

# EQUIP FOR EQUALITY

## A SPECIAL REPORT

from the Independent Monitoring Unit

### Choate Developmental Center Repurposing Plan: **Why No One Should be Left Behind**

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

Equip for Equality is the federally mandated Protection & Advocacy System for 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 disabilities.

Equip for Equality is the only comprehensive statewide advocacy organization for people with disabilities and their families. All individuals with a disability (as defined by the ADA) in Illinois, of any age and living situation, are eligible for services, including but not limited to individuals in state-operated facilities, nursing homes, and community-based programs.

## **Services, Programs, and Projects**

**Independent Monitoring 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; monitors transitions from SODCs to community settings; conducts abuse and neglect investigations; monitors settings that serve people with disabilities; and alerts service providers to dangerous conditions and practices.

**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 on Disability Rights** provides training for people with disabilities and their families. Topics include rights and responsibilities under the Americans with Disabilities Act, protections against employment discrimination, guardianship, advance directives and special education rights.

# Choate Developmental Center Repurposing Plan: **Why No One Should be Left Behind**

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\*Executive Summary Available\*

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## I. Introduction

Clyde L. Choate Developmental Center (Choate) was originally constructed in the late 1800s as the Anna State Hospital and is Illinois' southernmost state-run institution. It currently houses approximately 225 residents, a little over half of which live on units licensed by the Illinois Department of Public Health (IDPH). Individuals living on licensed units are funded by Medicaid. The remaining individuals live on unlicensed ("non-certified") units that are 100% state funded. The problems that have plagued Choate over the years have implicated both the licensed and non-certified units.<sup>1</sup>

As the federally mandated independent Protection & Advocacy System for Illinois and at the Illinois Department of Human Services' request, Equip for Equality monitors spent over 2,000 hours during the past two years evaluating Choate's care and treatment of individuals with developmental disabilities. Our monitoring activities consisted of in-person and off-site reviews that included interviewing individuals who reside there, staff and administration; communicating with guardians; observing physical plant conditions; and conducting chart, incident and restraint reviews. Throughout this time, Equip for Equality was in regular communication with State officials and Choate's administration about on-going and repeated problems that have resulted in some of our State's most vulnerable citizens experiencing harm and poor health outcomes, all while being isolated from the broader community.

In response to Equip for Equality's reports about care and safety problems at the facility as well as those of state investigative authorities, in June 2022 the Department of Human Services announced multiple steps it was taking to turnaround conditions at Choate. These steps included creating an environmental plan to update living areas; adding surveillance cameras to public areas; increasing security staff by four positions; increasing management and professional staff presence in living areas, and supplementing that monitoring with rounds by statewide and regional management personnel; temporarily assigning a licensed clinical psychologist to provide staff support; contracting with the Illinois Crisis Prevention Network (ICPN) to provide independent support for staff and residents, make recommendations on behavior plans, support plans and human rights committee processes, train staff on trauma informed care, and provide one-to-one clinical supports to residents; making policy changes and providing additional training in the areas of individual rights, supervision, support plans, and interventions; and adding additional enhancements and support to the community transition process.

Unfortunately, Equip for Equality's site visits from October 2022 through July 2023 revealed that the measures that have been implemented to date, despite being

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<sup>1</sup> The campus also includes a state-run mental health center, Choate Mental Health Center. The contents of this report are unrelated to this portion of the campus.

meaningful, have not translated into sufficient improvement to the care and safety of individuals at the facility.<sup>2</sup> As shared with the Department, we continued to observe the same problems identified in 2021. And, while staffing shortages and COVID-related restrictions negatively impacted the facility's ability to provide quality care, the problems observed were a repeat of problems Equip for Equality previously identified (including in its 2005 public report<sup>3</sup>), and the Department of Justice (DOJ) cited in its 2009 report.<sup>4</sup> Despite the State's on-going investments in this institution and the high level of scrutiny it has been under since early 2021, these problems persist, making it clear that an influx of more resources will not fix the multiple and serious problems at Choate.

Recognizing the on-going problems, on March 8, 2023, the Governor announced his plan to repurpose much of the Choate Developmental Center. This plan includes transitioning individuals living on four units to community settings or other state or private institutions, the SIU School of Medicine assessing whether the remaining four units (described as the dual diagnosis, forensic and step-down units) should remain,<sup>5</sup> and appointing a Chief Resident Safety Officer and implementing other safety initiatives to improve safety at both Choate and other state operated developmental centers. While Equip for Equality acknowledges these efforts to protect individuals in the State's care, significant problems continue at the Choate campus. As a result, Equip

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<sup>2</sup> Though the impact of safety measures likely to improve investigations remain to be seen, including installing cameras in common areas and a recent law to remove staff who obstruct investigations from the health care field – both of which Equip for Equality supported – those measures do not ameliorate the harm done to individuals who have experienced or seen abuse, nor do they prevent abuse from occurring. They also do not impact the other long-standing problems at Choate detailed in this report.

<sup>3</sup> <https://www.equipforequality.org/wp-content/uploads/2014/04/Clyde-Choate-Developmental-Center-How-an-Archaic-System-Results-in-Tragic-Consequences-for-People-with-Disabilities.pdf>.

