intervention, lack of required transition planning to return students to their resident district, unclear use of clinical / therapy services and the absence of therapists during crisis situations, lack of training on communication devices, staff retaliating against a student by grabbing the youth's face and pushing him/her, youth reports of staff mistreatment, staff intimidation of a youth sharing concerns with ISBE, student dignity concerns, poor school attendance, students without their assigned paraprofessional, inadequate remote schooling, hygiene concerns, lack of clean and appropriate clothing and shoes (with the exception of the last date of ISBE monitoring on March 10), facility safety and disrepair issues, and staff non-compliance with COVID-19 measures. Of additional concern is that DCFS and ISBE observed these issues despite NIA being under scrutiny for many months, and despite the known presence of monitors.

Before further addressing EFE's findings and recommendations, EFE notes it observed some small improvements as compared to its late 2019 review. The Therapeutic Day School unit is inviting and school-like, and EFE was happy to see that two of the small classrooms were combined to make a large room to address overcrowding. Although EFE continues to have concerns surrounding restraints, it was pleased to see NIA's formal efforts to eliminate supine restraint, effective December 15, 2020, as well as its stated policy to reduce restraints overall. While there have been supine restraints since December 15, there has been a significant reduction in such restraints and the directive is a step in the right direction. In addition, the length of restraints has significantly decreased. Restraints are typically under 10 minutes, which is a noteworthy improvement. The facility is also trying to shift to the Ukeru method of addressing

aggressive behavior, which is a positive step that if used effectively and appropriately could lead to reducing other physical holds.

EFE's record review and interviews also revealed that NIA is taking seriously its responsibility to ensure that the youth maintain connections with family and friends, and NIA has made appropriate adjustments to ensure on-going and appropriate levels of contact despite COVID-19 restrictions. Youth who had previously resided at other facilities reported that NIA's policies providing for on and off-site visitation were better than other providers. Finally, EFE was pleased to receive reports from youth about positive interactions and relationships with certain staff (on residential units and at school), and EFE observed some positive interactions demonstrating a good relationship between specific staff and youth and those staffs' ability to maintain patience and not engage in power struggles with youth. Likewise, a few parents made positive comments about the quality of therapists at NIA, including noting that a particular therapist was able to get to the root of her child's issues after many others had failed. Another parent had positive comments about a particular staff working with her son on an important safety goal. An over-arching theme was that NIA has some good staff, just not enough of them.

Unfortunately, the positives were far over-shadowed by the systemic failures and problems further discussed below.

A. Problem Area 1: Chronic Understaffing / Staff Overtime Concerns

- NIA is chronically and significantly understaffed, leaving youth at substantial risk of peer-to-peer abuse, self-harm, elopements, and preventable physical behavioral interventions. Understaffing also severely undermines the quality of services youth receive, both in terms of programming and treatment plan implementation, resulting in unnecessarily lengthy stays at a costly and restrictive level of care.

This has been a long-standing issue at NIA and, although NIA has previously reported to DCFS that it addresses this problem through overtime and PRN staffing, EFE's on-site visits and staff interviews reveal that NIA routinely operates short-staffed. Examples of under-staffing include:

- During a January 3, 2021 elopement that resulted in police involvement, NIA management told police that they were down 7-8 staff in explaining why they had difficulty stopping the youth from leaving, and why they could not send someone to the station to accompany the youth on his ambulance transport to the hospital.

- During an unannounced visit in February 2021, EFE learned that there were supposed to be 44 direct care staff, but only 32 direct care staff were present. Staff who were supposed to be a on 1:1 with a youth, instead served 2 youth. On another unit, only 1 staff was present for over 20 minutes despite the presence of about 9 residents on the unit, one of whom was supposed to be on 1:1 status and was instead in his bedroom with a chair blocking his egress.

- During multiple EFE site visits in February 2021, EFE observed youth on 1:1 status without 1:1 staff. EFE also observed units where there were only 1 or 2

staff present, and 8 or more youth, including youth on 1:1 status. Staff reported regarding a unit that was supposed to have 4 staff, that on a good day there are 3 staff present and more often only 2 staff.

- An analysis of staff assignment sheets for a two-week period in early February 2021 revealed an obvious pattern of overwhelming staff shortages. The below reflects the total direct care staff (combining all 3 shifts) on the residential units for a one week[2] period:

2/4-Th	2/5-Fri	2/6-Sat	2/7-Sun	2/8-Mon	2/9-Tu	2/10-Wed
91	96	91	77	77	96	95

  - On units other than Blackhawk, the records revealed that NIA routinely did not meet the 1 staff to 4 children ratio. These records further revealed multiple instances where there would be no assigned unit staff if the assigned 1:1 staff truly maintained their duties, as well as assigned 1:1 staff being assigned 2 youth. During the overnight shift, these units often only had 1 designated staff and, when there was a second staff, that staff was often a floater to multiple units, with the result that those units had an actual ratio of 1:6 or 1:11. Youth on 1:1 staffing during the day / evening hours, of which there were several, did not have a designated 1:1 staff overnight, which included at least one youth who was on 1:1 for suicidal ideation during this period.

  - Blackhawks was not exempt from these staffing shortages. This unit routinely had 11-15 staff on day or evening shift, depending on the day, even though there were 18 to 19 youth who were each supposed to have 1:1 staffing. Blackhawk only had 2 staff assigned for each overnight shift.

  - As another consequence of staff shortages, the staff assignment sheets reveal that on overnight shifts NIA is not consistently meeting regulatory requirements that female youth be directly supervised by female staff. 89 Ill. Admin. Rule 404.28(g) and (h).

- NIA's staffing levels are negatively impacted by its difficulty attracting qualified staff who have a desire to work with children in this admittedly challenging and low paying job. Poor working conditions have also harmed staff retention, with EFE receiving reports that staff are over-worked and often do not receive required breaks due to the lack of adequate staffing levels.

- Another analysis of the daily shift assignment sheets revealed that a significant percentage of assigned staff worked double shifts (16 hours), and on February 6, 2021, 2 staff worked a triple shift (24 hours). Below is the percentage of staff who worked at least a double shift on the analyzed days:

[2] EFE used this one-week period as an example because NIA was unable to provide unit staffing sheets for all three shifts for this two-week period.

2/4-Th	2/5-Fri	2/6-Sat	2/7-Sun	2/8-Mon	2/9-Tu	2/10-Wed
30%	41%	57%	48%	21%	37%	25%

- Among the staff working double shifts in this 7-day period, 7 staff worked 3 doubles shifts, 4 staff worked 4 doubles, 6 staff worked 5 doubles, 4 staff worked 6 doubles, and 1 staff worked 7 double shifts. Most of these staff also worked single shifts on many of the days they did not work a double. For one of the staff who worked a triple shift on February 6, she also worked 5 doubles and 1 single shift that week. As a result, in addition to the units being understaffed, many staff are working far too many hours to provide adequate care and supervision to the youth NIA serves.

- An analysis of NIA's staffing records indicates that 62% of its 125 direct care staff (called "Residential Counselors") were hired in the past 2 years, and 37% were hired in the past year. 21% of the Residential Counselors were hired in the past 6 months. This staff turnover also has a significantly negative impact on youth care. The guardian of a youth who resided at NIA for 2 and ½ years, and was discharged in the past few months, reported that he had 10 different therapists due to high turnover rates.

- Finally of note, NIA was without a speech therapist and occupational therapist for at least two months in late 2020, with the result that some youth did not receive services included in their treatment plan for that period.

- **Recommendations:**

    - NIA's population should be reduced, and the bed hold continued, until such time that NIA is able to demonstrate that it has adequate staffing levels to serve the youth within its care. For NIA to demonstrate that it has adequate staffing levels, it must be transparent about how it is staffing the units and 1:1 assignments, through detailed daily staff assignment sheets and payroll records, and specifically document where it has staffing deficits on any particular shift.

    - NIA must develop a comprehensive plan to both maintain staffing levels and to ensure all positions are covered each shift. It also must not accept new youth unless it has adequate staff to meet the youth's needs.

