Clyde Choate Developmental Center:
How an archaic system results in tragic consequences for people with disabilities

Advancing the human and civil rights of people with disabilities in Illinois.
Mission

Established in 1985, the mission of Equip for Equality is to advance the human and civil rights of people with disabilities in Illinois. Equip for Equality is a private not-for-profit legal advocacy organization designated by the governor to operate the federally mandated Protection and Advocacy System (P&A) to safeguard the rights of people with physical and mental disabilities, including developmental disabilities and mental illness.

Equip for Equality is the only comprehensive statewide advocacy organization for people with disabilities and their families. All individuals with a disability in Illinois (as defined by the ADA) are eligible for services, including children, senior citizens, and individuals in state-operated facilities, nursing homes, and community-based programs.

Services, Programs, and Projects

Abuse Investigation Unit works to prevent abuse, neglect, and deaths of children and adults with disabilities in community-based programs, nursing homes, and state institutions. The Unit works with public investigatory agencies to improve their performance and coordination with each other; conducts investigations of abuse and neglect cases; alerts service providers to dangerous conditions and practices. The Unit is funded by Congress as a national demonstration project.

Public Policy Advocacy achieves changes in state legislation, public policies and programs to safeguard individual rights and personal safety, enhance choice and self-determination, and promote independence, productivity, and community integration. The Program drafts and secures passage of state legislation and participates in state regulatory and policy-making processes. It also undertakes in-depth policy research and reform projects on complex issues that have a significant impact on the lives of people with disabilities.

Self-Advocacy Assistance offers free, one-on-one technical assistance to inform individuals about their rights, alternative options and strategies, and steps they may take to advocate on their own behalf or on behalf of a family member.

Legal Services provides free legal advice and representation in administrative proceedings and federal and state court. The Program also engages in systems and impact litigation.

Training Institute on Disability Rights provides education through seminars for people with disabilities and their families. Seminar topics include rights and responsibilities under the Americans with Disabilities Act, protections against employment discrimination, guardianship, advance directives and special education rights.
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Equip for Equality appreciates the Department of Human Services’ and its Secretary, Carol Adams’, prompt response to the serious problems at the Choate Developmental Center as revealed by this report. The Department’s lengthy response to the report, attached as Appendix A, details the Department’s actions to address the problems at Choate in an effort to reduce the likelihood of future tragedies.

Equip for Equality also appreciates the Department of Public Health’s prompt response to the problems identified at Choate. The Department’s written response is attached as Appendix B and identifies its actions to ensure that residents needs are met.

While Equip for Equality respectfully disagrees with the Departments as to the best course of action – investing additional resources to fix the problems or closing the institution – identifying and responding to the problems at Choate has been a collaborative process between Equip for Equality and the Departments. This process has further demonstrated the State’s and the Departments’ continuing commitment to support Equip for Equality’s Abuse Investigation Unit as a joint state and federal initiative and the commitment to independent oversight to enhance the safety and well being of people with disabilities in Illinois.
Introduction

Clyde L. Choate Developmental Center (Choate), originally constructed in the late 1800s as the Anna State Hospital, is Illinois' southernmost state-run institution. Choate is licensed by the Illinois Department of Public Health (IDPH) as a 200-bed intermediate care facility for individuals with developmental disabilities. Choate also has the state's only forensic unit for individuals with developmental disabilities. In addition, the Department of Human Services (DHS) Division of Mental Health maintains a state-run hospital for individuals with mental illness at Choate, which is a separate facility from the developmental center. The activities of the Abuse Investigation Unit and the information contained in this report do not relate to the mental health hospital at Choate.

From April through December of 2004, Equip for Equality's Abuse Investigation Unit (Investigation Unit) staff conducted 13 days of site visits to Choate Developmental Center in Anna, Illinois. While picturesque in its rural setting, the serious and longstanding problems at Choate as revealed by this report depict an institution that is in sharp contrast with its setting. After more than 200 hours of observations throughout the facility on different days and various times, and the examination of hundreds of pages of relevant material, including medical and treatment records, restraint records, and state agency investigative reports, the Investigation Unit documented a longstanding pattern of significant failures and mistreatment of residents.

The Investigation Unit's examination revealed areas of tremendous concern, including deaths of residents due to the failure to provide adequate healthcare, the failure to keep residents free from abuse and neglect, the excessive use of restraints in violation of state and federal law, the failure to address the needs of residents with pica behavior, the failure to protect residents from sexual assault, the failure to provide adequate supervision or programming, or effective communication for residents who are deaf or hard of hearing, the failure to document critical information, the failure to adequately investigate injuries of unknown origin and the failure to afford dignity to the residents. Discussions with residents revealed a culture of fear in which residents are afraid to exercise rights or express their needs for fear of retaliation or being "tied up."

The incidents and the records examined by the Investigation Unit, along with the documented observations as revealed by this report, clearly illustrate the systemic failure of this institution and the need for its closure.
Preventable Deaths and Other Serious Injuries Due to Inadequate Healthcare

Choate’s failure to provide adequate healthcare to its residents has resulted in serious harm, including preventable death. This failure, including the lack of staff supervision of residents and accountability of staff, remains evident at Choate. Consequently, residents continue to be at risk of serious harm.

Deaths:

In April 2003, IDPH cited Choate for its failure to monitor a resident’s physical and mental status during the decrease and subsequent discontinuation of psychotropic medication. This resident subsequently died. IDPH findings and Choate’s records reveal that:

■ The resident functioned at a profound level of mental retardation. He was blind and deaf. In November 2002, the resident’s interdisciplinary team held a “Special Program Review” to address his recent abnormal electrocardiogram, his medication reduction, and the potential effects of the medication reduction. The team noted that the medication reduction could cause extreme agitation, including property destruction and physical aggression. The team was concerned about what effect this could have on his heart condition. As a part of the medication reduction plan, the team determined that staff would be instructed to closely monitor this resident’s vital signs, sleep patterns, and behaviors.

■ Throughout the next several months, the resident displayed an increase in maladaptive behavior, including self-injurious behaviors and increased aggression toward his peers.

■ A review of the resident’s progress notes from November 25, 2002, through April 16, 2003, the date of his death, indicated that he displayed self-abusive behavior on more than 30 of those days. Nursing staff did not contact his physician regarding the increase in aggressive behavior. There was no evidence that vital signs had been consistently taken during this period. When interviewed by IDPH on March 28, 2004, the resident’s physician stated that she was not aware of his increased agitation and not aware that blood pressure and pulse were not being taken daily. Several unit staff stated that they did not know that vital signs were to be taken on a daily basis, as they were never instructed to do so.

■ On the day that the resident died, he displayed numerous signs of distress. He became aggressive toward himself and his peers and threw chairs. At 11:11 a.m., staff placed him in mechanical restraints. While in restraints, he began to yell, pick at his buttocks, and foam at the mouth. Staff gave him an injection of Thorazine at 1:00 p.m. After he was released from the restraints, he continued to show signs
of distress, screaming, grabbing at staff, and banging his head on the wall. At 3:55 p.m., staff gave the resident an injection of Ativan. Choate staff escorted him to the bathroom, where he became weak in the legs. He attempted to escape from the room, and then he sat on the floor. When he stood up again, his breathing became labored and he began stumbling. Staff put him to bed at 7:00 p.m. At 7:30, he got out of bed and began pacing and stumbling in the hallway. His legs gave way several times. Staff put him back to bed, where he remained restless, moaning, with “clammy” feeling skin. The resident then sat on the floor. Staff gave him 100 milligrams of Thorazine by mouth at 8:15 p.m. Fifteen minutes later the resident slumped forward and became unresponsive. He was pronounced dead at the local hospital at 9:05 p.m.

Medical staff referred to this incident as a “comedy of omissions.”

The Department of Human Services’ Office of Inspector General (OIG) did not substantiate the allegations of abuse or neglect as a result of the resident’s death. However, OIG did recommend that Choate develop a system of documentation that places a resident’s data in a central location so that it can be more easily communicated to the physician and treatment staff.

In May 2004, IDPH again cited Choate for its failure to protect a resident from harm, which resulted in that resident’s death. On April 22, 2004, the resident choked on a meatball approximately two inches in diameter. The resident was admitted to a local hospital, where she died on April 24.

The resident had a known history of pica (the ingestion of inedible objects) behavior. Because of a recent pica incident, she had been placed on one-to-one supervision, requiring a staff member to “maintain visual observation within one arm’s length” at all times. In addition, in July 2003, the resident had a swallowing evaluation. This evaluation revealed that staff should be alert to each bite size. None of the residential unit staff were instructed to monitor the size of bites of her food.