<sup>4</sup> [https://www.justice.gov/sites/default/files/crt/legacy/2010/12/15/Choate\\_findlet\\_11-09-09.pdf](https://www.justice.gov/sites/default/files/crt/legacy/2010/12/15/Choate_findlet_11-09-09.pdf).

<sup>5</sup> The SIU School of Medicine released its Phase One report on July 14, 2023. The report recommends converting the dual diagnosis unit to a certified unit and in the long-term creating short-term stabilization units for such individuals on the Choate campus. It also recommends that the forensic and step-down units for individuals with developmental disabilities remain on campus. The report does not explain why these units should remain in Anna, even though most of the individuals on these units are not from Southern Illinois. The report also does not adequately answer how the facility can overcome its historical problems and culture, or how it can provide therapeutic care despite individuals' experiences with abuse and neglect at the facility.

for Equality urges that any decisions regarding the remaining four units consider whether Choate can offer therapeutic care and legally required active treatment, regardless of workforce improvements, given the long history of troubles at Choate.

Individuals on the units under consideration – Redbud, Dogwood, Sycamore Lower and Sycamore Upper – should not be expected to remain at an institution that has both failed to meet their needs and exposed them to abuse and neglect. Under these conditions, requiring this group of individuals to remain at Choate is antithetical to their well-being and the reason for their placement, i.e., to receive intensive treatment that assists them to timely progress and move to less restrictive settings that do not isolate them from the broader community. Long-standing efforts to address problems at Choate have not resulted in meaningful change, and the entrenched cover-up culture among staff as revealed in multiple Office of Inspector General (OIG) reports leaves people at continued risk. As a result, no individuals with developmental disabilities should remain at Choate.

## **II. From Past to Present – Systemic Problems Place Individual Safety and Well-Being at Risk and Result in their Continued Isolation from Society.**

Multi-level problems contribute to the simple fact that Choate is not meeting the Department of Human Services’ stated purpose for institutions such as Choate. Specifically, the Department states:

State-Operated Developmental Centers (SODCs) provide intensive services that presently cannot be provided in family homes or in community-based residential programs for people with developmental disabilities. Emphasis is placed on assisting people to achieve their personal goals of living where and with whom they choose, coupled with the development of community resources over the past several years, which is intended to target a census reduction at the SODCs. This emphasis is consistent with national trends in residential services where focus has shifted to helping people remain in their homes or community-based residential programs.<sup>6</sup>

In fact, many individuals at Choate want community placement – including ninety-one that we interviewed during October 2022 through July 2023 site visits, plus an additional thirty-one who we did not interview but were on the community transition list before the Governor’s announcement.<sup>7</sup> Yet, their progress to the community is slow

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<sup>6</sup> [https://www.dhs.state.il.us/page.aspx?item=115717#a\\_OverviewofServices](https://www.dhs.state.il.us/page.aspx?item=115717#a_OverviewofServices).

<sup>7</sup> The Illinois Department of Human Services maintains a list of people who want to explore and transition to community placements. People who are not on this list are not in the process of actively exploring placements.

or, for those not on the transition list, non-existent.<sup>8</sup> The barriers to community placement vary, but “behavioral” and “mental health” concerns predominate, and there is an absence of intensive, therapeutic and coordinated care to help address the emotional health needs of individuals at Choate.

In addition, the large majority of individuals we interviewed during these site visits reported experiencing one or more problems, many of which directly impact wellness and safety, including being bored with little to do all day, peer-to-peer abuse and lack of staff intervention, needing but not receiving counseling or other mental health services, lack of treatment for medical conditions, staff “egging on” behavioral episodes, abusive and disrespectful treatment by staff, disliking sharing a room with three others, wanting (but not having access to) a community job and/or more community outings, a desire to work on skills related to community living that are not addressed, lack of access to the internet, and poor food quality (including poor nutritional value and under-cooked or cold food).

Our review of twenty-five charts during monitoring visits from October 2022 through March 2023, further revealed continued problems with the quality of medical services and treatment team follow-up in response to incidents, such as self-harm, peer-to-peer incidents, non-intensive and non-responsive treatment planning, and treatment that is not focused on progression to a community-integrated setting. In addition, although efforts the Department announced in June 2022 are on-going, Choate’s physical plant remains in a poor condition. While construction can take time, we saw multiple issues that are not impacted by supply chain or procurement delays, including continuing problems with cleanliness and availability of basic supplies, like toilet paper.

This is not to say that all staff at Choate are bad. Staffing challenges have an impact on care and there are, of course, some good and committed staff at Choate. However, the presence of good staff has not and cannot overcome the facility’s long-standing culture and quality problems. The end result for the individuals living at Choate is an atmosphere and treatment model that is coercive, non-therapeutic, and unnecessarily institutionalizes them for long periods without providing the required intensive array of services designed to ensure the shortest stay possible. Given the long-standing history of current concerns, no individual with a developmental disability should remain at Choate.

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<sup>8</sup> This number does not include the many individuals who are unable to communicate their wishes to Equip for Equality. Included in this number are twenty-three individuals on the forensic unit, Sycamore Lower. Although these individuals have court-related barriers to leaving Choate, the lack of necessary services at Choate delays their progression through the court process and ultimately community placement.