    - To stabilize staff retention, NIA must implement new hiring and compensation practices to attract and retain qualified staff who are committed to working with vulnerable youth with behavioral challenges.

B. Problem Area 2: Underreporting to DCFS and Other State Funders

- Record / video reviews and interviews with staff and stakeholders reveal that NIA is not meeting its obligation to fully report incidents to DCFS and other State agencies. Areas of concern in relation to underreporting include:

    - Front-line staff are fearful of reporting abuse / neglect allegations directly to DCFS due to retaliation concerns (including fear of discharge). As a result, and per policy, most DCFS reports go through NIA's Quality Assurance Department ("QA") or other administration staff. Contrary to regulatory requirements, management does not inform front-line staff after management reports the staff's allegation to DCFS. EFE has also uncovered instances where direct care or nursing staff report abuse allegations to QA, but it did not appear that the incidents were reported to the DCFS hotline.

    - Unusual incident reports, which EFE understands NIA provides to multiple State funders including DCFS, appear to be sanitized.

        - On January 9, 2021, the police received reports from members of the public that a youth was running in a highway lane. Suspecting it might be a NIA youth, due to a history of elopements from the facility, the police called NIA. NIA reported that they had just discovered that a youth had been missing, and that he had likely been missing for about 10 minutes. The Director of QA submitted an unusual incident report indicating that the youth slipped out an unlocked door behind staff, and that they tried to follow him but lost sight. The report did not mention the police involvement or that he had been gone long enough for community members to observe him running on the highway.

        - Likewise, NIA's report about a January 3, 2021 elopement did not mention police involvement, despite NIA's call to 911 after failing to locate the child. The police found the youth after a business in the community called to report a youth standing at their door. When the police found the child, he was wet and shivering, wearing only shorts, a t-shirt, and socks. Staff, who observed the youth leave the facility, told the police that they did not stop the youth from leaving because they are a "hands off" facility.

        - A December 27, 2020 police report provides that a child had made suicide attempts throughout the day and that staff found her in the shower trying to slit her throat with a broken DVD player. The unusual incident report merely notes that the youth was displaying suicide attempts throughout the day, resulting in NIA sending her to the hospital by ambulance.

        - A January 13, 2021 police report indicates that a child was found with a sheet hanging from the door twisted around his neck, and that the youth went to the hospital after the police arrived. NIA's unusual incident report

merely noted that the child went to the hospital after trying, multiple times throughout the day, to tie something around his neck.

- A February 13, 2021 unusual incident report indicates: "During room checks, it was discovered that resident had pushed her desk and chair in front of her door. When staff opened the door, resident was found with the belt from her robe wrapped around her neck." Other records show that this child had been to the emergency room on February 5th and 11th for suicidal behavior. The February 13 unusual incident report does not reflect the recent hospitalizations, nor does it indicate the child's supervision level.

- A video dated January 31, 2021 (though an unusual incident report states it occurred February 2, 2021), shows a staff member grabbing a youth by the back of his shirt to keep him in his bedroom, forcefully shoving him towards his bed. As the staff member walks out of the room, she retrieves something from the floor and aggressively throws it at the child's upper body. The unusual incident report, prepared by the Director of QA, fails to mention that the staff threw something at the youth, and merely noted an undocumented seclusion and improper escort. EFE has no indication that NIA made a DCFS hotline report regarding this incident. In a separate document, the staff received a verbal disciplinary record for the "improper escort" and "throwing." Also absent from this unusual incident report is the fact that none of the unit staff reported these events or another improper restraint and seclusion incident involving a different child on the same unit during the same period, and that the only reason management saw this video, days later, is that the second child alleged physical abuse against a staff member, credibly alleging that the staff punched her in the face. The "undocumented seclusion" for both children lasted approximately 50 minutes, and the "improper escorts" involved multiple abusive physical interactions and undocumented, unauthorized, and seemingly unjustified restraints that put the children at risk of harm.

- NIA is not reporting incidents that qualify as "unusual incidents" to the appropriate State agencies. From February 4, 2021 through February 11, 2021 there were 25 incident reports, all of which should have resulted in an unusual incident report. As a result, these incidents should have been shared with the required state agencies through the unusual incident reporting system. It appears that only 6 of these incidents, consisting of 3 restraints and 3 emergency room visits, resulted in an unusual incident report. The remaining incidents, which included multiple elopements, aggression towards peers and staff resulting in injuries, self-harm, and a medication induced seizure-like episode lasting more than 60 minutes, did not result in an unusual incident report. Failing to report these as unusual incidents leaves State agencies with the inaccurate perception that these extremely concerning events are not a daily occurrence at NIA.

- EFE also reviewed a NIA workbook that documents 257 incident reports in December 2020 and January 2021. Of those, we received approximately 57 in the form of an unusual incident report. Based on the review of all incidents reports for a 2-week period in early February, we suspect that most of these incident reports should have resulted in an unusual incident report.

    - Of those approximately 200 incidents not reported in an unusual incident report, around 18 involved physical injury to a resident. According to NIA's records, none of the incidents were reviewed by video or critical incident reviews. Although we do not have the initial incident report, the workbook documents that one of the injuries was a black eye and another injury / alleged injury resulted in an x-ray. Other workbook entries on injuries contained little detail.

    - Of the 19 restraints for that period, NIA's workbook indicates that 4 involved inappropriate physical technique, but that is not noted on the unusual incident reports or reported to DCFS licensing as required. Likewise, NIA noted in the workbook that another restraint incident that was off camera was unjustified, but again did not report this as an unusual incident report or note the violation to licensing.

    - Contrary to the provided unusual incident reports, NIA separately documented that two restraints violated policy by exceeding 60 minutes. NIA did not report the violations to DCFS licensing.

    - NIA's policy requires that a critical incident review be completed for every use of restraint, which includes a video review and discussion on what should have happened or not happened. NIA's files reflect that only 8 of the 19 restraints resulted in management conducting a critical incident review.

- Note, an alarming number of serious events continued in the first two weeks of March, with about 15 successful elopements (some of which involved children who were naked, one of whom was found walking along the street, and youth running into traffic), around 8 suicide attempts, and over 10 hospitalizations for injuries (including self-harm and peer-to-peer) and psychiatric stays. It appears that at least some of these did not result in an unusual incident report, but EFE stopped receiving these reports beginning around March 10, 2021. In addition, in a late March 2021 police report, the police officer observed a staff member strike a child in response to the youth striking her. Police reports from March do not reflect that NIA is improving and instead manifest a facility with a continuing high frequency of serious safety problems.

- On a related note, EFE reviewed over 80 unusual incident reports for the period of December 1, 2020 through March 10, 2021. Approximately 85% lacked adequate details of the incident (before / during / after / or staff involved in the incident). About 70% of the reports did not include required information such as supervisor approvals / reviews, or whether and when it was reported to outside State agencies or parents / guardians. In addition, parents / guardians reported that NIA did not notify them of concerning incidents and that NIA was overall poor at follow-up.

- Also in relation to this concern, and because it did not appear that NIA reported abuse / neglect incidents to the DCFS hotline, EFE reported a few the above incidents as well as the below to DCFS' hotline as part of its review. Some of these neglect issues relate to NIA's mismanagement of the facility, as opposed to front-line staff's conduct, which is a basis for a neglect as blatant disregard under 325 ILCS 5/3. Although the reported incidents mainly focused on the period of December 1, 2020 through February 14, 2021, because that is the period for which EFE had the most information, it does not likely identify all abuse / neglect concerns as EFE did not receive all videos for that period or after, and we did not have all incident reports. Due to a specific request for incident reports (IR) for the period of January 31, 2021 through February 14, 2021, which we found are more detailed than unusual incident reports (UIR), we had information beyond that contained in the UIR, which suggested that the stated incident involved abuse / neglect. Finally, we included the incident from August 2020 because we received this information as part of our review and the allegations were very serious. EFE does not know the status of its reports to DCFS.