On the evening of April 22, 2004, while under one-to-one supervision, the resident choked on the meatball.

The unit nurse called a “Code Blue.” The staff’s attempts to dislodge the meatball were unsuccessful. When the paramedics arrived on the scene, they utilized a laryngoscope and were able to remove the meatball. However, by that time, the resident was already unresponsive and had no pulse.

When questioned by IDPH, the physician on that unit stated that his pager malfunctioned and he did not receive the Code Blue page. The physician was only 30 feet away in his office and stated that, had he been properly notified, he would have used the facility’s laryngoscope and if that was not successful, could have done a different emergency procedure to create another airway.

At the time of the resident’s death, the facility was aware that its Code Blue system did not function properly. The facility had conducted several Code Blue
preparation drills in the previous months, all of which indicated that the system was malfunctioning.

- Documentation reviewed by Investigation Unit staff revealed that, on September 29, 2003, a Code Blue preparedness drill was conducted at 11:11 a.m. Three of the pagers did not sound, and the appropriate medical and nursing staff did not respond. On October 24, 2003, at 6:14 a.m., another drill was conducted. Again, several pagers did not respond. In addition, a drill conducted on March 27, 2004, at 4:27 a.m. revealed again that the system was not functioning properly. Three pagers did not sound, it took the operator five minutes to call the code, and the doctor was uncertain of where to go and arrived late to the scene.

Even though the facility was aware of the malfunctions and had ample opportunity to remedy the issue, the system was not repaired in time to prevent the resident’s death.

Reports from the Illinois Department of Public Health’s recent monitoring activities document that, despite this recent tragedy, Choate residents continue to be at serious risk of choking.

- A July 20, 2004, report indicates that one resident is to have pureed food, as he is at risk for choking, yet no swallowing report could be found in his chart.
- On August 24, 2004, an IDPH monitor observed a resident stuffing food into her mouth very fast when staff were not watching her.
- On September 8, 2004, a resident whose bread is supposed to be cut into bite-sized pieces was observed by the IDPH monitor eating his biscuit on his own. He took large bites, his cheeks were puffed out with food, and he paced about the room with his mouth full. Staff did not redirect him. He also took food from another resident’s tray and from the floor without staff intervention.
- Another resident who is on a meal pacing program and is also to have his bread cut by staff put one half of a biscuit in his mouth and, while the biscuit was in his mouth, he drank one half of a cup of juice.
- An IDPH monitor noted that multiple other residents have orders for their bread to be cut or soaked in milk, which was not done.
- On September 24, 2004, the monitors again observed residents having lunch on one of the units. Choate staff did not redirect one resident who is on a meal pacing program to slow down his food consumption.
- The monitors observed another resident, with a service plan that instructs staff to provide verbal prompts to take small bites, chew and swallow, not to stuff food, and to maintain good posture, leaning over her dish and quickly taking large bites of food.
On September 27, 2004, an IDPH monitor observed a resident who is on a supervised meal pacing program eat 75 percent of her meal in less than five minutes.

In addition, despite the April 2004 tragedy of Choate’s malfunctioning emergency paging system, Choate has continued to jeopardize the safety of its residents by failing to properly conduct emergency evacuation procedure drills. IDPH, in its September 22, 2004, Annual Certification Survey, cited Choate for:

- Failing to evacuate residents during at least one drill each year on each shift.
- IDPH reviewed Choate’s fire/evacuation drill documents from September 1, 2003, through September 13, 2004, conferred with Choate personnel on the topic, and discovered that during all third-shift (10:45 p.m. to 7:00 a.m.) drills, the residents were not in fact evacuated, as the drills were “simulated.”
- On September 10, 2004, IDPH called an Immediate Jeopardy regarding Choate’s failure to train staff and residents in procedures to evacuate during the third-shift hours.

**Serious injuries:**

In June 2003, OIG substantiated an allegation of neglect against a nurse at Choate who gave the wrong medication to a resident.

- In January 2003, two residents resided on the same unit with the same last name. During evening medication administration, one resident was to receive only eye drops and topical cream. The nurse, however, gave him several pills. A staff person attempted to stop the nurse, explaining that this was the wrong resident, but the nurse claimed that she knew what she was doing. Had the nurse checked the photographs of the residents maintained in their charts, she would have seen that the two residents with the same last name looked nothing alike. One hour later, Choate unit staff reported that the resident who received the wrong medication became lethargic, disoriented, and “drunk looking.” His blood pressure and pulse became dangerously low, and Choate staff were concerned that he would go into shock. He was transported to the local hospital, where they found the other resident’s medications in his system. He remained in the hospital for two days. DHS personnel stated that if the resident had not received timely medical intervention, death may have resulted from this error.

The Investigation Unit reviewed the records of a male resident with severe mental retardation, Parkinson’s disease, chronic constipation, chronic fecal impaction, hearing impairment, and seizure disorder. The records revealed that he sustained injuries from a fall on June 20, 2003. He required sutures near his eye. Later that evening, a nurse noted that the resident’s nose was deviated toward the left. The nurse contacted the physician, who ordered an x-ray be taken three days later, on June 23, because he did not “feel” there was a fracture. The records indicate that the June 23 x-ray results...
were not received until July 3 – 10 days from when they were taken and 13 days from the date of the injury. A July 3 nursing note completed at 7 p.m. stated that the report revealed a probable fracture.

An April 2004 review of another resident’s records by the Investigation Unit revealed serious concerns about Choate’s improper medical attention with respect to the administration of Depakote.

- On March 17, 2004, documentation in the resident’s chart indicated that he engaged in uncharacteristic behavior by striking a staff member in the throat. As a result of this incident, he was placed in restraints.

- In April 2004, the resident’s chart reveals that he experienced excessive sleepiness and lethargy during all waking hours and an increase in difficulty with ambulation, which resulted in his needing assistance with moving about the unit, including the use of a wheelchair. A program review recommended increased monitoring. However no order for appropriate medical follow-up was written.

- On April 1, 2004, a VPA (Depakote) level was drawn, and the lab result reported a toxic level of 123, which presented a substantial risk to the resident’s health. Nursing personnel contacted the physician on April 2 and reported the elevated level. Nursing notes document that no new orders were written but that another physician would evaluate the situation. On April 17, a nursing note documented that the resident had bilateral edema (swelling) to his lower extremities. It also noted that he was unsteady on his feet. On April 19 and 20, Choate staff documented that he was experiencing edema and shortness of breath. On April 20, staff documented concerns regarding his unsteady gait.

- The resident was not assessed by a doctor until April 20, 2004. A physician’s note on that date indicated that no cause for the pain in the resident’s feet or legs was found but that he should be followed. To address the shortness of breath, the physician ordered an exercise program. No plan to address the reported unsteady gait, the increased Depakote level, or staff concerns regarding lethargy was noted.

- The Investigation Unit’s review of that resident’s records during the April 2004 site visit revealed that the toxic Depakote level reported on April 1 had not been addressed. The Investigation Unit met with the physician and brought this to his attention. Only after this meeting did the physician order additional laboratory testing. The laboratory test results obtained on May 3, a full month after reports of elevated Depakote levels, showed increased levels of 137, which resulted in a physician’s order for an immediate reduction in his Depakote dosage by nearly 30 percent. A subsequent review of this resident’s records in August revealed that the Depakote levels are now being checked on a monthly basis.

On June 23, 2004, IDPH again cited Choate for its failure to provide adequate healthcare to a resident who was transferred from Choate to another facility. The resident arrived at the new facility with bruises, broken bones, and a substantial fecal
impaction. Based upon IDPH’s June 2004 report, as well as the Investigation Unit’s review of the resident’s records obtained from the new facility, it is clear that Choate failed to provide adequate care to the resident.

- The resident, a male with severe mental retardation, was transferred from Choate to another facility on May 3, 2004. A Significant Incident Report completed by the new facility and dated May 4 indicated that, upon his admission to the facility, he was noted to have bruising of the left eye and swelling of the left hand and both knees. In addition, a chest x-ray showed healed fractures of right ribs and recent fractures of the seventh and eighth rib on the left side. There was a large amount of stool in his colon. He became unresponsive and was sent by ambulance to a local hospital.

- Choate records reveal that during the months of March and April 2004, the resident suffered from fecal impactions. The Bowel Movement Monitoring forms for March 2004 documented bowel movements only on March 8 and March 20. The monitoring form for April documented bowel movements only for April 4, 7, 14, 22, and 25. There was no evidence that any follow-up or closer monitoring was put in place, nor was there any evidence that a physician was notified about his condition. The resident’s physician told IDPH surveyors that the failure to initiate fiber in his diet was an “oversight” on his part. An x-ray completed upon his arrival at the new facility revealed a large amount of stool through the entire colon.