A. Choate Fails to Provide Federally Required Treatment and Adequate Programming to Assist People with Developmental Disabilities Live in Their Communities.

Federal law mandates that individuals with developmental disabilities living in restrictive settings such as Choate must “receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services ... directed toward – (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status.” 42 C.F.R. § 483.440(a). To meet these requirements, facilities must develop an individual program plan that, among other things, identifies and meets the individual’s needs, identifies presenting problems and their causes, identifies strengths and behavioral management needs, identifies needed services without regard for the availability of such services, and identifies “independent living skills necessary for the client to function in the community...” 42 C.F.R. § 483.440(c).

Choate has long struggled to meet these requirements. Equip for Equality’s 2005 report noted Choate’s ongoing failure to provide active treatment and adequate programming to help individuals become more independent, and that these failures were impacted by lack of planning and activities, incomplete and outdated documentation that did not track progress or update goals, inadequate staffing and staff oversight, and lack of communication access for individuals who were deaf or hard-of-hearing. Likewise, DOJ cited Choate for similar deficiencies in its 2009 report, noting that the programming was not responsive or individualized and relied on control-based interventions, monthly reviews were perfunctory and did not result in updates to the treatment plan, assessments were often outdated or appeared to be based on inaccurate information, treatment was not directed to addressing factors hindering discharge, and the facility did not meet its obligation to prepare individuals to move to a less restrictive setting (including by teaching individuals skills in community spaces).

Monitoring activities over the past two years, including as recently as July 2023, demonstrated that this lack of required treatment and adequate programming remains a significant problem. As DOJ noted in its 2009 report, and as remains true now, Choate’s “failure to focus its treatment and care on moving individuals into the most integrated settings appropriate to their needs in violation of *Olmstead v. L.C.*, 527 U.S. 581 (1989).” (DOJ 2009, p.2). DOJ’s concern plays out in the numbers. In 2013, DOJ reported to Congress it was ending its Choate investigation because the “State significantly expanded its commitment to community-based services.”<sup>9</sup> At that time, the

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<sup>9</sup>[https://www.justice.gov/sites/default/files/crt/legacy/2014/08/07/split\\_cripa13.pdf](https://www.justice.gov/sites/default/files/crt/legacy/2014/08/07/split_cripa13.pdf), p. 12.

census at Choate was starting to go down; in 2005 there were 173 individuals at Choate, as compared to 159 in 2012.<sup>10</sup> That trajectory did not last, however, with Choate's population currently sitting at 222.<sup>11</sup>

In addition, the lack of active treatment leaves individuals stuck in a restrictive setting, with multiple providers rejecting their applications for placement, and subject to a sometimes-chaotic environment that leaves them at risk of harm and deterioration – all of which is in direct conflict with federal requirements. This outmoded model of care is not therapeutic and prevents individuals with developmental disabilities from living a full life in their communities. It also adds to the multiple traumas many of them have already experienced.

- Treatment Failures: There has not been any meaningful progress in individuals' programming and treatment plans. This lack of progress is facility-wide, including two of the units under consideration for remaining open, Redbud and Dogwood, where the contracted crisis prevention team (ICPN / SST) has focused most of their work since starting in Summer 2022.
  - Equip for Equality's review of twenty-five charts for the period of October 2022 through March 2023 revealed that treatment is not focused on addressing individuals' barriers to community placement. In addition to the lack of therapy and counseling, discussed further below, a significant concern for most of the charts reviewed included many individuals having the same goals. In addition to not being individualized, these goals are not focused on individuals becoming more independent, developing copings skills, and achieving community living. Moreover, treatment files contain incomplete and outdated information and often did not track progress or update goals, and monthly reviews were perfunctory and did not result in updates to the treatment plan. In fact, goals were often unchanged from one year to the next, even if the individual was showing no interest or progress on the listed goal.
  - A large treatment deficit at Choate includes the continued lack of therapy, counseling and psychological services essential to helping individuals cope with significant trauma, address their basic emotional / mental health needs, or to simply address the issues that lead to them being placed at Choate in the first place. For instance, the facility started assessing individuals to determine their need for specialized therapies based on their trauma history in late 2022

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<sup>10</sup> <https://www.dhs.state.il.us/page.aspx?item=61088>.

<sup>11</sup> <https://www.dhs.state.il.us/page.aspx?item=82095> (visited 8/2/23). Note, the population at Choate was over 230, but has recently started to go down following the Governor's March 2023 announcement.

(a formal recommendation Equip for Equality made in September 2021). For multiple individuals, the assessments we saw did not recommend therapy or any alternative mental health services despite the presence of multiple damaging life events, including being removed from their family and placed in foster care, and being a victim of sexual abuse, physical abuse and/or extreme neglect.