    - August 18 and 23, 2020, UIR, unknown if video preserved. Youth eloped at 12:30 a.m. on August 18. She was missing for more than 2 days. We do not know exactly when, after those 2 days, she was found. Youth was allegedly sex trafficked during her elopement and the police located her, though EFE is not aware of a UIR that references the trafficking allegation. The Director of Quality Assurance met with youth's mother, who demanded she be taken to the hospital for a rape kit due to the alleged trafficking. Youth again eloped on August 23. Police located her 3 hours later. NIA should have reported these incidents to DCFS to investigate for neglect due to inadequate supervision.

    - December 7, 2020, UIR, EFE reviewed video. Staff carried youth by his hands and feet to the calm room and staff threw him into the calm room. NIA should have reported this incident to DCFS to investigate for abuse.

    - January 31, 2021, no UIR, IR #2021-02-01-005. Unknown if video preserved. Staff tried to separate peers in an altercation in the gym; code was called. Staff attempted to control the youth. While doing so, youth yelled that the supervisor on duty was choking him. This is noted in the IR. Staff writing the report documented he did not see youth being choked. No document of restraint. It is noted in the IR that youth tried to contact

911 to report the abuse, but unclear if call completed. The supervisor on duty was removed from unit. NIA should have reported this incident to DCFS to investigate due to the allegation of abuse (choking).

- February 7, 2021, no UIR, IR #2021-02-07-027. Unknown if video preserved. IR notes that youth is biting himself, among other things, for approximately 20 minutes. The staff describe that youth is "ripping" his skin and getting "his blood all over." He is a DCFS ward. NIA should have reported this incident to DCFS to investigate for neglect due to failure to protect from self-harm.

- February 8, 2021, UIR, EFE reviewed video. Lengthy and multiple video angles show multiple concerning events. Staff appear to egg-on child. Staff aggressively push child against the wall on a couple of occasions, and there are multiple abusive interactions with child. Staff do not intervene when the youth engages in on-going self-harm. NIA should have reported this incident to DCFS to investigate for abuse and neglect.

- February 9, 2021, no UIR, IR #2021-02-09-046. Unknown if video preserved. From 1:28 p.m. to at least 3:00 p.m. (we do not have an end time because it crossed over shifts and another IR was not written) youth was having seizure like symptoms. A seizure disorder is not noted. Nurse said it was a result of medication. Noted "resident began twitching his neck and his eyes began rolling to the side." This behavior continued for at least 1.5 hours. Nursing staff appeared to be awaiting direction from the doctor for the documented 1.5 hours, and as a result merely sat with him while he continued to have these seizure-like symptoms. There are three other youth who had seizure-like symptoms in previous months and were immediately transported by ambulance to the hospital. NIA should have reported this incident to DCFS to investigate potential for medical neglect.

- February 12, 2021, UIR, EFE reviewed video. Youth is, among other things, dragged and carried by staff across the unit at least twice. NIA should have reported this incident to DCFS to investigate for abuse.

- February 14, 2021, no UIR, IR #2021-02-15-007 and #2021-02-15-005. Unknown if video preserved. Elopement of multiple youth resulting in minor frost bite burns on 2 youths' feet. Incident reports mention short staffing. NIA should have reported these incidents to DCFS to investigate for neglect due to inadequate supervision.

- February 14, 2021, no UIR, IR #2021-02-15-010. Unknown if video preserved. Youth has a history of self-harm. We have seen IRs for at least 5 incidents, from December 2020 through February 2021, involving self-harm. Her incidents of self-harm results in pools of blood and the youth pulling out blood clots from her body. One IR said the youth should not be

left alone in her room. Yet she continues to be left alone resulting in injuries to herself. NIA should have reported this and similar incidents to DCFS to investigate for neglect due to inadequate supervision.

- February 14, 2021, UIR, EFE reviewed video. Youth is seen being pushed and held against the wall with the Ukeru pad following a behavior. Later in this episode, a male staff member picks her up and carries her while she is naked. Staff also drag her across the unit to her room, among other concerning staff conduct. NIA should have reported this incident to DCFS to investigate for abuse.

- **Recommendations:**
  - An independent outside oversight process must be put in place to ensure the accuracy and adequacy of NIA's reporting.
    - EFE understands that since it began this comprehensive review process, HFS has been working with the College of Nursing to provide training at NIA regarding completing UIRs.
    - Following such training activities, robust and independent oversight activities must occur for at least six months to ensure that NIA is accurately and adequately reporting incidents.
  - DCFS should investigate every suicide attempt and elopement.
    - EFE understands DCFS' position that its usual procedures do not require investigation of every suicide attempt or elopement. EFE is continuing this recommendation because, until NIA addresses its failure to provide adequate supervision, each suicide attempt and elopement has a high potential to be the result of systemic neglect on the part of NIA.
  - DCFS should require that NIA furnish video for every incident resulting in a DCFS investigation, and investigators must review the videos to verify the accuracy of NIA's reports. NIA should be cited if their report is not consistent with events the video depicts.
  - Every camera on each unit should have full range view of the unit.
  - As part of investigation, DCFS investigators should confirm the individual's supervision level through a chart review and determine whether the child received the required oversight through staff interviews and review of staffing levels (including through daily shift assignment sheets) on the applicable unit.
  - NIA must conduct an internal review of its practices to ensure management, quality assurance, and direct care staff are complying with the Mandated Reporter

Act. Upon completion of its review, NIA must take disciplinary action to address management's and quality assurance's failures in this regard.

- Following EFE's comprehensive review activities, DCFS committed to providing training at NIA regarding mandated reporting. This training should include examples of where staff have not met those obligations in the past.

- NIA management should review video associated with every incident report and must impose discipline where staff fail to report abuse and neglect, including witnessing unauthorized restraint and seclusion.

- NIA must report every improper or unauthorized restraint and/or seclusion to DCFS. In turn, DCFS should investigate these incidents for abuse and neglect.

C. Problem Area 3: Treatment Planning and Implementation Failures

- Treatment is not focused on timely resolution of the behavioral issues that resulted in child's placement at NIA. The treatment goals are not measurable and do not appear to be tracked, and the monthly plans often remain unchanged throughout the six-month record review EFE conducted. Although the treatment plans contain objectives, at times they are missing what the youth needs to do to meet a particular goal. There is also often a disconnect between the plan and therapy notes, and reports from the unit often do not reflect that the youth is working on their goals or progress. Also, when there is a significant increase in behavioral episodes, such as in one instance over 10 supine restraints in one month, the treatment file does not reflect that the team met to discuss why and what adjustments should be made. Of note, when this youth later moved to a different unit his behavioral incidents decreased significantly.

The direct care staff advise, and the documents reflect, that they do not participate in treatment planning discussions. These staff also reported that the youths' therapists do not train direct care staff regarding treatment plans and/or de-escalation techniques to address a particular youth's needs during a crisis. Instead, it appears that therapists only go to the units to respond to an emergency.

- NIA presents itself as a top provider of services to youth with challenging behaviors. That said, there is very little behavior programming at the facility. This includes a lack of individualized behavior plans (referred to as crisis and/or safety plans) that address behaviors from a function standpoint, inadequate training for staff members regarding appropriate positive behavior supports and interventions, no reinforcement inventory being completed with the youth, no identification of precursor behaviors, antecedents, proactive strategies, early intervention, etc. The crisis / safety plans also often do not meet NIA's policy requirements, and routinely do not include positive behavior supports and long-term planning goals. The strategies noted in the incident reports often do not correspond with the interventions listed in the youth's safety plan.

Behavior data is collected on a "behavior tracker," which are often missing from the youth's chart or the information is incomplete or so lacking in specificity that it is unhelpful. These are not reviewed within a specific time frame, but when "full" per the training manual. The data is not graphed or analyzed to identify trends or patterns. It is supposed to be reviewed by the therapist, but it is unclear what happens after it is reviewed. The six-month chart review did not reveal that the behavior plans are updated to reflect incoming data. With the lack of attention to behaviors and progress on goals, treatment and safety plans are not responsive to current needs, or indicative of readiness for discharge.

Interventions to address extreme behaviors appear to all be based in punishment techniques which is not an evidenced-based means to increase appropriate behaviors. Interventions include precautions, physical holds / restraints, and seclusion. These types of interventions are not therapeutic and lead to trauma. Many of these youth experienced significant trauma before arriving at NIA.