- Choate’s documentation reveals that the resident lost a significant amount of weight in the past year. In fact, on January 4, 2004, he was noted to have lost 19 pounds in one month. Nonetheless, no recommendations were made regarding this weight loss. On January 21, the resident’s treatment team discussed his weight and erroneously agreed that his weight remained “stable.”

- The resident’s nursing care plans instructed Choate staff to monitor his urine for signs of urinary tract infections, such as frequency of urination, blood in urine, foul odor to urine, or signs of distress exhibited. A nursing note dated March 22, 2004, states, “I observed drops of bloody urine seeping from his penis.” IDPH’s review of subsequent progress notes found no evidence that a physician was contacted, nor was there evidence of any ongoing monitoring.

- Additionally, the resident was noted to have a blister on his buttock in March of 2004 and a pressure sore on his heel in April of 2004. Choate’s director of nursing acknowledged to IDPH that Choate does not have a system in place to ensure that residents who are at risk of skin breakdown are adequately assessed.

- There is also documentation that his condition deteriorated immensely within the year prior to his transfer to the new facility. In July of 2003, the resident was noted to be ambulatory. By the spring of 2004, he required the use of a wheelchair and became dependent on staff for all activities of daily living.

- By the time the resident arrived at the new facility, he was unable to function independently, and he became unresponsive within a day after arriving.
IDPH, in its recent monitoring of Choate Developmental Center, noted another serious incident involving a Choate resident. According to Choate’s director of nursing, this resident had a declining level of health since August 10, 2004. On August 16, a progress note states that the resident has mild congestive heart failure, has borderline cardiomegaly, was lethargic, and was transported by wheelchair. A progress note on August 17 stated that the resident was hypothermic and had a decreased level of responsiveness. At the request of this resident’s family member, she was transferred to the hospital, was admitted to the intensive care unit, and was discovered to have a temperature of 90 degrees.

In its September 22, 2004, Annual Certification survey, and September 2004 monitoring reports, IDPH noted additional incidents of Choate’s failure to provide adequate care to its residents.

- In its September 22, 2004, survey, IDPH reported that a male Choate resident has a diagnosis that includes a seizure disorder. He has taken Dilantin for at least eight years, according to a past psychiatric evaluation. However, no evidence could be found in this resident’s chart that he has had a seizure since his admission to Choate in 1992. There was no indication that he had a neurological evaluation to determine whether or not Dilantin is justified, as Dilantin is reported to have a potential side effect of damaging an individual’s gums. This resident’s last dental examination occurred in 2002. On September 16, 2004, a dentist treated the resident after IDPH brought the issue to Choate’s attention. The dentist discovered that the resident’s gums were severely inflamed and that he needed treatment for four of his teeth.

- In the September 2004 survey, IDPH also noted that a Choate resident who functions at a profound level of mental retardation and is reported as being “chronically underweight” did not receive two trays of food as ordered by his February 2004 nursing assessment. This assessment stated that the resident should be offered seconds and be encouraged to eat. On September 7, 2004, the surveyor observed this resident at meal time. He finished his meat and potatoes, and held up his plate to indicate that he wanted more food. Choate staff told the resident that he could not have seconds as he was “on a diet.” He was eventually given more peas and carrots but no additional meat and potatoes. The staff person reported that she did not know how many calories this resident was permitted to have, as she had thrown his diet slip away. The resident held up his plate six more times in an attempt to express to staff that he wanted more food.

- On September 24, 2004, IDPH monitors saw that a Choate resident who has experienced significant weight loss was not eating her meal. The resident is on a one-to-one meal pacing program, is to receive a soft diet, Ensure with each meal, and an extra Ensure if she does not eat. At the noon meal, this resident threw her food and drink, receiving no food intake. No Ensure was provided, and staff’s
statement regarding the missed meal was that the resident had “eaten a good breakfast.”

The deaths of residents, along with the other instances of Choate’s failure to monitor medication, failure to monitor and assess medical conditions, failure to closely supervise residents at risk of harming themselves, failure to implement plans to ensure safety, failure to have a working response to emergencies, and failure to implement policies and procedures to prohibit neglect, suggest that residents at Choate continue to be at risk of serious injury, illness, and even death. Longstanding and deadly failures to ensure the safety and well-being of the residents illustrate the extent of the dangers to which the residents at Choate have been and continue to be subjected.

**Excessive Use of Restraints in Violation of State and Federal Law**

While the facility has undertaken an ongoing effort to reduce restraint usage, in reviewing numerous investigative reports, both substantiated and unsubstantiated, as well as conducting a review of 12 Choate residents’ records and more than 500 “Restriction of Rights” documents, it is apparent that the use of restraints at Choate has been extraordinarily excessive and used as punishment or for the convenience of staff, in violation of state and federal law. In fact, Choate had the highest number of physical restraints of any State Operated Developmental Center (SODC) in Illinois in 2003.

Almost one-quarter of Choate’s current population has Behavior Intervention Plans (BIPs) that authorize the use of physical restraints. As recently as May 2004, several of these BIPs authorized the use of restraints for physical as well verbal aggression. This raises significant concerns on a systemic level regarding the use of restrictive and aversive techniques in situations other than those instances in which an individual is an imminent danger to him/herself or others. Repeatedly residents have been restrained when the documentation demonstrates that the requisite standard has not been met.

- One resident’s BIP authorized the use of restraints for physical and verbal aggression. His BIP from May 2003 indicated that his aggression is due to wanting tangible items (soda and cigarettes) or to his being upset with the behavior of peers. The file suggested that two episodes of restraints were due to other residents’ behavior upsetting him. The file also indicated that “He gets tired of ‘waiting’ to smoke or obtain a soda and expresses frustration through aggression.” Further, the BIP indicated that if the resident does not cooperate with relaxation
breathing techniques and/or continues to threaten after one prompt to calm down, staff should initiate four- to five-point restraints. If he physically aggresses, including threatening gestures with fists and arms, staff should immediately separate him and do a holding restraint only until four- to five-point mechanical restraints can be applied.

- A nursing summary in another resident’s chart states that he has been in restraints 46 times “this year;” 20 for inappropriate sexual behavior, including for declaring “I horny;” 17 times for verbal and physical aggression; seven times for physical aggression only; and two times for self-injurious behavior (SIB).

At RAVE, a large local developmental training program utilized by Choate for approximately 60 residents, Investigation Unit staff were informed by RAVE personnel that only the individuals from Choate have restraints in their behavior programs. None of the other individuals sent by other providers utilize restraints to address maladaptive behaviors.

During the June 2004 site visit, many Choate residents indicated that staff repeatedly threaten to “tie them up.” On June 11, 2004, Investigation Unit staff observed a female resident in the day training room who was agitated and swearing at staff. As staff approached the resident, she turned and automatically walked into an open restraint room without staff instructing her to do so. While in this particular instance, she was not restrained, her reaction demonstrates that this woman assumed that she would be put in restraints, and it highlights the extent to which restraints have been a common practice at Choate.

**Failure to Address the Needs of Residents with Pica Behavior**

IDPH has repeatedly cited Choate for its failure to appropriately address the needs and safety of residents with pica behaviors. Rather than working with residents to address, reduce, and prevent this behavior, Choate has implemented highly restrictive interventions, such as confining residents to their rooms, isolated from their peers, with no stimuli. Residents have been deprived of the opportunity to dine with their peers or go to work or programs, and denied other basic rights.

Moreover, even when a plan has been developed to increase supervision and otherwise protect individuals with pica behavior, these plans are not adequately or consistently implemented.
IDPH has cited Choate four times since April 2003 for its failure to address the needs of residents with pica behavior.

- In March 2003, one male resident told a nurse that he had swallowed batteries at his workshop. He was taken to the hospital for x-rays, which showed that he had swallowed “3-4 batteries as well as a ring-shaped object.” He underwent surgery, wherein four double-A batteries and a ring were removed.

- The Department of Human Services Office of Inspector General recommended that Choate establish a verification system to ensure that Choate residents’ day programs receive proper documentation about these behaviors.

- In May 2003, the same resident required medical intervention after having ingested soda tabs.

- In light of the March 2003 incident and the May 2003 incident, the same resident was placed on one-to-one supervision. Nonetheless, in November 2003, while under this supervision, he informed Choate staff that he had swallowed two triple-A batteries. This again required surgical intervention.

