East Central Regional Human Rights Authority
Cornerstone Services
Report of Findings
Case # 19-060-9009

The East Central Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission voted to pursue an investigation of Cornerstone Services after receiving the following complaints of possible rights violations:

Complaints:

1. Provider failed to keep the consumer free from abuse by not taking any action to prevent another peer in the residence from physically assaulting the consumer.

2. Provider is not following the consumer's treatment plan as agreed upon.

Complaint Summary: The Community Integrated Living Arrangement (CILA) home where the consumer is currently residing is not keeping the consumer free from harm because another resident in the home has physically abused the consumer on at least 3 occasions. The provider is not following the consumer's service plan because she is not allowed to work.

If the allegations are substantiated, they would violate protections under the Mental Health and Disabilities Code (405 Ill. Comp. Stat. Ann. 5/2-102, 405 Ill. Comp. Stat. Ann. 5/2-112, and 405 Ill. Comp. Stat. Ann. 5/3-211), CILA regulations (59 Ill. Admin. Code 115) and Office of Inspector General regulations (59 Ill. Admin. Code 50).

Investigation

The HRA proceeded with the investigation after having received proper consent. To pursue the matter, the HRA visited the facility and the program representatives were interviewed. Relevant practices, policies and sections of the consumer's record were reviewed.

Interviews:

On August 14, 2019 at 2:00pm, the HRA met with the Cornerstone Coordinator of Residential Services. The meeting occurred at 1475 Harvard in Kankakee. The meeting began with introductions, a review of HRA procedures, and a review of the allegations being addressed in this investigation.

The staff provided some general information about Cornerstone. This provider offers many disability services in the community, including 4 CILA homes and a day program. They serve approximately 500 people, 14 of these people reside in the CILA homes. There are 20 CILA staff members. Each staff member is Direct Service Professional Certified and receives Abuse and Neglect Training and Human Rights Training at their employment orientation and every year after that. Additional optional trainings are offered monthly on topics like new mandates and other information as staff sees that there is a need. Cornerstone has a grievance process that is

provided to all consumers (and guardians) at admission. The provider also has an internal Human Rights Committee that meets weekly. There have been no grievances or committee reviews discussing the matters in these allegations.

Staff report that if anything "unusual" occurs in the home (ie harming others, self-harm, emergency services contacted, etc.) an incident report is completed instead of a case note. Guardians are notified of any unusual incidents unless the guardian has specified not to be notified for specific things.

Cornerstone utilizes the "Safety Care" model of behavior intervention. The Safety Care program is designed to prevent, minimize, and manage behavior challenges with dignity and safety. Staff reported that in most cases this means that each consumer has an extensive behavior plan designed to change behavior problems and limit the use of restrictions, like restraint use, unless necessary. Consumers are made aware of this behavior intervention model at admission and consumer-specific interventions are reviewed at the discovery meeting and during reviews.

Staff reported that the consumer has been residing in the CILA home for a couple of years. The consumer requires structure and routine and does very well in the home when things are predictable. The consumer has been involved in altercations since arriving at the CILA home, however, in all the incidents the consumer is the aggressor. The most serious altercation occurred on 2/4/19 when the consumer assaulted her housemate and they were separated but emergency services had to be contacted when the consumer attacked the housemate again. Staff reported that the staff in the home at the time of the altercation tried to redirect the consumer and stability holds were used but the consumer was not restrained. Staff stated that the incident quickly deescalated when emergency services were contacted. The guardian was notified of the incident and requested that the consumer be taken to the emergency department for a cut on her head. Staff believe that the consumer's glasses were pushed into the consumer's face during the struggle which broke the consumer's glasses and resulted in a cut. The consumer was treated and sent home and her glasses have been replaced. The guardian has stated that he/she does not want the consumer residing in the home anymore because the guardian wants the consumer to have more restrictions (less smoking, less accessibility to a telephone, and more use of restraints when the consumer is aggressive). In addition, the consumer's physician believes that the consumer would benefit from an increase in one of her medications to lessen the aggression, and the staff agreed but the guardian declined to consent.

Staff reported that the consumer has two service plan tasks. These tasks are to attend work at the day program and exercise. The consumer currently works at the day program and staff report that she enjoys work and likes having money and would like to work in the community. Staff have agreed to take the consumer on job site visits during this year, but the consumer currently requires supervision in the community making employment challenging.

Records Reviews:

Cornerstone provided the HRA with the following records:

The HRA was provided 27 incident reports from December 2018 until April 2019. In each of these incident reports the consumer was the aggressor. In some reports the consumer could be calmed down and redirected, but in others the police were called, and the consumer was sent to the emergency room. There is nothing in the incident reports or case documentation that confirms that the guardian was notified of the incidents (or why they were not).