- There is a level system at NIA. It is not individualized or based on the youth's problem behaviors and needs. Treatment files do not include an individualized plan for (1) when privileges will be removed, (2) what precautions are to be put in place for what behaviors, nor (3) when they should be lifted. Files were missing physician approvals of precaution status. NIA's universal precaution system can result in youth not being able to go on home visits or go outside, and the precautions are not individualized, even to the youth's particular behavioral issue. For instance, the child cannot go outside, but elopement is not an issue. The treatment files often also do not contain risk assessments (including in response to suicidal statements) or documentation showing daily approvals of precaution status. Files are also missing tracking data related to precaution status.

- Treatment files were often missing documentation, suggesting that certain treatment is either not occurring or staff are not attending to their duties. For example:

    - Some treatment files fail to include therapy records, and a youth who had speech therapy as part of his treatment plan had no speech therapy notes in his chart. Likewise, in some youths' files there are no notes to suggest occupational therapy services were provided despite being part of the youths' plans.

    - Lack of programming identified elsewhere in this report, is obvious from review of treatment files. In addition, daily notes sometimes conflict with records regarding school attendance, with notes reflecting attending 50% of the school day, but a box checked indicating the youth attended the full day.

    - Charts reference concerning events that did not result in any type of incident report, including aggression towards staff, peers and/or self, medical emergencies, and elopement. At other times, shift notes fail to reference concerning incidents that resulted in an unusual incident report or "precautions" status. Multiple treatment files were missing some or all daily shift notes. For some youth, there were no close observation forms documenting the youth's status every 15-minutes, despite the fact that the youth was on 1:1 status.

- Lack of documentation in treatment files explaining side effects or risks of psychotropic medication.

    - Relatedly, in one file, NIA abruptly discontinued Seroquel with no tapering, and the youth experienced vomiting the next two days. The youth also had increased behavioral problems for about a month. NIA did not note the possible relationship between his increased behaviors and sudden discontinuation of Seroquel.

- Treatment files contain multiple references to the facility being a PRTF.

- The required "Discharge Plan" is generic and not focused on the behaviors that lead to the restrictive placement.

- The lack of proper treatment planning and implementation, in addition to the record review, is reflected by the following:

    - 53% of the 72 children at NIA have been there for over 1 year, and 36% have been there for over 2 years. There are 14 children who have been at NIA for over 3 years (with the longest being there almost 10 years).

    - Staff interviews revealed that they are generally unaware of the children's treatment goals, communication accommodations, and crisis / safety plans. For example, when communicating with two direct care staff about a youth's plans, both staff were unfamiliar with the existence of such plans and instead noted that they came to know the child's needs through their daily interactions with him. These staff also reported that the child does not use any devices to assist with communication, despite a treatment plan which reflects that, when upset, he requires a visual picture system and communication device to assist in communicating his concerns. This same individual's treatment plan did not include communication goals and it did not appear he received appropriate assistance to benefit from remote schooling.

- On the Blackhawk Unit, which serves children with Autism Spectrum Disorder ("ASD"), the paper files on the unit did not include treatment plan information for any of the youth, and staff do not have ready access to electronic treatment files. Other units appear to have short form sheets detailing the child's basic treatment goals and behavioral needs.

    - In one concerning example, a youth was supposed to have a communication board and tablet as a communication device, but neither were available to him during a February 2021 on-site visit. Staff reported he uses the boards posted throughout the unit that are not specific to him, and that he can only use the tablet on weekends during minimal, specified times. His chart did not reference any restriction to his communication device, nor would a restriction be appropriate given that it accommodates his communication deficits.

- Also related to the formerly constituted Blackhawk unit, where there were 19 youth, it was EFE's understanding that NIA deemed each youth in need of 1:1 staffing. It is unclear how often these youth are reassessed for their need for 1:1 staffing. While these staff ratios are important where necessary, it is also restrictive and important that assessments are occurring to ensure it is necessary.

- **Recommendations:**

  - Treatment files must be streamlined and organized in a way to benefit the youth by enabling staff at every level to understand treatment goals / methods, so that such plans can be implemented.

  - Accessible short-form documents for each youth must be available to unit staff, and the child's therapist must train each direct care staff working with the youth.

  - Therapists should be integrated onto the units to support direct care staff and residents, and direct care staff should be involved in treatment planning.

  - QA must ensure that direct care staff are following treatment and crisis / safety plans, and that treatment plans are being updated and adjusted based upon actual data from the child's progress or lack thereof.

  - The crisis / safety plans must be revised such that behavioral supports focus not only on behavior reduction, but replacement behaviors as well as skill building (coping skills, learning new behaviors, reinforcing existing behaviors). The plan must include a step-by-step plan to help staff learn how to de-escalate the youth, and when to justify use of more restrictive procedures. A BCBA must be used to help NIA develop evidence-based interventions, to help youth develop skills important for community re-integration.

  - State funders and local school district that placed the students should provide oversight to ensure youth are progressing at an acceptable rate based upon their individual condition, and that they are transitioned to home and community-based services or a less restrictive setting once behavioral concerns resulting in this restrictive placement are addressed.

D. Problem Area 4: Undocumented and Improper Use of Seclusion / Isolated Time-Out

- Staff regularly implement restrictions that include isolating children to their bedrooms for staff convenience and/or as a behavioral response without classifying the restriction as seclusion (referred to as "close observation" in NIA's policy) or isolated time-out. As detailed in the policy section below, NIA's policy on close observation needs to be redone and must not allow 4-hour room restrictions. Examples of concerns are as follows:

- A youth was housed in a room listed on a staff schedule as the "precautions room," located in the hallway between White Sox and the Therapeutic Day School. The child appeared to be housed in this room from at least February 4-7, 2021. A staff was assigned to sit outside the room, blocking ingress and egress, and the child received all her meals in this room. The room included a bed and the child appeared to be calm. This was not documented as seclusion. Another youth, who no longer resides at NIA, indicated that this room is used when a youth is "in trouble," and that the youth remains there even after they are calm and could be held there overnight.

- During video review and on-site visits, EFE observed staff blocking youth from leaving their bedrooms on multiple occasions for extended periods. This most often involved staff sitting in a large chair, placed in the doorway to the child's room, blocking the child's egress. On other occasions, it simply involved placing a large chair in the doorway to the child's room. Staff seemed to use this technique to make-up for the lack of staff and/or programming on the unit, and to avoid supervising the youth on the unit milieu. Video review showed staff physically redirecting youth back to their rooms when they managed to push through the chair and/or staff, and it was clear that the youth did not have the option to leave their rooms.

- Youth reported that staff often require them to go to their bedrooms if another peer is engaging in a serious behavior on the milieu. It is so common, that this practice has a name, "The Five Second Rule." We received multiple reports from youth that if they do not respond to the Five Second Rule by going to their rooms, or do not stay in their rooms until staff tell them it is okay to come out, staff will write them up for non-compliance, which can lead to a status drop if there are other issues.

- Video review and interviews revealed that staff often carry youth to the "calm" or "quiet" room, and that it is not uncommon for youth to be subject to physical restraint once in the room. The two rooms used for this purpose are in the education unit. While one room appeared to comply with regulations, and had affixed pads on the floor and walls, the second room did not meet the size requirements in that it was not at least 6 x 8 feet. Staff agreed that it would be difficult to calm in such a small room.

- **Recommendations:**

  - NIA must ban these practices, and staff must receive extensive training on what constitutes seclusion and when it may be used. Also of note in this regard, the State must provide NIA more direction as to what laws require, as the DCFS licensing regulations (89 Ill. Admin. Code 384.20), the School Code (23 Ill. Admin. Code 1.285(a)), and the Mental Health and Developmental Disabilities Code (405 ILCS 5/1-126) conflict in multiple ways and contribute to confusion on this issue.

  - NIA must discontinue use of the non-compliant quiet room.

- NIA must also ensure adequate staffing and greater supervisory oversight to address any continued use of such staff practices. Staff failure to comply with seclusion requirements must be met with appropriate discipline.