- IDPH called an Immediate Jeopardy on November 25, 2003, for Choate’s failure to adequately monitor the individual.

- In December 2003, a female resident with documented pica behavior ingested seven ponytail holders.

- On January 7, 2004, an IDPH surveyor observed the female resident sitting on her bed with a Choate staff member sitting beside her. The room contained only an empty nightstand and a locked closet, purportedly to prohibit the resident from having any access to items that she might eat. The staff person informed the IDPH surveyor that the resident had been confined to her bedroom since “before Christmas.” She had to eat all meals in her bedroom and was allowed to leave her room only to go to the bathroom. She was not allowed any activities, and staff were allegedly instructed to make only minimal eye contact with her and not speak to her.

- This resident’s family members visited her on Christmas and brought her gifts. Staff took all gifts from her, in an effort to prevent her from eating them. The resident’s mother, who is also her legal guardian, stated that she should have “at least been able to keep the cards.”

- This restrictive intervention was not contained in her behavior plan, nor was it authorized by her legal guardian. Her guardian said that she has never signed such a behavior plan and that she never would as long as it contained room seclusion and such “inhumane treatment.”

- In its January 2004 survey, IDPH reported that the male resident noted above was also, without the consent of his legal guardian, being confined to his bedroom, depriving him of all activities or other stimuli, purportedly as a way to address his pica behaviors.
When Investigation Unit staff met with this resident on April 30, 2004, he stated that he has not been able to go out and that all he wants to do is to be able to go outside and chew his tobacco and to visit his best friend on another unit.

In April 2004, the Investigation Unit also reviewed the records of the male resident. Choate had implemented a plan to increase supervision, which included conducting frequent body searches of the resident. However, from the Investigation Unit’s review of the records it appears that, after implementation, the plan may not have been adhered to. There was no documentation in progress notes of April 24 at 2:55 p.m., April 24 at 8:00 p.m., and April 25 at 6:30 a.m. that staff conducted body searches.

An IDPH monitor report, dated August 19, 2004, described another incident in which a resident with pica behaviors was placed at risk by Choate staff’s failure to intervene in a timely manner.

A resident was left alone with a magazine with a Choate staff member in the room. Another staff member entered the room and explained that this resident has pica behavior and needs one-to-one supervision with magazines, and then left. The first staff member then left the resident unsupervised with the magazine. The resident rolled up a page of the magazine and began to eat it until another staff member entered the room and intervened.

**Failure to Protect Residents from Sexual Assault**

IDPH and OIG have determined that Choate has failed to ensure the safety and well-being of residents with sexual predatory behaviors and residents sharing rooms with those individuals.

In September 2002, IDPH cited Choate for its failure to develop policies and procedures regarding the placement of residents in bedrooms with residents who are known sexual predators. A resident was admitted to Choate on September 13, 2002, and only four days later, alleged that his roommate “forced him to have anal sex and he could not stop it…”

IDPH’s review of the resident roster at that time on that particular unit revealed that, out of 48 male residents, 15 were on behavior programs for sexually inappropriate behavior and four of those 15 had a documented history of sexual predatory behaviors. At that time, the Choate administration confirmed that there was no specific policy in place for residents sharing rooms with residents who have sexually predatory behaviors, raising a serious systemic concern about resident safety.

Subsequently, the facility developed a Roommate Risk Assessment. However, this form did not take a proactive approach to assess the risk of actually being
sexually assaulted. Nor did it address ways in which such incidents could be prevented. Instead, the form assesses residents’ ability to defend themselves if they are assaulted and their ability to communicate that they have been sexually assaulted after the fact.

IDPH’s survey dated July 1, 2003, and OIG’s investigative report dated January 22, 2004, addressed another incident of Choate’s failure to protect residents from sexual assault.

In late 2002, several of the cottage units at Choate were closed, apparently for economic reasons, and a resident who is a known sexual predator was moved to a different unit, where he was assigned a bedroom with two other roommates. Despite this resident’s tendency to commit sexually predatory acts and over the objection of the Interdisciplinary Team, Choate administrators used the Roommate Risk Assessment and contended that the assessment supported the move. Several months later, on March 11, 2003, the resident raped one roommate by covering his mouth and forcefully penetrating him. The second roommate said that he too was sexually assaulted.

OIG substantiated the allegation of neglect against the former facility director and assistant facility director. In its report, OIG recommended that Choate, “stop using the Roommate Risk Assessment” and pointed to concerns about the assessment’s lack of clinical validity.

Four of the 12 residents whose records were reviewed during the Investigation Unit’s April 2004 site visit have behavior programs for sexually inappropriate behavior, and two of those four have documented histories of sexual predatory behavior. Choate has created a new Roommate Risk Assessment form; however, it was not implemented until the spring of 2004, and it does not appear to gather significantly more information than the prior assessment.

Failure to Provide Active Treatment and Adequate Programming or Meet Basic Needs

Supervision and programming:

IDPH has cited Choate for its lack of supervision of Choate residents and failure to provide meaningful programming.

In September 2002, IDPH cited Choate for its lack of supervision and programming. Certain staff did not know any behavior programs. A particular resident with inappropriate sexual behaviors was, according to his behavior program, to be closely supervised so that staff could appropriately address and prevent certain
maladaptive behaviors. Staff admitted that behavior programs were not being implemented because of the inadequate staffing levels.

- IDPH surveyors observed residents on the units demonstrating inappropriate behaviors and witnessed no staff intervention. Residents were rocking in front of the television, wrapping legs around the curtains, and rocking on the sofas.

During the site visits, Investigation Unit staff observed many of these same problems. There did not appear to be any organized programming taking place. Most of the residents were simply sitting around or roaming the hallways of the units with no staff present. The materials available, including children’s toys, were not age-appropriate or designed for meaningful programming or active treatment. For example:

- On April 28, 2004, in the evening, while observing the activity on Cedar Hall Upper, Investigation Unit staff noted that a young female resident was seated in the corner of a common room masturbating. She then put both of her hands in her mouth. Two staff were present and did not intervene until they noticed Investigation Unit staff observing this behavior. They intervened by taking her hands from her mouth and then walking away.

- On April 28, 2004, a male resident was observed, unaccompanied, coming out of the women’s bathroom. He then ran to a water fountain and proceeded to lick the water spout of the fountain with his tongue. He then knelt on the floor and sniffed a soiled rug that was beneath the water fountain. No staff were present in the hallway to intervene or redirect the resident.

- On April 29, 2004, Investigation Unit staff toured the Cypress Upper unit. Investigation Unit staff observed a day room with 15 males and four staff. The room was extremely crowded, and no materials or supplies were available for individuals to engage in any sort of programming. Many of the individuals appeared restless, engaging in rocking movements or pacing. Only one staff member appeared to engage certain individuals.

- On July 20, 2004, Investigation Unit staff, accompanied by a DHS consultant, discovered a resident in the “alternate program room” at 1:45 p.m. The door to the room was locked from the outside. The resident was alone in the room looking at a telephone book with no staff present to observe or monitor his activities.

IDPH, in its recent monitoring activities, noted many of these same failures to provide appropriate supervision or meaningful programming.

- The resident noted above who was observed licking the water fountain was observed by the IDPH monitor on August 24, 2004, sitting at a table in the dining area repeatedly kissing and licking his feet. Staff did not redirect this behavior. He also licked a piece of equipment by the sink before leaving the room. Again, on September 27, the IDPH monitor observed the resident licking his shoes at the table in the arts and crafts room, with minimal staff redirection. Several minutes later, he licked the sink and the floor in the room, with no staff redirection. On
October 12, an IDPH monitor witnessed this resident licking his shoes. Several hours later, the monitor saw him licking seat cushions with no staff redirection. The IDPH monitor reviewed this resident's personal service plan, which indicated that the resident has a potential for infection related to licking surfaces in his environment. He has had repeated episodes of intestinal parasites and was treated for pinworms in June of 2003.

- The monitors observed residents displaying inappropriate sexual behaviors and the staff did not redirect them in a timely manner, and, in some cases, these behaviors went entirely unnoticed by staff. On August 19, 2004, a resident was masturbating and rectally penetrating himself for over 15 minutes before staff intervened.

- Another resident had her hands in her pants beneath her underwear while waiting for her breakfast. Her hands were not washed and staff did not redirect her.

- On August 23, 2004, an IDPH monitor observed a resident on one of the units put his hand inside his sweatpants and rub himself between the legs. Staff did not appear to notice this.