Case notes from 12/1/18 to 3/15/19 were reviewed:

A 2/4/19 case note documents a fist fight between the consumers residing in the home. Documentation states that the consumer's glasses were broken, and the consumer was thrown to the ground and punched resulting in pain in the consumer's side and buttocks. The consumer contacted the guardian and the guardian contacted the staff and complained that the staff do not intervene in the physical altercations. The guardian also expressed concern that the consumer was not taken to the hospital for the pain, but the nurse assured the guardian that the consumer was given Tylenol.

2/5/19 medical documentation states that the consumer was seen at the doctor's office for "eye trauma". Diagnosis was "contusion of left orbit, contusion of coccyx, and abrasion without infection on face". The consumer was treated for the injury and discharged.

A 2/21/19 case note stated that the guardian called and spoke with Cornerstone Director of Quality Enhancements and Compliance. The guardian expressed concern that the consumer could get injured during physical altercations and that the guardian wants the staff to physically intervene and restrain the consumer during altercations. The director reiterated that staff only intervene in situations that are life threatening and that staff will not be restraining the consumer at this location.

A 2/25/19 psychiatric note states that the medication was scheduled for increase to assist in behaviors, however, the guardian refused to consent.

An implementation strategy for the consumer dated 2/8/19 has the following outcomes: Work (touring new employment and continuing to work hard where she is to gain/maintain employment in a workshop setting) and Exercise (participation in sports and other exercise that consumer enjoys). The consumer's behavior guidelines include things the consumer enjoys, possible triggers, proactive procedures for boundaries, expectations, and redirection. Targeted behaviors are broken down into physical aggression, elopement, requesting rules be changed, verbal aggression, going to multiple people with the same issue, false allegations, inappropriate touching, and psychiatric symptoms. Each of these targeted behaviors is followed by directions for staff on how to address the behaviors. The plan for physical aggression is to move the other consumers to another area, not talk to the consumer during the incident, and then if the consumer is unable to calm down, they will follow the "Safety Care" procedures. In addition, the plan discusses "Reactive procedures" that outline some of the signs that the consumer displays when becoming agitated and how to address those, for example staff are advised not to tell the consumer that the consumer is "wrong" when she is agitated as this is not the moment for "teaching". This plan has a signature page signed by the guardian on 2/28/19.

The Support Services Team (SST) Action plan states that the consumer was referred for physical and verbal aggression. The recommendations include Skills Acquisition using therapy to learn new skills for emotional regulation, Staff/Family training to increase the effectiveness and consistency of the support the consumer receives, Environmental Modifications to include clear and consistent boundaries and routines, and Team Communication to help the SST develop and revise interventions as needed.

The DHS Medicaid Home and Community-Based Services DD Waiver Rights of Individuals Form was signed by the guardian on 2/20/19. This form outlines that the consumer and guardian have the right to express a grievance and lists the agencies in Illinois that are available if they need assistance. In addition, the Client Grievance Procedure can be found in the Residential Client Handbook.

Policy Reviews:

Cornerstone provided the HRA with the following policies:

An Emergency Behavioral Intervention Policy states that the provider will use "the most positive and least restrictive interventions necessary to assist an individual in de-escalating." The policy also documents that "The use of seclusion and/or restraint by Cornerstone Services Staff is Prohibited" and "If physical intervention is required to keep the person and others safe, these procedures may only be implemented by staff that have completed training in the agency-approved crisis intervention procedures."

A Restrictive Procedures Policy states that restraint (direct restriction through mechanical means or personal force) is prohibited. The policy specifies that in the event of an emergency the staff should call 911.

Conclusions

1. **Provider failed to keep the consumer free from abuse by not taking any action to prevent another peer in the residence from physically assaulting the consumer.**