E. Problem Area 5: Undocumented and Improper Restraint of Youth

- Record and video review revealed that staff are frequently placing their hands-on youth to physically move them without documenting the incident as a restraint. Moreover, these reviews revealed that even when staff report a restraint, the related documentation often underestimates the length of the restraint (by not including the period of physical hold) and/or the number of times the youth was subject to restraints on a particular day.

    - As an example, if only looking at February 2021 unusual incident reports, one would see 10 restraints. This gives an appearance that youth are not being physically handled as often as they are. When factoring in the incident reports that did not result in an unusual incident report for first half of February, EFE found an additional 9 incidents of restraint likely meeting regulatory definitions when factoring in physical escort. Note, EFE did not request all incident reports for the second half of February.

- Physical holds that NIA's QA staff labeled an "improper escort" in unusual incident records were instead unlawful and abusive physical holds. The physical holds were unlawful in that they were not authorized (or even documented) per legal requirements, and abusive as noted in connection with the cited February 2, 2021 incident where staff was seen grabbing the child and forcefully shoving him towards his bed. This same video revealed another staff roughly picking up a small child and carrying her across the unit to her bedroom. Another video from a December 7, 2020 restraint incident included staff roughly shoving a child into the quiet room. EFE also saw videos of staff dragging and carrying youth, shoving youth, and forcefully grabbing items from youth. These hands-on techniques are abusive and leave the child (and youth observing these incidents) at risk of injury and emotional harm but are described in incidents reports as an "escort."

- Video review revealed that it is not uncommon for children to be "escorted" to the quiet room by physical hold, to then be restrained in the quiet room. These lengthy physical interventions put the youth at risk of injury and do not appear to be an appropriate use of a quiet room.

- Restraint documentation does not adequately reveal what de-escalation techniques were used, with the result that there is no data to evaluate the efficacy of de-escalation methods for a particular individual. Relatedly, the de-briefing paperwork is often inadequate or absent. There is sometimes a detailed debriefing-type form, in the form of a Critical Incident Review, but it is often performed several days after the incident. Moreover, based on records received for December through February, NIA is not conducting these reviews for most of the incidents it classifies as restraint, which is a missed opportunity because these reviews, which include reviewing video footage, are useful to identify

improper or abusive techniques, assist with staff training, and reveal conduct meriting discipline.

- Per NIA policy, staff were not to use supine restraint after December 15, 2020. EFE reviewed multiple unusual incident reports and videos which demonstrated that NIA staff are continuing to use this restraint practice, with over a dozen supine restraints since December 15, though at lower level than 1 year ago.

- Restraint and physical hold documentation also frequently fail to meet legal and NIA policy requirements. Specifically, the order / approval for restraint generally included a nurse's note that the doctor provided a verbal order and do not later include a doctor's signature approving the restraint. Records did not reveal that a doctor observed the child within 24-hours of the restraint. The restraint reports did not include the child's height, weight, sex, race, or age, as regulations require. Records also generally did not contain the required signature by the supervisor approving the restraint, or an administrator's signature within the next business day. Although NIA's internal records identified certain restraints as improper, we did not see NIA include this information on the restraint report, and in 2 out of 6 incidents EFE did not see paperwork to suggest that NIA reported the improper restraint to State agencies as required. Restraint records and charts also did not include 15-minute tracking log sheets.

- **Recommendations:**

    - Administration (not QA) must provide oversight of each physical intervention and confirmation that oversight occurred. Oversight must include a detailed (and documented) debriefing of both staff and youth, as well as a review of the child's plans and corresponding amendments to those plans to address their needs.

    - Staff must continue to receive education on Ukeru or other methods to reduce and eventually eliminate the use of physical intervention, and extensive training regarding what constitutes a restraint and illegal restraint practices. Given the on-going nature of improper restraints, an independent agency with expertise in the type of restraint practices the State permits NIA to use, should conduct this training.

    - NIA should obtain an improved video system that includes sound recordings to better determine whether events leading to restraint or seclusion meet legal requirements and to improve quality of care through staff training. This system should also allow NIA to retain video for longer than 7 days.

        - Of note, we understand that NIA facilities in Florida have the capacity to retain video for at least 30 days, and sometimes as long as 90 days.

    - NIA must discontinue staff practices of transporting youth by physical hold to the quiet room for the purpose of implementing a more formal restraint procedure.

- NIA must advise staff, in writing, that it is a serious rule violation for staff to carry, drag, shove, or throw youth and that such offenses will be subject to discipline up to and including termination.

- NIA's must improve its restraint documentation procedures to ensure they are complying with state law and that required doctor orders are actually obtained.

F. Problem Area 6: NIA Continuing Inability to Meet the Needs of Youth on the Blackhawk ASD Unit

- As noted, EFE previously conducted monitoring at NIA in November and December 2019 in response to reports of serious concerns related to NIA's restraint practices and failure to meet the needs of the youth in its care. At that time, EFE noted NIA's failure to meaningfully engage youth on the Blackhawk unit, which houses youth with ASD. EFE also noted that the overall chaotic nature of the unit was inappropriate setting for children with ASD. Despite expressing these concerns at the time, NIA has failed to make any noticeable improvements on the Blackhawk unit. Specifically:

    - On-site visits revealed that staff do not actively engage the youth. Instead, a majority of the 19 youth on this unit are oftentimes in their bedrooms, with a staff member sitting in a chair blocking the doorway to their bedrooms to prevent egress. Many of the youth who were in their rooms were laying on their beds doing nothing. The few youth who were not in their bedrooms kept to themselves on benches in the milieu.

    - When the youth are allowed out of their bedrooms, the unit is often loud and congested, and there do not appear to be any planned activities. Despite multiple visits to this unit, EFE observed one, 4-minute group activity, which mostly involved youth finding a seat in the large or small group forum, as opposed to an actual activity. We observed very little staff / youth interaction unless the youth began to act out.

    - Although there is a sensory room on the unit, it is very small and unorganized. Items were strewn about the floor, creating a chaotic atmosphere that was difficult to navigate. The materials in the room also were not true "sensory" items. Staff reported using the sensory room as a "calming room" for residents who needed to get away from others.

    - Staff showed little concern for privacy and human dignity issues. EFE observed a 1:1 staff monitoring a youth on the toilet from the hallway, with the door open. Most residents were barefoot, and their feet were dirty from the unit floor. Of those wearing socks, the socks were mismatched and dirty. Bedrooms were in disarray, with clothing and miscellaneous items on the floor. The bedrooms were not personalized, and multiple beds were without bedding or pillows. During snack time, youth did receive a drink or napkins.

- Although Blackhawk staff showed EFE body check documentation, it was not being kept routinely for each youth and it did not appear that these records were being reviewed unless there was an investigation. This is particularly concerning because most of the youth on Blackhawk have significant communication challenges. EFE believes that previous monitors at NIA had also noted this concern, but the issue continues.

- Since EFE's on-site activities, DCFS advised that NIA has since reduced the population on Blackhawk by rearranging the units. While EFE is in support of reducing the size of the Blackhawk unit, EFE is not aware of what steps NIA took to assess the propriety of moving these youth to other units and is concerned about whether NIA made these decisions in a manner that ensures the safety of these youth due to NIA's inability to meet 1:1 staffing levels.

- Regarding youth on or recently moved from the Blackhawk unit, EFE also observed the following: Of the 8 clinical therapists / case workers, 6 were assigned to youth on Blackhawk, as well as youth on other units. Unless all 6 of these clinical staff have a specialization in individuals with ASD, realigning caseloads to ensure that youth are matched with the most specialized staff may be appropriate.

- **Recommendations:**

  - NIA has shown itself uncapable of serving this vulnerable population after extensive direction and monitoring. As a result, EFE recommends that the Blackhawk unit be closed, and that the State find appropriate placements for these vulnerable youth (including those recently transferred to other units at NIA). As part of the State's exploration of appropriate placements, EFE encourages exploration of community placements with adequate home and community-based services where possible.

    - If NIA is to continue serving these youth, the State should further assess whether the recent unit movements from Blackhawk were appropriate and that the new groupings provide a safe environment for these vulnerable youth.