- In one instance, involving an individual who has been at Choate since 2011, who was sexually abused by a sibling at age seven and subject to significant neglect as a child, the assessment noted she qualified as having experienced trauma but that the individual “does not feel that she needs counseling at this time.” Not only does this contradict what this individual has stated to multiple Equip for Equality monitors on different occasions, it further demonstrates Choate’s lack of commitment to addressing people’s needs. This individual has communicated for many years that she wants to be discharged yet has been told that her “behaviors” are too significant to be managed in the community. Yet, Choate has failed to provide her with the necessary treatment to address her severe trauma history where her “behaviors” are very likely coping mechanisms resulting from her past. Instead, the team prepares a nearly identical treatment plan year after year, with largely the same programs, despite continued lack of progress. This issue is not unique to this individual and plays a major role in multiple individuals being stuck at Choate without meaningful progress, all while being told that their behaviors cannot be managed in their desired community setting.
- There are also multiple individuals at Choate due to, at least in part, inappropriate sexual behaviors in community settings, some of whom are on Sycamore Lower due to criminal charges related to that conduct.<sup>12</sup> However, Choate does not have staff who are qualified to provide sex offender treatment and little treatment is being offered to educate individuals on appropriate sexual behavior, which negatively impacts their progression to a least restrictive setting as well as their success when they move to such a setting.
- During multiple interviews conducted during eleven site visits in October 2022 through July 2023, the common refrain our monitors received when asking individuals if they received / needed therapy was: “they have that here?” Forty-one people we interviewed expressed that they needed but were

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<sup>12</sup> As of February 2023, there were approximately eighteen individuals on Sycamore Lower with underlying criminal charges involving inappropriate sexual behaviors in the community.

not receiving counseling services. Included among their reasons for needing therapy were:

- Severe childhood and/or adult trauma history, including physical abuse, extreme neglect, sexual assault, and/or a history of family separation including through DCFS involvement.
  - To help me “be more happy” as “I’ve been depressed” since coming to Choate.
  - Because “I cry and sleep a lot due to stress.”
  - Anger-management issues interfering with providers accepting them for community placement, with a long-term staff at Choate noting the need for individuals to be provided such treatment, as many end up at Choate due to anger-management issues.
  - “I would love to get counseling. [There is] nothing helping me here.”
- Not only does a lack of therapy leave individuals stuck in a facility for lengthy periods, contrary to their wishes and separate from the broader community, it is also dangerous to their immediate health.
- For instance, at a December 2022 visit an individual told our monitors that he injures himself by scratching his skin with his nails and showed recent injuries to his arm. He is capable of actively participating in therapy, but it is not offered or available to him. In connection with this lack of therapy, the facility continues to have a high incidence of self-injurious behavior (SIB) and peer-to-peer abuse.
  - In September 2022, another individual who also has a significant history of self-harm, removed all ten of his toenails. This horrific and deeply disturbing event was addressed with no more than bacitracin ointment and increased supervision. Later, in October 2022 he engaged in significant self-harm to his legs, requiring on-going wound care. Regarding these chronic wounds and significant self-harm, the doctor noted in late November 2022 that mental health intervention should be considered. As of the January 2023 chart review, there was no indication that this had occurred.
  - Of further note, in this individual’s initial psychiatric consult from 2015, the doctor noted that he is “well-versed in communicating his unmet needs by increasing the intensity” of his behaviors, but also

demonstrates “good insight into the reasons he became behaviorally dysregulated.” As a result, the doctor noted: “It is possible therapeutic interventions may expand his repertoire of coping skills and increase his options for community placement.” “‘Engagement’ and ‘connection’ appear important to [him]. Activities where ‘meaning’ may be attached.” When he was admitted in 2015, he was expecting to have a brief readmission to Choate until a community provider more appropriate to his needs and interests was identified. Yet, almost eight years later, he remains at Choate.

- The fact that these incidents are occurring with such frequency shows the lack of effective treatment and therapies to help individuals improve. It also demonstrates that the current control-focused and reactive treatment protocols are ineffective. They also do not prepare people to live in community settings.
- The programs offered are inconsistently available and individuals regularly report being bored, with little to do besides arts and crafts, puzzles and watching television. In fact, fifty-one individuals we interviewed from October 2022 through May 2023 reported this concern. Equip for Equality’s on-site monitoring activities confirmed these reports, with individuals on the units commonly being observed to be sitting around, doing little more than watching television, coloring, or sleeping, regardless of the time of day.
- Lack of quality programming not only negatively impacts an individual’s progress, but it also contributes to a chaotic and sometimes unsafe environment with individuals acting out due to their needs not being met, boredom, or simply feeling ignored. As one individual residing at Choate stated insightfully: “people get agitated with little to do.” This plays out in the documentation, as multiple incident reports and charts reflect individuals engaging in self-harm or peer to peer incidents, PICA (ingesting inedible objects), and other behaviors that have extended their stay in an institutionalized setting that causes its own stressors (such as living on a large unit with multiple individuals who are also bored and have emotional and other issues that are not being adequately addressed). In fact, multiple individuals reported that they **do not feel safe** at Choate, with peer-to-peer interactions contributing to their stated concerns.
- Equip for Equality identified additional concerning conditions on the forensic unit, Sycamore Lower, during both October 2022 and January 2023 site visits. Residents uniformly shared that they were often confined to their bedrooms all day due to low staffing. This meant that these individuals did not have access to television, had to eat meals in their bedrooms (usually with up to

three other roommates), and had very little to do all day as most rooms are merely equipped with a bed and dresser (i.e., no desk, no chair). They reported that this isolating room confinement occurred at least 50% of the time and that they very rarely had the opportunity to go outside. Although these staffing issues are being addressed and there was some improvement in these conditions after January 2023, when Equip for Equality initially reported this concern to Choate management in October 2022, they did not seem to be aware that people were not going outside and were being confined to their bedrooms due to staffing issues. And, these very troubling conditions persisted during Equip for Equality's January 2023 monitoring activities.