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-112) states "Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect." The Code (405 ILCS 5/3-211) also states "When an investigation of a report of suspected abuse of a recipient of services indicates, based upon credible evidence, that another recipient of services in a mental health or developmental disability facility is the perpetrator of the abuse, the condition of the recipient suspected of being the perpetrator shall be immediately evaluated to determine the most suitable therapy and placement, considering the safety of that recipient as well as the safety of other recipients of services and employees of the facility." The Illinois Administrative Code (59 Ill. Admin. Code, § 50.10) states the definition of neglect is "An employee's, agency's or facility's failure to provide adequate medical care, personal care or maintenance, and that, as a consequence, causes an individual pain, injury or emotional distress, results in either an individual's maladaptive behavior or the deterioration of an individual's physical condition or mental condition, or places an individual's health or safety at substantial

risk of possible injury, harm or death." Additionally, 50.20 states "If an employee witnesses, is told of, or suspects an incident of physical abuse, sexual abuse, mental abuse, financial exploitation, neglect or a death has occurred, the employee, community agency or facility shall report the allegation to the OIG hotline according to the community agency's or facility's procedures. The employee, community agency or facility shall report the allegation immediately, but no later than the time frames specified in subsections (a)(2) and (3)." The Illinois Administrative Code (59 Ill. Admin. Code, § 115.220) states "A CST member who is a QMRP or a QMHP shall be designated for each individual and shall: 1) Convene the CST as required by Section 115.230 to revise the services plan as part of the interdisciplinary process; 2) Assure that the services specified in the services plan are being provided; 3) Assure the participation of team members and necessary non-team member professionals; 4) Assure and document in the individual's record, at least quarterly, that the individual's residence meets environmental standards as specified in Subpart C of this Part; 5) Identify and address gaps in the service provision; 6) Monitor the individual's status in relation to the services plan; 7) Advocate for the individual's rights and services; 8) Facilitate individual linkage and transfer; 9) Provide for a written record of team meetings within 30 days after each team meeting; 10) Assure that information specified by the services plan is included in the individual's record; 11) Initiate and coordinate the interdisciplinary process as often as specified in the services plan or when required by problems or changes; 12) Assure availability of a written services plan to all team members; and 13) Work with the individual and parent(s) and/or guardian to convene special meetings of the CST when there are issues that need to be addressed as brought to the attention of the team by the individual, parent(s) and/or guardian." 115.230 states "m) At least monthly, the QMRP and QMHP shall review the services plan and shall document in the individual's record that: 1) Services are being implemented; 2) Services identified in the services plan continue to meet the individual's needs or require modification or change to better meet the individual's needs; and 3) Actions are recommended when needed."

Cornerstone staff confirmed that the consumer was not the victim of abuse, but rather the perpetrator. The consumer's service plan indicates that the consumer needs behavior interventions. A Support Services Team Action Plan was put into place. The behavior plan is specific and outlines the consumer's positive qualities, targeted behaviors, and multiple interventions, including Safety Care procedures. There is documentation that the guardian requested that more restrictive restraints be used during altercations (and at other times), however, staff stated that the use of restraints is against the agency policy. Cornerstone provided the HRA with the policies and handbooks (with signatures) that support that restraint is not used at their facilities and that the guardian was aware of these policies at admission.

Based on the findings above that the recipient was the perpetrator versus the victim of peer aggression the East Central Human Rights Authority finds the complaint **unsubstantiated.** However, the HRA is concerned about the extent to which evaluations and assistance were provided per 405 ILCS 5/3-211 when the resident's behaviors continued. The provider is responsible for ensuring that the residents are safe and that proper treatment planning is being conducted and documented (Ill. Admin. Code tit. 59, § 115.220 and 115.230). The HRA suggests that thorough evaluations, treatment team reviews, and additional resources be pursued when a resident is the perpetrator of abuse. Ongoing peer altercations without any action on the part of the provider is neglect (405 Ill. Admin. Code tit. 59, § 50.10) and requires reporting (50.20). The

HRA also strongly suggests that guardian notification be incorporated into incident reporting forms to ensure that the guardian is notified and that the contact with the guardian is properly documented. Finally, the HRA suggests reviewing the practice of involving law enforcement and engaging the criminal justice system, unless needed, and if the behaviors are related to one's disability can be addressed in an alternate manner.

2. **Provider is not following the consumer's treatment plan as agreed upon.**

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) states "A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient. The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the treatment plan."

The consumer has a service plan task for work and currently attends the day program. The treatment plan also states that the consumer wishes to work in the community and Cornerstone has agreed to take her on a tour of a local workplace. Unfortunately, working in the community is currently a challenge for the consumer because the consumer has increased supervision needs. Staff reported that they are willing and able to help the consumer transition into a community employment position, however, the consumer's current behavior makes that inappropriate at this time.

Based on the findings above the East Central Human Rights Authority concludes that the consumer's rights not were violated and, therefore, the complaint is **unsubstantiated.**

No recommendations are being made in relation to this complaint, however, the HRA notes that the consumer had goals to work in the community that were not being achieved. In the future, when a consumer's goals are not being achieved, other methods or plan alterations should be considered to make the goals measurable and attainable for the consumer.