  - During such time that the unit remains open and/or is under a corrective action plan, NIA must have BCBAs and/or other professional staff <u>on the unit</u> (and must also support youth transferred to other units) from 8 a.m. to 8 p.m. each day, with a detailed plan for positive behavior supports, to protect children from further harm resulting from lack of engagement and to reduce the number of serious incidents on this unit.

G. Problem Area 7: Restrictions and Lack of Programming Throughout NIA

- Many of the charts for youth at NIA reflect that the child will engage in behaviors when they are bored. EFE's on-site visits revealed that NIA is continuing to fail to offer meaningful programming to engage youth. For instance, the posted calendar would reflect activities such "vocational outing," "arts and crafts," "creative expressions group", "sensory group," or "life skills group," but with few exceptions, EFE observed youth milling about the unit with little to no staff interaction other than redirection. On one unit, the calendar had no activities listed for Saturday and Sunday from approximately 9 a.m. until 2:30, failing to distinguish weekend days from school days. This is a long-standing problem at NIA and contributes to the numerous and serious behavioral incidents that occur daily.

    - The lack of activity is also true of remote school hours. In-person schooling occurs 1.5 hours each weekday, with the remaining 3 hours designated as remote school. Neither on-site visits nor video reviews showed staff working with youth on remote school activities or youth otherwise meaningfully engaged in remote schooling activities.

    - Youth reported lack of availability of outdoor activities (possibly related to cold weather conditions).

- EFE's interviews and record review also revealed that youth must "earn" access to their personal property, resulting in unnecessary conflicts in order to "enforce" the rules. Relatedly, a staff member shared concerns about a situation where staff would not provide a youth with a piece of paper, because "it was not time yet," resulting in a behavioral incident. The staff member shared that these types of power struggles occur frequently, all in the name of enforcing the rules. A notice on the wall also indicated that if youth do not follow the rules they can lose their allowance, and that those funds can be allocated to purchase items for other youth on the unit.

- Lead staff advised that youth are allowed only one day per week phone time of maximum 15 minutes. The remaining days they can have up to 5 minutes. Maintaining relationships with family and friends when visitation is limited due to COVID-19, in particular, is vital to a child's success.

- When youth are placed on safety precautions, they experience far-ranging loss of privileges. These restrictions are not individualized to address the individual's actual safety needs. On some units, the names of youth on precautions are listed in public areas, creating privacy concerns.

- Sequel Policy & Procedure for Children's Rights 2019, 06/19 provides regarding "Body Search" that such searches are not allowed unless licensing provides permission. An Incident Report reflects that staff conducted a body search on a youth on January 28, 2021 and there was no indication DCFS licensing was contacted or gave approval.

- **Recommendations:**

- NIA must increase both direct care and professional level staff to dramatically enhance programming, expand school hours (including on the unit if COVID-19 precautions are in place), remove punitive practices, expand phone times, and incorporate the items and activities that have been documented to assist youth to calm and/or engage in unit activities. When weather permits, the activity schedule must include daily outside time at least twice per day.

- When precautions are necessary, the youth's therapist must develop an individualized plan reflecting the precautions necessary to keep the youth safe. A youth's precaution level and plan must be maintained in a private manner. In addition, staff implementation of precautions must be well-documented, and they must be discontinued in a timely manner.

H. Problem Area 8: Overall Physical and Other Conditions at the Facility Impact Quality Care

- Apart from the Therapeutic Day School, many areas of the facility are dirty and uninviting. We observed multiple concerning conditions, including broken water fountains, lack of shower curtains, hanging wires, lack of pillows, and lack of on-unit first aid kits. In addition, the units did not have posted evacuation plans. Many of the bedrooms are messy and not individualized.

- The windows on the units are covered in paper that was often observed to be scratched and dirty. While these window coverings may be necessary for privacy, such coverings could be cheerful and more appropriate for the youth NIA serves, and allow for at least some sunlight.

- The phones available to youth are currently in the middle of the unit, where there is no privacy. In addition to hampering youth from having meaningful conversations with friends and family, the lack of privacy inhibits their ability to report abuse and neglect to family, friends, and others.

- The units did not have a posted grievance procedure or apparent grievance box for staff or residents. Only one unit had a grievance form on the bulletin board, but this was not posted in other units. Staff and at least one youth indicated that there had been a grievance box, but it was removed a few months ago. Cubs had a DCFS suggestion box, but staff did not know is purpose. EFE did not observe a posting with DCFS' contact information for reporting abuse/neglect on some units.

- Staff are not consistently complying with NIA's COVID-19 policy. EFE on-site visits revealed that staff often wear their masks below their nose, and video reviews revealed staff not wearing masks at all. In addition, EFE staff observed temperature check failures for staff starting their shift during a February 2021 visit.

- Despite having a history of sexual assaults at this facility, NIA places male and female youth on the same units. While this may be appropriate at times, EFE is unclear whether NIA is making these decisions with the required level of care.

- NIA has a detailed procedure for internal investigations and there were incidents occurring within the review that would have resulted in such investigations. NIA was not able to produce any evidence of internal investigations despite multiple requests. This raises serious concerns about their quality assurance mechanisms, particularly where NIA's policy requires an investigation for anything that compromises safety.

- **Recommendations:**

    - NIA must establish a plan and completion date to address the above concerns, to be reviewed and approved by DCFS.

I. Problem Area 9: Inaccurate Discharge Notices

- EFE reviewed 14 discharge notices spanning the period of October 3, 2020 through January 13, 2021, and received 3d party information regarding a few of them. At least 3 of the 14 notices included an inaccurate basis for discharge, i.e. that the youth was transitioning due to successful completion of NIA's program. Further, these notices appeared to be knowingly false given the content of the notice as compared to the 3d party information. For instance:

    - In two discharge notices for separate youth, both indicated that the youth were discharged after successfully completing NIA's PRTF program and needed a less restrictive program. Setting aside that NIA was not licensed as a PRTF at the time of the discharges, the circumstances of these discharges were that the State offered these families FSP funding for a PRTF in Arkansas as part of its plan to transition youth on FSP funding away from NIA after NIA lost its license as a PRTF. The involved families instead to chose to take their youth home, but NIA's discharge plans were significantly lacking and only recommended a psychiatric consult and therapy. The discharge plan for one youth with autism spectrum disorder did not include any resources to assist the youth and neither raised the possibility of home and community-based services.

    - Another youth's discharge report also incorrectly stated she successfully completed NIA's (unlicensed) PRTF program and was in need of a less restrictive setting in Arkansas. Instead, the basis for the transfer was the State's decision to work with families to transition youth on FSP funding from NIA to other placements, and the State's FSP program paid for this youth to be moved to a more restrictive setting, an actual PRTF out-of-state.

- **Recommendations:**

    - The applicable State agencies must review all discharge plans for the next 12 months to ensure they are accurate and include an actual plan with the resources the youth needs following discharge.

J. Problem Area 10: Training Practices:

- As part of EFE's review, we obtained NIA's training log and other training materials. The below reflects multiple areas of concern regarding staff training.

    - Direct care residential staff (including shift supervisors and supervisors on duty):
        - Many staff were not listed as being trained on Compliance and HIPPA.
        - An even larger number of staff were not listed as being trained in the areas of: Incident Reporting Policy, Cultural Competence, Prudent Parent, Debriefing, Developmental Milestones, Resident Rights and Grievance Procedure, Relationships and Boundaries, Suicide Prevention & Response,
        - Almost no staff were listed as being trained in the areas of NIA Program and Standards and Resident Monitoring / Precautions / 1:1 & Documentation, Mandated Reporter, Motivational Interviewing, Sexual Harassment, Infection Control & Bloodborne Pathogens, Defensive Driving, or Safety and Emergency Management.
        - One staff was listed as having training in Self-Care.
        - None of these staff were listed as having training in the areas of Debriefing, Safety Plans, or the ISBE Training on Privacy / Dignity / Time Out. Although these were not educational staff, there was no other training relating to seclusion / close observation listed.