- On multiple occasions during its monitoring activities, Equip for Equality communicated with Choate administration and SODC operations about the on-going need for group programming to assist or support individuals on the units, and that we had received reports that people specifically needed anger management groups, and groups to assist people learn about what to expect if they move to a community setting. In January 2023, we learned that some groups were in place, and limited documentation was made available upon request. The facility provided progress notes from a "coping skills" group held in January. Unfortunately, for at least this group, it appeared that the facility was simply going through the motions of holding the group rather than creating individualized programs appropriate for the individuals participating. Specifically, for all five of the individuals who attended this 20-minute group, per the staff's notes none were deemed to have the cognitive ability to understand the topic. Later provided participation notes similarly indicated that group programming is not being developed or structured to meet the needs of each individual participating in the group.

Choate has long been unable to meet federal requirements for active treatment. This has been to the detriment of all individuals living at the facility, and as a result **no** individuals with developmental disabilities should remain at Choate.

**B. Choate Staff Continue to Use Restraints as a Mechanism for Control and Without Adequate Oversight.**

As was true almost twenty years ago, current monitoring activities continue to reveal that restraint is often used as a mechanism for control as opposed to a last resort when imminent risk of serious physical harm to self or others is present.<sup>13</sup> That the use of restraints remains a continued problem is not surprising given the lack of active

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<sup>13</sup> Equip for Equality's 2005 report detailed improper use of restraints and DOJ's 2009 report found restraints were used often without implementing less restrictive measures.

treatment, noted above. People sitting around, doing nothing, with their needs otherwise not being adequately addressed leads to chaos. Moreover, the facility's treatment style continues to be reactive rather than proactive, with Equip for Equality monitors frequently observing staff sitting around, ready to respond to a problem but not otherwise engaging residents.

In repeated interviews since October 2022, including as recently as July 2023, multiple individuals report that they are threatened with restraint if they do not comply with direction (even when the legal standard for restraint – imminent risk of serious physical harm to self or others – was not present). Also relevant to the staff abuse section below, in interviews occurring from February 2023 through early July 2023 we received multiple reports of people being hit and verbally abused while in restraints, and that restraints were applied in a manner that was physically painful. People reporting having these experiences included individuals residing on Dogwood, Redbud, and Sycamore Upper.

Recent substantiated reports from the Office of Inspector General (OIG) also reflect these abuses and improper use of restraints. For instance, a March 1, 2023 report substantiating a nurse for neglect found that in April 2022 the nurse ordered an individual be placed in restraints despite the fact that multiple staff reported the individual had already calmed down following the incident, and she had not observed him after the incident. Similarly, in a November 1, 2022 report, in which OIG substantiated a staff member for mental abuse occurring in November 2021, the investigation found that the staff did not follow the individual's plan and instead agitated him, resulting in him being placed in restraints. Note, the allegation was more egregious, including that the staff slapped him and threatened to put him on the ground if he kept up the "bullshit," and there was an injury report noting injuries. However, OIG found the evidence of physical abuse did not meet the evidentiary standard. Finally, in an April 13, 2023 OIG report substantiating a staff member for physical abuse in August 2019, the investigation revealed that staff (undetermined if it was one or three) held an individual down on his bed facedown, which is a dangerous restraint technique that can result in death by asphyxiation,<sup>14</sup> while a staff member struck him. Two other residents witnessed this abuse. Note, the first incident occurred on Sycamore Upper and the other two occurred on Dogwood, units that are being assessed for continued use.

A review of restraint records for the period of September 2022 through February 2023 also revealed multiple concerns.

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<sup>14</sup> See, <https://www.equipforequality.org/wp-content/uploads/2014/04/National-Review-of-Restraint-Related-Deaths-of-Adults-and-Children-with-Disabilities-The-Lethal-Consequences-of-Restraint.pdf>, p. 7.