- In September 2004, an IDPH monitor observed a Choate staff member seated at a desk reading a paper. Residents were not involved in any activity. When the monitors entered the room, staff got up and attempted to engage residents in activities. The monitor also observed one of the residents on that same unit involved in self-injurious behavior with no staff redirection. That resident was noted to have areas of redness and a welt with teeth marks on the right forearm.

- IDPH, in its September 2004 survey, cited Choate for its failure to have available activities, games, or materials for residents to choose from in several of the group rooms. For an entire hour, IDPH surveyors witnessed a male resident in his program room who sat in his chair, then roamed around the room, and then returned to his chair. According to the resident’s annual Recreation/Leisure Assessment, the resident “needs assistance in identifying recreational preferences.” No choices of activity were offered to this resident.

- On September 8, 2004, an IDPH monitor noted that a female resident spent more than one hour eating her meal. This resident needed assistance staying on task. After 30 minutes, staff assisted the resident once in drinking her chocolate milk and later in drinking her juice. Another staff member asked the resident, “How are you doing?” This resident is nonverbal. She lost 14 pounds between July 31, 2004, and September 11, 2004. The monitor report states that the resident “is at risk.”

- On September 24, 2004, IDPH monitors observed a male resident with profound mental retardation and blindness sitting in a chair in one of the group rooms. Staff were not interacting with this resident until the monitors entered the room. A Choate staff member brought a wire ball to the resident and placed it on the chair next to the resident. The resident did not react to the ball. The resident’s service plan has guidelines that state that the resident is to first receive manual guidance with activities, and, if he does not respond, he is to receive verbal cues. The staff
member did not provide manual guidance or verbal cues. The resident was then left alone, and the monitors did not observe any other interaction with this resident or any other attempt to engage this resident in another activity.

- On that same day, the IDPH monitors observed a resident engaging in self-injurious behaviors by slapping his forehead and biting his hands. His forehead was reported to be “bright red” from the behavior. The resident has a behavior intervention plan that instructs staff to direct the resident to his room, provide verbal stimuli to stop, block the behavior, separate him from the room if the behavior continues, and if the behavior still continues, contact a nurse. Staff did not block the behavior to prevent the resident from hurting himself. He was taken to his room, where he was left alone, and the monitors could hear the slaps from the hallway outside his room. There was no intervention from Choate nursing staff. As a result of this failure to follow this resident’s behavior plan, the resident continued to harm himself.

- On September 24, 2004, the monitors observed several residents fondling themselves, with little staff redirection.

- On September 27, 2004, an IDPH monitor noticed that a resident was repeatedly getting up from the dinner table. Staff would instruct her to sit down, but she continued to get up. The monitors inquired about this resident and if this was a common behavior displayed. Staff responded by stating, “She’s got a problem.”

- The following day, the monitor observed a Choate resident sitting in a chair with his feet up, his eyes closed, and his head down. Staff stated that this resident “won’t do anything.”

**Communication access for deaf and hard-of-hearing residents:**

Several residents at Choate are deaf or hard of hearing and use sign language as their primary mode of communication.

- During the Investigation Unit’s April 2004 site visit, Choate staff were not observed using sign language to communicate with residents. Investigation Unit staff were informed that some Choate staff know “some” sign language. However, “some” sign language does not facilitate effective communication. Without effective communication, it is not possible to provide any type of meaningful programming or to address resident needs.

- A male resident has been identified with a hearing loss. On April 3, 2003, the resident’s treatment team requested a hearing evaluation to determine appropriate amplification. On April 10, a speech and language evaluation was conducted. The Personal Service Plan (PSP) also identifies his involvement in a Functional Communication Training Program. The PSP contains goals such as “will communicate in an understandable manner five times per day.” The goal does not take into account his hearing loss, its impact on speech intelligibility, or the fact that the resident is said to be more understandable in the morning before he is given his medications. Moreover, to remediate the impact of his hearing loss, staff
are encouraged to get the resident’s attention and talk to him in a louder voice. While talking in a “loud” voice does not generally remediate the impact of a hearing loss, for this resident, it is contraindicated in that his service plan identifies loud peers as one of the environmental conditions that result in maladaptive behavior.

■ That same resident was observed by Investigation Unit staff in August 2004, sitting in the dining area on his residential unit. He appeared agitated and held both of his hands tightly over his ears. Choate staff commented that he likes to sit in the area and socialize in this manner.

Recent reports from IDPH’s monitors indicated that Choate is also failing to provide services to other residents related to the provision of meaningful communication.

■ In August of 2004, an IDPH monitor noted that a resident had a hearing evaluation conducted in February of 2004. This evaluation included a recommendation that he be re-checked in six months. There was no documentation that this had been done.

■ That same resident had a speech and language assessment conducted in March of 2004, which recommended language therapy. There was no documentation that the resident had received any therapy.

■ A recommendation for a reading program was made for another Choate resident. There was no documentation that the resident is involved in such a program.

**Failure to Document Critical Information**

IDPH has cited Choate for its failure to properly document residents’ progress and obtain consent for rights restrictions. This failure renders it impossible to adequately assess the progress of residents’ goals and preferences, ensure that restrictive procedures are authorized, and verify that all Choate personnel are made aware of essential information about the health and safety of the residents.

The Investigation Unit staff in their review of residents’ records also noted that in five of the 12 residents’ records they studied in April 2004, the facility has continued to fail in this area.

In April 2003, IDPH cited Choate for failing to ensure that written informed consent is secured prior to the implementation of behavior plans that involve restrictions of rights.

■ In the Investigation Unit staff’s April 2004 review of one resident’s records, Investigation Unit staff noted that consents for restrictive procedures were blank. A Monthly Progress of Individual Program dated November 15, 2003, noted that the resident had been in restraints many times, even though the record indicated
that consents for physical restraint, holding, transport, and access restrictions were only current through June 2003. The last consent for the resident’s behavior intervention plan was dated June 28, 2002.

- The two residents with pica behaviors were confined to their rooms, and their guardians did not sign any type of consent. When asked, they stated that they would not have signed a consent for such restrictive practices.

In September 27, 2002, IDPH cited Choate for its failure to appropriately monitor and revise residents’ programs, including situations in which a resident has successfully completed an objective or goal. In those instances where Choate failed to update residents’ goals and progress, appropriate programming is rendered impossible. Choate’s continued lack of monitoring was evident in the documentation reviewed by the Investigation Unit.

- In an October 2003 monthly review for one resident, the vocational skills objective required him to attend to assigned tasks to completion 100 percent of the time for three consecutive months. One hundred percent completion was documented for July, August, and September 2003. This resident’s goal was not updated or amended in response to this met objective. This objective remained on his March 2004 Individual Program Plan.

- That same resident’s program plan was not updated in regard to his personal goals, despite achieving a 100 percent accomplishment rate for all four components. There was no monthly review of his IPP for December 2003, January 2004, or February 2004.

- The charting of another resident’s Personal Preferences had identical narrative for reports from June 15, 2003, to March 15, 2004, which stated, “home visits, community outings and events, transitional living plan.” It did not contain any updated information, nor did there appear to be any evidence that these preferences had been addressed or met.

- In reviewing another resident’s records in April 2004, “late entries” were written in the progress notes dating as far back as June of 2003.

Recent reports from IDPH monitors reveal multiple instances of Choate’s failure to document vital information about the residents.

- The medication administration records (MARs) for January and March for one of the residents could not be found in his chart. The last vision evaluation was dated January 29, 1988.

- The monitors noted that in another chart, there were no physician progress notes for June and July.

- Another resident’s chart noted that the resident, who was admitted in January of 2004, had made many attempts to exit the facility since his admission. There was
no documentation in his chart indicating that this resident should be monitored as an elopement risk.

- On August 20, 2004, IDPH monitors noted that, on two of the residential units, every chart showed the last monthly progress note updates were all dated June 2004.

- On that same day, the monitor asked unit staff for recent incident and accident reports. Unit staff stated that Choate administration keeps such reports. When the monitor asked the administrators about this, they responded by saying that these reports are kept on the units.

- A female resident, recently admitted to Choate, had multiple episodes of self-injurious behavior. This resident’s psychiatrist stated that staff are inconsistent with the behavior intervention program when such behaviors occur. Staff have been taking the resident to a different room, which is reported to be what the resident prefers and therefore reinforces her behaviors. The psychiatrist recommended that the behavior intervention program be modified to use “room time” as a reward. The IDPH monitor reviewed the program, and found that there was no change in the document to reflect this modification.

- On September 28, 2004, in reviewing three different behavior intervention programs, an IDPH monitor noted that these programs were last updated on April 16, 2003, April 23, 2003, and May 8, 2003, in excess of the annual requirement.