    - Education staff training was limited to the areas of TCI, Ukeru, First Aid & CPR, Compliance, HIPPA, Incident Reporting Policy, and Suicide Prevention & Response. No education staff were listed as being trained in the ISBE Training on Privacy / Dignity / Time Out.

    - Nursing staff training was limited to the areas of TCI, Ukeru (a more limited number of staff), First Aid & CPR, HIPPA, and Suicide Prevention & Response. Only two nursing staff were listed as being trained in Compliance, and only one nurse was listed as being trained on the Incident Reporting Policy.

    - Like other staff, the two Compliance staff were not recorded as being trained in most of the listed training modules. One did not have training in TCI, Cultural Competence, Prudent Parent, DCFS Licensing Standards, or Suicide Prevention & Response. The other was not trained in Debriefing. Neither were noted as being trained in Mandated Reporter. Administration staff also were not listed as being trained in a large majority of the training modules, and only 1 of 4 was listed as being trained in Debriefing and Mandated Reporter, and 2 of 4 listed as trained in DCFS Licensing Standards. No Compliance or Administration staff were listed as

being trained on NIA Programs and Standards, Resident Monitoring / Precautions / 1:1 & Documentation, Resident Rights and Grievance Procedure, ISBE Training Privacy & Dignity / Time Out, or Safety Plans.

- Clinical staff training appeared limited to TCI, Ukeru, First Aid & CPR, Compliance, HIPPA, Cultural Competence, Prudent Parent, DCFS Licensing Standards, and Suicide Prevention & Response. A few of the clinical staff (4 of 11) were not listed as trained on the Incident Reporting Policy. No clinical staff were listed as being trained on NIA Programs and Standards, Resident Monitoring / Precautions / 1:1 & Documentation, Debriefing, Resident Rights and Grievance Procedure, ISBE Training Privacy & Dignity / Time Out, Mandated Reporter, or Safety Plans.

- NIA provided EFE with the "Sanctuary Staff Training Manual: Edition Two" but it is not listed as one of the staff trainings in NIA's Training Log. This training is referenced in NIA's restraint reduction initiative and focuses on creating a healing environment for youth that have endured trauma in the past. If done correctly, this would be a good training for all staff who interact with youth.

- Also as part of the review EFE reviewed the New Hire Orientation training materials, which represent approximately 680 pages of materials.

  - An over-arching concern was that as presented it appears that new employees are not individually trained on many of the child care related topics in this lengthy document, and sign acknowledgement forms indicating that they have reviewed the materials. Employees take tests on some, but not all childcare related topics. A review of 8 personnel record revealed that in some cases trainers did not sign training sheets, including those verifying that training materials were reviewed and documentation that shadowing activities occurred and were successful. In a couple files, some tests were ungraded, and one staff did not complete a lot of the new hire testing documents.

  - In addition, the materials are at times out-dated, incomplete, and redundant. For instance, at various junctures the materials suggest that the facility is a PRTF, and the packet includes old versions of some policies, most significantly the old policy regarding Use of Physical Restraints. Although Emergency Safety Procedures are referenced, there is no indication that staff are exposed to evacuation routes (and the postings of such routes are often missing on the units). There are multiple sections where information is obviously incomplete (i.e., stating that materials will be added, but they are not, or a title with no information following the title). Information about the important subject of behavior training falls under a section regarding occupational therapy.

  - In one section of the materials that discusses the different units at NIA, new hires are told "residents are all food driven," creating inappropriate and unhelpful generalizations. New hires are also requested to "familiarize" themselves with a

list of possible diagnoses, when they instead should be receiving training by a qualified mental health professional and/or BCBA on this subject.

- Of further note, the materials note circumstances where employees might use their own vehicles for transport, but do not address requirements surrounding insurance coverage, and the human resources materials do not define employee entitlements to meal and rest breaks. This later omission is conspicuous given reports and observations which indicate that staff do not receive legally required breaks.

- **Recommendations:**

  - NIA requires an independent and complete review of their training procedures, resulting in a detailed training plan that must be followed, to ensure that staff are adequately trained to provide safe and therapeutic care to the youth at NIA.

K. Policy Review / Recommendations

- EFE conducted a thorough review of NIA's policies, resulting in the following comments and recommendations on omissions that NIA must address:

  - Unusual Incident Reporting, 9/20: This policy does not provide sufficient detail for staff to understand or comply with state regulatory requirements and is otherwise lacking in detail. It lists some circumstances where written or oral notification to outside entities is required, but does not indicate who is responsible to make such notifications and by when, or how it is documented. In other areas, it does not list situations where reporting should occur, such as controlled observation, physical holds, and time-outs. The policy does list seclusion, but this terminology creates confusion because NIA no longer has a policy that provides for seclusion, and instead has policies on close observation, the calm room and time-outs that govern such practices. The policy does not include information about when reports must be made to DCFS, although NIA has reporting obligations to DCFS under 89 Ill. Admin. Code 331.10, 331.30, and 384.90, and our review indicated that NIA is <u>not</u> reporting all required incidents to DCFS licensing or otherwise. Similarly, we understand that there are reporting obligations for IDHS, but the policy does not reference them. In addition, the policy does not address required reports to ISBE or the local school districts under 23 Ill. Admin. Code 401.10(a)(5), referencing 23 Ill. Admin. Code 1.285. Although the policy references what should reviewed for unusual incidents that require further investigation, it does not define what type of incidents should be subject to further investigation.

  - Notification Policy, 10/20: This policy requires the supervisor on duty to notify the manager on duty of certain incidents, who is then to notify the Executive Director and Group Living Director. Unusual incident reporting documents do not have a space for staff to document that the notification occurred. The Unusual

Incident Reporting and Notification policies should be combined to create a uniform step-by-step procedure for notification and reporting requirements.

- TJC Incident Report Policy, 06/19: Should include requirement that staff document a youth's weight and height on incident report. Where a UIR is completed, it should include the narrative(s) from any related IRs, and reference any related materials and assessments completed in relation to the incident.

- Investigation Process Policy, 11/19:

    - This policy provides for and defines in-depth investigation procedures for allegations that involve compromised safety, with all investigation materials maintained in an investigation file. Despite multiple requests, and EFE's knowledge that there have been multiple incidents where a child's safety was compromised during the review period, NIA was unable to produce any investigation files as part of EFE's comprehensive review.

    - In addition, it appears that by policy such investigations are to be kept separately from the individual's file, and destroyed within 3 years after the child reaches majority. 89 Ill. Admin. Code 404.48 requires that child records be maintained 5 years after the age of majority.

    - The policy also addresses events reportable to the hotline, without expressly referencing DCFS, noting that the compliance director will make the hotline report within 24 hours despite the legal requirement that such calls be made immediately. In addition, the policy does not require the compliance director to give a written report to the involved mandated reporters, who have an independent obligation to report to DCFS absent receiving such notification.

    - The policy further provides that where there is a hotline report staff will remain on administrative leave until NIA knows the results of the report, but EFE does not believe this is being strictly followed based upon two incidents occurring during the review period where staff continued to work with youth following hotline reports.

    - In addition to addressing the above issues, the policy should be revised so that it no longer limits 3d-party review of incidents on camera to (1) law enforcement conducting a criminal investigation or (2) those with a court order.

- Patient Safety Event and Sentinel Event Management, 1/20: Although the policy appears appropriate as written, it is not being followed in terms of: required notifications to family / support for family and notification to others, an immediate investigation, a comprehensive systematic analysis for identifying the causal and contributory factors, strong corrective actions derived from the

identified causal and contributing factors that eliminate or control system hazards or vulnerabilities and result in sustainable improvement over time, a time line for implementation of corrective actions, and systemic improvement.

- Grievance Policy, 1/17: The grievance policy is detailed but EFE's review revealed that it is effectively not in use. The units did not have the required "conspicuous" grievance box, grievance forms were not openly available, and interviewed staff knew nothing about it. Further demonstrating that the youth grievance procedure is largely defunct is that NIA was able to produce 1 grievance for the entire review period. The policy also states that grievances must be maintained 10 years or 2 years beyond the child's majority, which conflicts with 89 Ill. Admin. Code 404.48.