- First, the restraint order is not individualized. The authorized length of the restraint, the release criteria, and the approved restrictive procedures (physical hold, transport device, mechanical restraint, then contraband search) were routinely the same for different individuals. Also of note, there was no justification for the routine approval of contraband searches even though an unjustified search could cause the individual to again become upset.
- Second, restraint documentation continues to provide little detail on techniques staff used to deescalate the situation prior to resorting to restraint, little to no detail about what resulted in restraints beyond “physical aggression,” and most of the descriptions did not contain an explanation of what was occurring prior to the concerning conduct. As a result, the programs for intervention, precursors and antecedents are not updated using information from each incident, and new and individualized strategies are not introduced. This is a missed opportunity to avoid restraints in the future, leaving the individual at continued risk of physical and psychological harm from this restrictive procedure and thwarting their ability to move from an isolated setting to a less restrictive and community integrated setting.
- Third, the process does not include adequate debriefing, again presenting a missed opportunity to learn more about how to avoid future restraints. A supervisor completes the first page of the debriefing form and does not include the individual or front-line staff. Also, debriefing is generally attempted with the individual within thirty minutes or less of the restraint, resulting in a debriefing process that is not meaningful or likely to result in efforts to reduce incidents that result in restraints. Relatedly, the Supplemental Report of Use of Restraint Form is often left blank, and when filled out never indicates a need for any changes to an individual’s plan or a need to hold a team meeting. This is true of the 283 restraints reviewed for the period of July 2022 through February 2023, creating the unlikely picture that there was not a single restraint incident where there was a problem that needed to be addressed or a treatment team meeting warranted.
- Fourth, during a restraint it is very important that certain safety precautions occur, including taking the individual’s vitals while in restraints. This requirement, which is part of Choate policy, is essential to monitor whether the individual is in distress that could lead to death or other serious injuries. Nonetheless, we observed multiple restraints where an individual’s vitals were not taken during the restraint, and the individual’s temperature is not listed in the order of restraint. Likewise, there were restraint reports where the personal exam was not completed in a timely manner, with the result that distress or injury from the restraint could go unnoticed and unaddressed.



- Finally, the restraint documentation was often incomplete, sometimes missing the above items, or missing times, staff names, clinical justification for the length of time authorized, missing release criteria, yet there was no indication that quality control reviews occurred. All of this persists despite OIG’s systemic review of Choate’s restraint processes and final recommendations on July 8, 2022 that the facility conduct systemic reviews of its restraint practices.

Restraints often indicate treatment failures, particularly where treatment is reactive and control based, and failing to learn from restraint incidents is a disservice and potentially harmful to individuals in Choate’s care. And, the fact that they have been used in an abusive fashion further contributes to the harmful use of this inherently dangerous technique.<sup>15</sup> That these practices continue, despite multiple opportunities to address these issues, further confirms the facility’s inability to fix this problem.

C. Continued Incidents of Staff Abuse Against Individuals at Choate, as Well as Peer-to-Peer Abuse, Leave Individuals at Risk of Physical and Emotional Harm, and Perpetuate an Environment of Fear and Coercion that is Antithetical to Therapeutic Services and Basic Human Rights.

The abuse history at Choate has been well-documented over the past two years, with multiple OIG reports exposing incidents of staff abusing residents, witnessing abuse and not intervening, or helping cover-up abuse. These problems are not new. In Equip for Equality’s 2005 report, we detailed concerns about the facility’s failure to protect individuals from harm resulting from abuse as well as its failure to adequately investigate injuries of unknown origin. We also noted that the facility maintained an environment of fear, impeding and discouraging abuse and neglect reporting, due to threatened retaliation through write-ups that result in reduced privileges, and individuals speaking candidly about their frustration about remaining at Choate, noting “numerous incidents in which staff curse at them, call them degrading names, and consistently threatening to ‘tie them up.’” At that time many requested Equip for Equality’s help to “get me out of here.”

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<sup>15</sup> As noted in Equip for Equality’s 2011 publication, *National Review of Restraint Related Deaths of Children and Adults with Disabilities: The Lethal Consequents of Restraints*: “Restraint remains one of the most controversial and dangerous measures used today in settings that provide services to people with disabilities. Restraint is an intrusive and dangerous intervention that can have significant adverse implications for the physical and emotional well-being of the individual who is restrained.” <https://www.equipforequality.org/wp-content/uploads/2014/04/National-Review-of-Restraint-Related-Deaths-of-Adults-and-Children-with-Disabilities-The-Lethal-Consequences-of-Restraint.pdf>, p. 4. As a result, it should be used sparingly with a commitment to reducing and eliminating restraints.

Likewise, DOJ's 2009 findings noted the "critical lack of oversight and supervision pervading most aspects of the care and treatment provided at Choate." (DOJ 2009, p. 3). As part of this, DOJ found that Choate was not sufficiently collecting, analyzing and synthesizing information so that administrative and clinical leadership could determine whether residents were safe and to prevent future harm.

Equip for Equality continued to receive credible reports of staff abuse as recently as an early July 2023 site visit. In total, we received reports of abuse from thirty-nine<sup>16</sup> individuals interviewed during eleven site visits from late October 2022 through early July 2023. These individuals reported experiencing staff abuse or witnessing staff abuse their peers. These abuse reports did not spare the units under review for continued use, with eight people on the dual diagnosis units (Dogwood and Redbud) and twelve people on Sycamore Lower / Upper, reporting staff abuse.

- Examples of individuals reporting abuse included:
  - During a late 2022 visit, an individual reported that a staff member came to her room, yelled at her for getting staff out of the count<sup>17</sup> after she reported abuse (and had injuries consistent with the alleged abuse), and slapped her. The individual was inconsolable while reporting this incident, stating that she feels "threatened and scared," that she cries every day, and that it "hurts my heart" to be here.
  - Another individual told an Equip for Equality monitor that she had been punched and choked while in restraints in Spring 2023. Other abuse allegations involving restraints included an individual reporting that a staff's knee was on his neck during a January 2023 restraint episode, and an individual reporting that staff choked him while he was in restraints in early July 2023.
  - In another Spring 2023 incident, an individual shared that staff threatened to put a towel around his neck while another staff laughed about it.