- A September 2004 monitor report from IDPH noted a Choate resident on a Zyprexa medication reduction program. While the physician’s orders instructed staff to document the resident’s sleep habits each night and notify of changes, the monitor reported that there was no documentation on any shift on September 4, 2004, through September 6, 2004.

  In the September 22, 2004, Annual Certification survey, IDPH cited Choate for its failure to document critical information, including failure to secure written informed consent from a resident or resident’s legal guardian regarding the rationale for the continued use of Mellaril, an antipsychotic medication, after the Food and Drug Administration has issued warnings concerning this medication and its potential to cause fatal heart problems. According to IDPH, seven Choate residents continue to receive Mellaril.

- A review of one resident’s chart revealed an unsigned copy of a consent form sent to the resident’s guardian. The consent stated that the physician talked to the guardian about what the medication may do, side effects, and alternative medications or treatments available. The consent further stated that the medication plan was attached. No plan was in fact attached to the consent.

- IDPH interviewed the resident’s legal guardian. He reported that he had not received any information about side effects of Mellaril, that no alternative medication had
been discussed with him, and that, in fact, no one had discussed the issue of Mellaril with him since the early 1990s.

- A meeting note in the resident’s chart dated April 21, 2004, stated that the resident’s guardian “does not want Mellaril reduced or discontinued.” No documentation could be found in the chart that would indicate such a preference from the guardian.

- Consent forms for six other residents contained no information that would ensure that an informed decision was made by the resident or a resident’s legal guardian regarding the administration of Mellaril and its potential risks.

With a population of more than 200 residents and well over 100 staff who work with Choate residents, without documentation that is complete, up-to-date, and disseminated, it is impossible for staff to provide appropriate services and protect the rights and safety of the residents.

### Failure to Investigate/Assess Injuries of Unknown Origin

Choate has been cited by IDPH for its failure to properly assess, investigate, and document injuries of unknown origin.

- In March 2002, IDPH cited Choate for its failure to ensure that injuries of unknown origin are thoroughly investigated. IDPH identified two nonverbal residents who had been injured and indicated that Choate failed to interview verbal residents to assist in determining the causes of the injuries sustained by their nonverbal peers. IDPH also cited Choate for its failure to implement additional monitoring and safeguards to prevent the recurrence of such injuries.

- In July 2003, IDPH again cited Choate for its failure to protect residents in the context of an unknown injury case. One resident was found on October 22, 2002, with abrasions to his back and arms, and on October 23, with bruises to the right arm, both thighs, and the left inner leg. Choate did not interview staff or residents present on the unit until three days later. When these interviews were conducted, it was learned that, on October 22, three residents witnessed a staff person hit him repeatedly with a pole and metal part of a dust mop. Since Choate did not promptly investigate, the abuser worked several more shifts before being removed from contact with residents. As a result, IDPH called an Immediate Jeopardy on June 25, 2003, for Choate’s failure to protect individuals from abuse after discovering injuries of unknown origin.

The Investigation Unit staff’s April 2004 review of that same resident’s records demonstrates that Choate continues to fail to take preventative measures and to implement additional monitoring with respect to injuries of unknown origin.
In the resident’s records, Investigation Unit staff noted many unexplained injuries, specifically scratches and bruises. The nursing summary discloses that he has sustained 45 injuries this year: 15 for self-injurious behavior (SIB); 15 unknown injuries; two peer-to-peer injuries; 10 accidental injuries; and three alleged injuries.

During their August and September 2004 monitoring activities, IDPH monitors reported multiple instances of injuries of unknown origin of Choate residents, with little or no corresponding documentation.

- On August 19, 2004, the monitor noted that one resident had bruises on her upper extremities. This was documented in an incident log, but there was no documentation in her clinical record of such bruises.

- On that same date, the monitor noted that another resident had bruises on his right foot, all toes, and other extremities. The source of injury was unknown.

- In IDPH’s August 20, 2004, report, the monitor noted a bruise above the left eye of one resident. No documentation was contained in the resident’s chart as to how the injury occurred.

- On September 7, 2004, the IDPH monitor noted scratches on the neck of one resident. Staff were unable to state the cause of injury, and the resident was unable to articulate the cause.

- A resident was found to have a “half-dollar-size bruise” on his right knee. Staff were unable to identify any recent falls or injuries, and the resident’s records did not contain any information regarding this injury.

- Another resident had an abrasion on his right knee. There was no documentation in the chart as to how this injury occurred, and, again, staff were unaware of how it happened.

- On September 7, 2004, the IDPH monitor noted that a resident had an injury to his first left finger, an abrasion to his right knee, an abrasion to his right shin, and an older healing abrasion to his right knee. The monitor inquired about these injuries and was informed by Choate staff that he falls due to his “unsteady gait.” However, recent documentation in his chart states that this resident “walks without difficulty.” The resident’s records do not contain any record of falls, nor do the records contain incident or accident reports to address the cause of these injuries.

- On September 17, an IDPH monitor found a note in one resident’s chart dated September 16, 2004, that stated that the resident was discovered to have an abrasion to the right nipple and a bruise on his penis, stated as one to four days old. The resident was reported to have engaged in self-injurious behavior related to “inappropriate sexual behavior” on the previous day, and staff stated that this resident is known to cause such injuries to himself during this type of behavior. However, there was no documentation in the resident’s chart that would indicate that was behavior created these injuries.
On September 17, 2004, the monitor noted a scratch on one of the resident's faces. No documentation was contained in the chart to indicate the origin of this injury.

In September 2004, IDPH called an Immediate Jeopardy based upon Choate's failure to properly evaluate and address injuries of unknown origin, thereby placing residents at continued risk of harm. On June 8, 2004, a resident was found to have sustained a suspicious injury. Due to Choate's failure to take immediate appropriate action, this same resident was found to have numerous additional injuries of suspicious origin throughout the next several months. As a result, the Immediate Jeopardy was called on September 10, 2004, at 3:55 p.m.

The resident was found on June 8, 2004, with bruises on his abdomen and on June 9, with swelling of his finger. On June 10, the resident indicated that one of his roommates was the person who had hurt him. The following day, the resident again identified a person who he said hurt him. No action was taken to remove the resident from his bedroom, and no additional monitoring was put into place to protect him. In fact, the resident remained in this same room for over two more months.

On July 2, 2004, an injury report revealed that the same resident sustained another injury of unknown origin, a bruised forearm, likely caused by a peer grabbing his arm.

On July 6, 2004, an Emergency Special Program Review was held for this resident. One of the recommendations from that meeting included increased supervision, especially during high activity on the unit. No documentation was found by IDPH that would indicate that any increased monitoring took place to prevent additional harm to this resident.

On July 13, 2004, the resident sustained another injury of unknown origin. He received abrasions to his eyebrow, cheek, and ear. On August 12, the resident was found to have a bruise on his chest and two bruises on his left arm. The resident's chart did not contain any documentation that indicted that the facility took any steps to determine the cause of the injuries or that additional safeguards were implemented to protect this resident. On August 14, additional bruises were discovered. Again, no protections were put in place.

On August 18, 2004, when the resident's shirt collar was pulled down away from his neck, a staff member noticed a purple bruise and initiated a body check. Additional bruises of unknown origin were found. Choate began an internal investigation on August 18, and OIG took over this investigation on the following day.
Eventually, another resident admitted to beating this resident on numerous occasions. Three other residents stated that they witnessed the incidents and corroborated the history.

Lack of Dignity Afforded Residents

The Investigation Unit’s observations as well as reports generated by IDPH in its monitoring activities of the past several months raise serious concerns about the lack of dignity afforded Choate residents by some staff.

- On August 19, 2004, an IDPH monitor witnessed a resident at the on-site workshop area of Choate with her pants torn across the front, exposing her entire front area below the navel to the upper thigh. Staff reported that there are generally clothes available at the workshop area, but none could be located that day.

- Another resident had a torn shirt and her breasts were exposed. As there was no extra clothing available, staff put her shirt on backward and tied it. Her pants were so large that they fell to the floor when she stood, exposing her undergarments.

- The monitor also noted on September 7, 2004, that a female resident had a large growth of facial hair. This was noted again on September 17.

- On September 8, 2004, on one of the residential units, the monitors noted that there were multiple residents wearing clothing that was too large and that many of those residents had to walk around holding their pants up.

- On September 27, 2004, an IDPH monitor, at 1:50 p.m., noted that a female resident had dried food on her face and on the collar of her shirt. At 4:30 p.m., the resident had the same shirt on.