- Camera Policy, 10/20: While this policy states that authorized employees are required to review the video routinely, and that the Executive Director will dictate the frequency and purpose, and designate staff, EFE did not see any NIA polices governing these routine reviews. Such reviews are an important part of quality control. This policy further provides that video can be maintained for more than 30 days where required as part of investigations, including safety and security investigations. This demonstrates that NIA can maintain certain videos for longer periods where required.

- Precaution Policy, 9/19: Although this policy provides for documentation of precautions in response to listed safety concerns via a "NIA Precautions Alert" form, the youths' files do not include such forms. In addition, the file reviews do not indicate that clinical staff are reviewing a youth's precaution status daily. Of final note, the policy has a list of precautions that apply once a child is on precautions, regardless of the nature of the safety concern, and resulting in overly restricting a child's basic rights. The policy does not fully define staff monitoring obligations for such youth, only noting that if they are using electronics they must be in view of staff, and that they must also be within staff view on overnight shifts. This policy also applies to people on clinically assigned 1:1 staffing, noting that staff must always be within arms' length for such youth and that they must be in eye view during overnight shifts. EFE's review revealed that NIA routinely fails to maintain clinically ordered 1:1 staffing levels.

- Increased Supervision General Policy, 11/20: The policy provides for timely assessments of escalating behaviors and a tracking form for youth placed on increased supervision. We did not receive information to indicate whether clinical staff are conducting assessments within the required 60 minutes. Treatment files are often missing the completed close observation forms, on which staff are supposed to record 15-minute checks.

- Use of Controlled Observation, 12/20: This is NIA's policy regarding seclusion, and defines controlled observation as a youth "alone in a room physically prevented from leaving…" The conditions for use of controlled observations do

not comply with state law and allows staff to use "room restriction" to require a child to stay in their room for up to 4 hours when licensing regulations only allow for time-outs up to 10 minutes (and only so long as the child has egress if they wish to leave their room). It also provides for doctor's orders, but is unspecific about who can implement a close observation order before receiving a doctor's approval, and EFE's review of youth files did not reveal doctors entering written order for close observation. The policy includes various unspecific reporting requirements, and EFE's review did not reveal that NIA was following the requirement that it aggregate controlled observation data monthly until February 2021. The policy's provisions on assessing youth during seclusion also do not comply with state law. There are other areas of concern as well, and this policy needs to be completely re-written to comply with the laws and staff need to be fully trained on the new policy.

- Time-Out Policy, 6/19; and Calm Room Policy, 6/19: Both contain very similar language. NIA is not following the policy's requirement that youth are never physically prevented from exiting a calm or time out room. The policy also requires that a form be completed about the use of these procedures, and that parents / guardian be informed, but it does not appear these requirements are routinely followed. The policy also provides for annual staff training on the use of these rooms, but NIA's training log did not track such trainings.

- Use of Physical Holds with Children and Youth, 10/20:

    - Although this policy provides that "restraint" does not apply to youth under 18, it defines a physical hold as a "physical intervention in which a person's freedom of movement or normal access to their body is restricted by means of staff physically holding them for safety reasons." Of note, this definition is nearly identical to the definition of restraint in the policy applicable to individuals 18 or older, and both definitions are similar to the definition of manual restraint found at 89 Ill. Admin. Code 384.20 and 23 Ill. Admin. Code 1.285. This causes great confusion in reporting, tracking and aggregating these restrictive procedures.

    - Although this policy prohibits prone physical holds, it does not contain NIA's December 15, 2021 prohibition of supine physical holds.

    - The definitions and conditions for when a physical hold can occur are consistent with regulations, but NIA's records and videos did not reveal consistent compliance with these requirements.

    - The policy's requirements on implementing physical holds without an order do not meet state regulations. NIA's policy provides that a psychiatrist must sign orders for a physical hold, but EFE did not see signed orders in its record review and only nurse notations of verbal approvals. The policy also contains various notification requirements that

are not being followed in practice. Although debriefing is required within 24 hours, it is not consistently occurring. Also, although the policy requires that separate documentation be completed for each physical hold, in practice this also inconsistent.

- The policy calls for compliance staff and the Executive Director to conduct a quality / compliance review within 1 business day, but EFE did not receive documentation to suggest this is occurring. The policy also provides for certain data to be aggregated on a monthly basis, but only 4 of the 16 items listed are being analyzed (location, shift, length of episode, and type of physical hold).

- Record review also revealed that treatment files generally did not include much of the required documentation for physical holds, and we did not see records indicating that staff are conducting the 15-minute checks or otherwise gathering the required information regarding the hold.

- Use of Physical Restraints, 10/20: This policy is nearly identical to the policy on physical holds, and is supposed to apply to individuals who are 18 or older and receiving treatment in a PRTF. As a result, the policy should be modified to address the reference to PRTF. It notes reporting is required, but is not sufficiently specific about what entities must receive restraint reports. This policy has many of the same flaws as the policy on physical holds, including in the areas of documentation, quality / compliance reviews, systemic reviews, and provisions that do not meeting regulatory requirements regarding approvals and assessments. On a positive note, the policy explicitly notes that NIA does not allow chemical restraints, prone restraints, and the use of physical restraints for more than 1 hour.

- Emergency Medication Protocol, 6/19: NIA maintains a policy for the administration of emergency medication, but such procedures are not allowed at this facility under 89 Ill. Admin. Code 384.20 and 23 Ill. Admin. Code 1.285.

- Agency Behavior Plan: NIA's existing plan, required by DCFS rules, does not comply with 89 Ill. Admin. Code 384.30 in multiple ways (for instance, it does not reference NIA's use of close observation or time-out as approved techniques, and fails to address required items in treatment plans), and is otherwise lacking in details (for instance, it does not define when it is appropriate to use Ukeru or TCI, or reference its quality assurance procedures to review restrictive procedures and any contraindications in the child's medical record). DCFS should review this plan in comparison to the applicable regulation and require that the Agency Behavior Plan meet legal requirements.

- CTS 01.03.01 Initial Treatment Plan, 11/19: Should include the title of the staff trained to develop treatment plans to assist in transparency of who is trained to develop initial treatment plans.

- Elopement/Truancy Procedures Policy, 11/20: The policy allows for an "escort" within the building but does not define what that includes. Note, NIA is not following the policy's requirement that safety plans be reviewed and revised following an elopement, and that such plans "should thoroughly document de-escalation procedures and be highly individualized."

- Sequel Policy & Procedure for Children's Rights 2019, 06/19: There is nothing in this policy regarding abuse and neglect, and it instead focuses on sexual abuse and harassment. This policy also provides that files will be destroyed seven years following discharge, however, 89 Ill. Admin. Code 404.48 requires that child records be maintained 5 years after the age of majority.

- NIA documentation Timeliness Requirements, 06/19: Should include requirements for documentation that must occur daily.

- CTS 02.01.02 Suicide Risk Assessment, 11/19: Should include title(s) of staff qualified to perform assessments and should define when an assessment should occur (there are no definitions of suicidal ideation and behaviors). There are two headings with nothing underneath: "Facility-specific Addendum to policy" and "Definitions."

- Emergency Intervention Policy, 07/20: This policy should be updated to note NIA's stated policy that supine restraints are no longer be allowed as of December 15, 2020. In addition, the policy should address contraindications to "emergency interventions."

- Emergency Phone Call Policy, 10/20: With regard to SASS resources, NIA is not following this policy. The policy states: "In the event SASS is unable to conduct an assessment and NIA staff feel they can no longer safely care for the resident; the nursing department will be responsible for a call to 911 for assistance and document the rationale in the resident's medical chart." Information received in the comprehensive review revealed that NIA does not call upon SASS to evaluate youth on-site, and instead resorts to assessment at the hospital, despite requests from SASS that their evaluations occur at NIA where possible.

- Based on EFE's review of NIA policies as well as its list of policies, it does not appear that the facility has a written policy covering recreation activities and schedules as required under 89 Ill. Admin. Code 404.36. In addition, we did not see a policy regarding managing each child's funds pursuant to 89 Ill. Admin. Code 404.33, though it is possible that NIA has a "procedure" for this that is not part of its policy manual.