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<sup>16</sup> As with other interview figures, this does not include the numerous individuals who are unable to communicate their experiences to Equip for Equality. In addition, due to the well documented concerns about retaliation, there are likely others who could communicate their experiences but were unwilling to do so for fear of retaliation.

<sup>17</sup> Where there is "credible evidence" supporting the abuse allegation, the staff must be removed from having contact with individuals at the facility during the investigation(s) that follow. 59 Ill. Adm. Code 50.30(f).

- One individual reported that staff make him take cold showers if he “has behaviors or pees in bed.”
- Another individual described an early 2023 incident where he was told to go to his room without explanation and slammed his door out of frustration. In response five staff came to his room and one staff pushed him. When he responded by pushing back, he was placed in a physical hold without nurse approval.
- Examples of individuals reporting that they witnessed abuse included:
  - In early 2023 two individuals separately shared that while staff did not abuse them personally, they have witnessed current staff hit other individuals living at the facility, including with a clipboard, and a staff who punched an individual with a walker in the back. In these instances, neither wanted to be associated with reporting what they observed because they were afraid of retaliation and feared it would delay their future discharge. Two individuals separately shared during interviews at an early July 2023 site visit that they have observed staff mistreat their peers but were visibly distressed about what they witnessed and not comfortable discussing the abuse.
  - Another individual reported that staff put their hands on people and jerk them around, and arbitrarily threaten to take away their privileges.
  - In summer 2023 an individual shared that a staff person hit her twelve times with an electric cord.
- In addition to these experiences, eleven individuals expressed during October 2022 through May 2023 interviews that they were afraid of staff retaliation if they reported the incidents, including fear of additional abuse, unjustified write-ups that reduce their privileges, and interference with their progress towards discharge. Some individuals shared what they experienced or witnessed using hushed tones, supporting that they were afraid to be overheard by staff. Further related to reluctance to report, individuals shared that they are directly and negatively impacted if they report abuse because accused staff will go out of the count, leaving the unit even more short-staffed, directly impacting the individuals’ access to basic enjoyments, such as outings, going outside, and being able to talk with preferred staff who become too busy when short-staffed.
- Feelings of unease / lack of safety at the facility also stem from peer-to-peer abuse. During site visits occurring late October 2022 through early July 2023, twenty-nine individuals shared concerns about their safety in relation to

mistreatment by their peers, with twelve of them coming from Redbud and Dogwood, and seven stemming from Sycamore Lower/ Upper. For example:

- One individual shared that he had a busted lip from peer abuse in early 2023.
- Another individual shared that she feels unsafe on the unit, especially when things are “popping off.”
- A separate individual shared that peer-to-peer events are worse now than they were in around 2005.
- Six individuals complained about unwanted sexual attention from peers.
- One individual shared that observing fights between peers upsets him, resulting in him harming himself.
- Another individual shared that she keeps her hair short due to peers pulling her hair.

These more recent reports of abuse follow the uptick in substantiated OIG abuse findings from June 2021 to May 2023. There were fourteen substantiated abuse cases during this period. While some of the cases involved older incidents, three were from fiscal year 2021 and four were from fiscal year 2022. Almost 50% (six of fourteen cases) arose out of the dual diagnosis units (Redbud and Dogwood) and Sycamore Lower / Upper. In addition to the victims in these cases, it is important to recognize that in many instances there were other residents who witnessed or heard about these events, further cementing an environment of fear and coercion.

While some of these fourteen cases came to OIG with direct reporting, in three cases, the fact that OIG was even alerted to the incident was due to the actions of someone outside of the facility.

- For instance, in OIG’s reports from December 2022 (2918-0064 and 2918-0065), involving two incidents that occurred in 2017, the abuse was only investigated because an outsider called to report the incidents three months after they occurred. In one of the reports, she indicated two staff held the individual down while giving him hot sauce for their own entertainment, and also alleged that two staff gave the individual a cold shower. She further noted that he had bragged about giving people cold showers as punishment.
- As for the second incident, she reported that two staff (one short-term staff and the other a three-year employee) had fractured the shoulder of an individual who was non-verbal. In that incident, the doctor had assessed the break and

found it consistent with an accidental fall. One of the involved staff members had bragged that “there was paperwork to get around stuff when you felt like you had to defend yourself,” explaining “[p]eople fall all the time.” OIG substantiated abuse in these cases, one for the hot sauce incident and the other for the abuse that resulted in a broken shoulder. The outsider who made the report was subjected to retaliation from the abuser after Choate security staff revealed that she had made the report. Had this individual not reported these two incidents, there is no reason to believe they would have been discovered.

- In another OIG report from March 2022 (2917-0099) involving a May 2017 incident, the guardian reported the alleged abuse after her son told her that staff had punched him a few days after the incident. As a result, he was assessed and found to have two broken ribs and the staff was criminally prosecuted. Had he not told his guardian, this incident may never have been investigated.