- The following day, that same monitor noticed a female resident in a room in the life skills building with her shirt off and no bra on. There were reportedly eight residents in the same room, including four male residents. Two staff members were attempting to put her shirt back on, yet, during this process, the male residents were watching and staff did not shield the resident from their view, nor did staff attempt to direct the male residents’ attention away from the female resident with her shirt off.

This failure to protect and uphold the dignity of Choate residents, even in very simple ways, exemplifies the disregard and indifference toward residents exhibited by some Choate staff.
Environment of Fear and Retaliation

Investigation Unit staff had discussions with numerous Choate residents. Many of those residents expressed fear of retaliation by staff if they exercise their right to make a complaint to the appropriate agencies, such as IDPH and OIG.

Residents consistently stated that staff threaten them with restraints and antecedent behavior cards (“ABC”). According to the facility director, these cards are supposed to be a proactive tool to address maladaptive behavior and not used as threats. In fact, on June 11, 2004, Investigation Unit staff observed a female resident in the day training room. This resident was agitated and swearing at staff. Within seconds, a Choate staff person stated in a threatening voice, “Do you want a behavior card?”

Choate has a large number of individuals who are high functioning and verbal who spoke candidly to Investigation Unit staff. Many of those same residents were able to fully discuss their experiences at Choate and their frustration in remaining at the facility. Residents referred to numerous incidents in which staff curse at them, call them degrading names, and consistently threaten to “tie them up.” Several residents repeated statements by staff such as, “You’d better not tell on me! I have kids to feed!” Many of these residents said to Investigation Unit staff, “Get me out of here.”

Conclusion and Recommendations

The pattern of deaths, serious injuries, and systemic failures documented by this report reveal a striking lack of even the most basic systems to ensure the health and safety of the individuals residing at Choate. The deaths of residents due to the failure to provide adequate healthcare, the failure to keep residents free from abuse and neglect, the excessive use of restraints in violation of state and federal law, the failure to address the needs of residents with pica behavior, the failure to protect residents from sexual assault, the failure to provide adequate supervision or programming, or effective communication for residents who are deaf or hard of hearing, the failure to document critical information, the failure to adequately investigate injuries of unknown origin and the failure to afford dignity to the residents, suggest that residents at Choate continue to be at risk of serious injury, illness, and even death.
In spite of recent efforts by the facility director and the Department to address the problems revealed by this report, the history of this institution, like the history of other large institutions generally, raises significant concerns regarding the sustainability of such efforts. More importantly, these longstanding systemic failures document the urgent need to transition residents from Choate to other less restrictive settings and to close the non-forensic long-term units at the facility.

Equip for Equality strongly recommends that the Departments of Human Services and Public Health take whatever action is necessary to:

- Prohibit new placements into nonforensic units at Choate;
- Develop a plan for the timely transition of residents into the most integrated settings in the community to meet their individual needs;
- Take the necessary action to ensure the provision of supports and services to meet those residents’ needs and to ensure their success in the community;
- Maintain on-site monitoring at Choate during the transition period; and
- Close all non-forensic long-term units at Choate Developmental Center.
Appendix A
December 10, 2004

Zena Naiditch, President and CEO
Equip for Equality
20 North Michigan Avenue - Suite 300
Chicago, Illinois 60602

Dear Ms. Naiditch:

Enclosed is a copy of Department of Human Services’ response to your organization’s cover letter and report regarding concerns at Choate Developmental Center. This response addresses the issues raised in your original draft report as well as the revised draft report issued after our meeting on October 27.

We took the opportunity to document the strides made in the attached document. You will note that we have continued to address concerns since our meeting on October 27th. Two of the most significant accomplishments are that an outside entity, the Illinois Foundation for Quality Health Care, will begin training in several key areas next month. The second significant accomplishment is that twenty persons have or will be discharged from Choate to community programs by the end of the year.

We value our partnership and would hope that your report would demonstrate our collaboration. If you have any questions, do not hesitate to call me.

Sincerely,

Grace Hou
Assistant Secretary

cc: Carol L. Adams, Ph.D
Secretary

Enclosure
Introduction

It is obvious from reviewing E for E’s report that your staff expended considerable time and effort on site at Choate Developmental Center and also in the review of historical information documented in previous years through Illinois Department of Public Health (IDPH) and the DHS Office of Inspector General (OIG). Many of the DPH and OIG issues identified prior to E for E’s beginning on site reviews in the Spring of 2004 have been addressed. As such, the DHS response to the report will be limited to current issues in the documents you forwarded. It should be noted that the Division of Developmental Disabilities has, on two occasions, sent staff to assist Choate in developing strategies to address deficiencies noted by DPH survey staff, an outside monitor (VP Circle of Quality hired by DPH to provide on site review and consultation on a weekly basis), and OIG recommendations.

E FOR E CONCERN - HEALTHCARE SERVICES- FAILURE TO PROVIDE ADEQUATE HEALTHCARE

We are in the process of instituting changes in medical practices based on recommendations by Ted Sunder, M.D., Neurologist and Clinical Director of the Division of DD, Rod Curtis, M.D. Internal Medicine and Psychiatry, and Gus Pedraza, M.D. These persons have thoroughly reviewed DPH findings and have provided on site consultation, on more than one occasion, with Choate’s Facility Director and medical staff. Medical care and communication among the different departments have improved at Choate over the past four months.

The accidental choking death of a resident in April 2004 was a regrettable event. Although 911 was called immediately and the EMT’s arrived quickly, an inadequate paging system complicated matters. Due to the hilly terrain in southern Illinois, cell phone and pagers are not as reliable as we’d like for them to be. However, many positive changes have taken place at the center since the above incident. First of all, Choate changed vendors and contracted with ARCH Wireless on July 26, 2004. A new tower was situated on top of the tallest building on campus on August 25th and now the signal is much stronger. In addition, nurses now carry a two-way radio as backup. Regular and frequent "code blue" drills have shown positive results. In fact, with the radio backup system the response rate is 100%.

As you may be aware, OIG investigated the above case and did not find Choate staff negligent in this case. In this section, E for E also noted that Choate had not completed a total evacuation fire drill during the past year and characterized their drills as simulated. On September 13th at 5:12 A.M. all residents were evacuated from all of the buildings for a successful third-shift fire drill. Documentation of the drill was given to Public Health on that date, and the existing Immediate Jeopardy citation was cleared.
E FOR E CONCERN - CLIENT PROTECTIONS-EXCESSIVE USE OF RESTRAINTS

The overall program philosophy continues to emphasize prevention and positive reinforcement for program participation. Despite a large number of very difficult behavior management cases, there has been a continuing downward trend in the use of restrictive procedures. There is also an ongoing effort to reduce the use of medication for behavior management purposes. Medication reductions are measured each month with the goal of having as few individuals as possible on Psychotropic medications. Many of our admissions come from the community and it is common for a person entering an SODC from a community program to be taking three or more Psychotropic medications and during his/her time with us for that to be reduced to one or even no medications.

During the past three months the number of restraint episodes and the number of individuals restrained have decreased significantly. Primary measures have been taken to improve the use of de-escalation techniques and to increase staff training. The number of restraints at Choate has decreased from 73 in June to 44 in July, 22 in August and 19 in September. This represents nearly a 75% reduction in the total number of restraints in a four-month period. In addition, the total number of separate individuals restrained was reduced from 30 persons in April to nine persons in September. Individuals no longer have Behavior Intervention Plans that call for restraints for verbal aggression. This has been in effect since June 2004.

E FOR E CONCERN - CLIENT PROTECTION- FAILURE TO ADDRESS THE NEEDS OF RESIDENTS WITH PICA BEHAVIORS, FAILURE TO INVESTIGATE INCIDENTS OF UNKNOWN ORIGIN, FAILURE TO PROTECT RESIDENTS FROM SEXUAL ASSAULT, FAILURE TO PROVIDE ADEQUATE SUPERVISION, AND FAILURE TO ENSURE SYSTEMS ARE IN PLACE TO KEEP RESIDENTS SAFE FROM ABUSE AND NEGLECT

The most important responsibility of Choate’s administration is to insure that residents are kept safe. Choate, and all of our SODCs, must insure that systems are in place to prevent abuse and neglect, whether it involves staff to resident issues or assaults by other residents. The Division of DD is committed to insuring any necessary changes required to improve resident safety at Choate are implemented immediately. Many examples of injuries to residents at Choate noted in E for E’s report are very disturbing, whether they occurred recently or in past years. DHS is committed to protecting individuals.

Based on DHS findings thus far Choate has made progress in Client Protection areas through the use of staff Competency/ Based Task Analysis (CBTA) Training. Visual sweeps to prevent incidents of pica behavior have been instituted. It should be noted that not one pica incident requiring medical intervention has taken place since November of 2003. This issue was discussed with you on October 27th and a point was made that although Choate as well as other centers provide services to persons with pica no serious events have occurred in more than one year.
Choate has established new procedures to prevent sexual exploitation by persons identified as sexual predators. Since these procedures have been implemented, no additional sexual assaults have occurred. A specialized training program, socio-sexual rehabilitation, has been refined to address the needs of persons at risk of committing sexual assaults. The incident cited in your report took place more than 20 months ago and since that time the center has been free of such incidents. Your report is silent about progress made in this area.

E FOR E CONCERN - FAILURE TO PROVIDE ACTIVE TREATMENT AND APPROPRIATE PROGRAMMING OR MEET BASIC NEEDS

Choate has improved vocational and educational programming by collaborating with Southern Illinois University and Dr. Brandon Green, Director of Project 12 Ways and professor at SIU Rehabilitation Institute. The training program includes all people regardless of the severity of their disability and utilizes the most effective training methods available in the field. Training methods meet the criterion set by IDPH, ISBE and DHS Rule 119. Small groups are utilized to teach active treatment strategies and to assist residents in developing basic living skills such as appropriate social skills. These include dining skills, food preparation activities and training for independence. Opportunities for persons to go out into the community for shopping, dining and leisure activities have significantly increased. Persons who require more individualized attention are also included in these outings. Graduate students from Southern Illinois University’s Rehab institute are working to teach direct care staff strategies to more effectively work with individuals who pose challenging behavioral issues. Preference assessments are being conducted with the goal of determining preferred activities so that stereotypic behavior is decreased. In September a study was completed which demonstrated that when individuals participate in set activities their preferences often change from age-inappropriate activities to more age-appropriate activities. Also, new program options now include an anger management group, DBT group, sex education, letter writing and scrap booking. Off unit activities are provided for two hours each night. These activities include dances, activities at the gymnasium and community outings.

E FOR E CONCERN - FAILURE TO DOCUMENT CRITICAL INFORMATION

Choate administration has undertaken a thorough review of all documentation requirements and a person by person review of each individual’s clinical record. Lapses in required documentation are then identified and corrected on an individual basis.

E FOR E CONCERN - FAILURE TO INVESTIGATE INJURIES OF UNKNOWN ORIGIN

The following are among the steps taken to address issues of injuries of unknown origin:

-All staff were re-trained by 10/29/04 on unknown/unobserved injury policy number 967. Training included the completion of injury reports to address action taken at the time injury was witnessed or discovered. Unit Directors/AOD now review and implement appropriate
recommendations immediately upon notification to ensure client safety.
-Morning Team Meetings conducted by Unit Directors now include review of persons who receive three or more injuries per month, injuries related to abuse/neglect, and injuries of unknown origin. Morning Team Meetings evaluate effectiveness of implementation and whether all recommendations have been addressed as ordered. Date implemented 9/17/04.
-Staff were retrained on identifying potential abuse and neglect.
-Staff were retrained on the completion of reports to include action taken at the time injury was witnessed/discovered.
-Unit injury analysis was revised to include reasons for increases/decreases in injuries by causes and classification, including team review of persons who receive three or more injuries per month. We are also now addressing abuse/neglect trends over time.
-Physician now reviews/documents on all injuries classified first aid or above.
-Nurses were in-service/trained on Abuse/Neglect.
-Physicians now review all accident reports and examine all individuals with First Aid or above.
-Physicians were retrained on identifying Abuse and Neglect.
-Special Program Reviews are held within five (5) days of unknown injury in which suspicion of abuse is peer-to-peer.

E FOR E CONCERN - SERVICES TO INDIVIDUALS WHO ARE IDENTIFIED AS DEAF OR HARD OF HEARING - ADDRESS THE COMMUNICATION NEEDS OF INDIVIDUALS WHO ARE DEAF OR HARD OF HEARING

As E for E references, there are eight people who live at Choate who are deaf or hard of hearing. Choate’s administration has made significant progress in improving specialized services to this group. The following are changes that have occurred or are planned for the very near future: 1.) Interpreter consultants are now more widely used in the areas of programming, testing, shopping and recreational activities, medical exams, and determination of personal preferences, 2.) Choate now has an ongoing relationship with the John A. Logan Community College Sign Language Interpretation Program and the statewide coordinator for deaf services, and 3.) Training is provided to staff in working with hearing impaired and deaf persons. Beginning in January 2005, a graduate student from the rehabilitation Institute at Southern Illinois University will work 30 hours per week along with the facility’s sign language consultants to coordinate services for deaf persons. Training skills for the direct care staff is also included in the project.

E FOR E CONCERN - LACK OF DIGNITY AFFORDED RESIDENTS

The events described in the E for E report concerning the lack of dignity afforded residents is very disturbing. We believe that the issues concerning lack of resident privacy, inappropriate clothing and sanitary procedures included in the report represent isolated instances. However, these lapses cannot be tolerated.
To address these and other staff related issues the state has retained the services of an outside, experienced, professional consultant to provide training to the direct care staff at Choate.

The Illinois Foundation for Quality Health Care will begin training in several key areas at Choate next month. A preliminary meeting was held on October 28th and the trainers met with the center director, nursing staff and SODC Operations staff to plot a course of action. After touring the entire facility it was determined that the Illinois Foundation for Quality Health Care would begin with one particular building and work their way through all of the units. In addition to the training that will be taking place privacy screens have been ordered and will be placed in the rooms so that the residents have more privacy while dressing. An employee satisfaction survey will be completed by all staff in order to determine deficient areas, to improve the level of staff ownership and to gain additional insight into the culture at Choate.

E FOR E CONCERN - AN ENVIRONMENT OF FEAR AND RETALIATION

Despite the claims from E for E that residents are afraid to talk about what is on their mind, our experience is that individuals are eager to talk to Public Health, OIG, outside monitors, DHS staff and other persons who are visiting the center.

E FOR E’S CONCLUSION AND RECOMMENDATIONS

Although Equip for Equality recommends that DHS prohibit new placements into non-forensic units at Choate, and develop a plan for the timely transition of residents into the community, this is exactly what has been in effect for many months. A freeze was put on all non-forensic admission to the facility. No new admissions have been made to the civil units since April 2004. During this nine-month period the census at Choate has dramatically decreased. Forty-three residents are now in the process of being interviewed by various community providers. Twelve people have been discharged from the facility and have moved to community ICFDDs or CILA’s since July 1st. Twelve others have discharge dates in the month of December. Eight residents on the forensic unit have also been discharged in FY’05. This will account for 32 persons being discharged from Choate in a six-month period. As stated earlier, no admissions have occurred on the civil units for the past eight months and the plans are for all new emergency admissions to go to other State Operated Developmental Centers. A transition counseling group has begun for persons preparing to enter community living. Group discussions cover issues of independent living and give participants a chance to voice any concerns that they might have about living outside of the center.
CHOATE PLANS FOR THE FUTURE

- Continue the downsizing effort in order to improve staff/resident ratios.
- Choate plans to continue the alliance with Southern Illinois University including gaining expertise from their psychology department, social work department, rehabilitation Department and their research department.
- Contact has been made with the Tri-County Special Education to develop age-appropriate programming opportunities.
- Continue to work on functional assessments in conjunction with SIU to develop behavior intervention programs, as well as programming to enhance individuals quality of life and community integration potential.
Rate of Restraint

Mean Number of Behavioral Episodes
Number of Restraints January thru September 2004

Number of Persons Restrained January thru September 2004
Appendix B
December 22, 2004

Ms. Zena Naiditch
Equip for Equality
20 North Michigan Avenue, Suite 300
Chicago, Illinois 60602

Dear Ms. Naiditch:

We are in receipt of your letter of December 2, 2004. Thank you for sharing the Clyde Choate Developmental Center report with us. Currently, we have a monitor at the facility two days a week. We will continue to maintain a monitor at this facility to ensure that all clients receive the services they need.

My staff is working to develop a contract with the Illinois Foundation for Quality Health Care to encourage a culture change at Clyde Choate Developmental Center to better meet the needs of all clients at this agency. We will notify you when a contract is signed and keep you informed of the progress made in this area.

If you have any further questions, please do not hesitate to contact Naomi Dunn, Division Chief, Long Term Care Field Operations

Sincerely,

[Signature]

Eric E. Whitaker, M.D., M.P.H.
Director

RW:sq