Other cases came to OIG due to anonymous tips, including: 2915-0057 (reported two days late), 2920-0098 (reported eleven days late), and 2922-0080, again leaving open the possibility that these incidents may never have been investigated due to staff fear of retaliation for reporting allegations. In another case (2920-0001), a nurse disregarded the individual’s report of abuse, and it was only reported to OIG after he told a second nurse. In many of these cases, there were multiple staff complicit in the events, leading OIG to make facility-wide recommendations to protect individuals.<sup>18</sup>

- For instance, in OIG’s September 2022 report (2915-0057) about an almost four-year employee physically abusing an individual on **Sycamore Upper** in December 2014, the investigation established that five other staff were present during the abuse but failed to intervene or report the full extent of the individual’s injuries or the cause of those injuries. Three of those five staff had long tenures at the facility – one with twenty-three years, another with sixteen years, and the third with eleven years. Upon learning of the incident from the abuser that day, stating he just strapped in the individual and had “fucked his world up this morning” a sixth staff member replied via text message: “U guys always do.” As a result of multiple staff failing to report what they observed or knew, the individual who was badly beaten, did not receive a complete examination, including x-rays, of all his injuries until two days after the abuse occurred, following an anonymous report. OIG further cited Choate for systemic failures related to prevention and reporting of abuse, noting at least eight Choate staff colluded to obstruct the investigations or lied to cover up the abuse, while

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<sup>18</sup> See OIG’s comprehensive report on these concerns, “Reducing Abuse and Neglect at Choate Developmental Center,” issued June 9, 2023, found at: <https://www.dhs.state.il.us/page.aspx?item=152646>.

others failed to report the abuse even though multiple witnesses described his injuries as the worst they had seen. OIG explained: “Accordingly, the facility must be held responsible for failing to prevent the establishment of a culture in which so many employees chose to protect their fellow employees instead of protecting an abused individual and apparently felt comfortable doing so.”

- Likewise, in an April 2023 OIG report (2920-0001) about staff abuse on **Dogwood** in August 2019, the evidence established that two employees watched while the lead worker (a five-year employee) punched a resident in the face and failed to intervene or take any action to prevent abuse. They also did not report the witnessed abuse, nor did the nurse to whom the resident initially reported the abuse. It was only when he told a second nurse, a day later, that the incident was reported to OIG. Given that the first nurse ignored his report, it is fortunate that this resident took the step to report it to the second nurse the following day. Also of note, the doctor shared that he had heard that this lead worker was a “bad actor” and had abused residents; yet the lead worker remained in this position of authority on the unit. Finally, the investigation also uncovered falsified paperwork, suggesting that the individual had injured himself by falling consistent with the scheme noted above in OIG Case No. 2918-0064.
- Similarly, in a March 2023 OIG report (2920-0098) about a five and one-half year employee who physically and mentally abused an individual in May 2020, three trainee staff witnessed the abuse and failed to report out of fear of retaliation. Though the mental abuse included forcing the resident to stand on one of the squares on the floor in the alcove with his hands above his head for an extended period,<sup>19</sup> other staff who were identified as being in the vicinity did not admit to seeing or hearing anything. The individual was crying during this episode, and the abuser called him a “pussy” and said that the longer he cried the longer he would be there.<sup>20</sup> The basis for the staff’s ire / meting out punishment? The resident tried to ingest a food item he was not supposed to eat before her shift. The lead worker admitted he had gone into the resident’s room before that staff arrived, asking why he “did such a stupid thing,” explaining “that was how he interacted with [the resident], and that sometimes staff had to get into his face to keep his attention.” In addition, a trainee staff who observed the interaction

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<sup>19</sup> One of the trainees noted that he put his hands up without hesitation, suggesting that this was not the first time he was punished in this manner. OIG also found that the evidence supported that this type of mental abuse had occurred previously.

<sup>20</sup> Per one staff witness, the abuser staff woke up the resident at 10:40 p.m. in order to administer this punishment. Also of note, one resident witness reported that he heard the abuser staff tell the resident if he “did it one more time, he would get a cold shower.”

stated that this lead worker also said the resident “would be in trouble” when the staff (abuser) started her shift. Also, although the resident told the residential supervisor about the abuse around the day after it happened, the supervisor also failed to report it despite assuring the resident he would. After OIG receiving the late anonymous report, a nurse and doctor completed an injury report, both indicating “no apparent injury.” Yet the photo from that time “showed a healing injury to the inside right lower lip.” This again raises concerns about documentation that directly relates to resident safety. The brazen nature of this abuse (in full display of staff and residents) as well as the lead worker’s interaction with the individual, further exemplifies the coercive and untherapeutic environment that exists at this facility.

- A March 2023 OIG report (2922-0080) involved abuse that included a two and one-half year employee pouring a pitcher of water over an individual’s head in January 2022. This individual has mild intellectual disability, autistic disorder, and intermittent explosive disorder. A three and one-half year employee was present and failed to intervene, with the incident being witnessed by three residents.<sup>21</sup> A third staff, who reported the allegation anonymously, heard the resident scream after the abuser entered the room with a full pitcher of water, and next saw that the resident was wearing a soaking wet shirt that was later placed on the floor, leaving him sitting without a shirt for a couple of hours. The non-reporting staff removed the empty pitcher from the room and was the lead worker on that shift.

Staff mental or physical abuse in place of care and treatment was also a theme of substantiated OIG reports. In addition to the reports noted above:

- In a November 2022 OIG report (2022-0052), a four-year employee was substantiated for mental abuse for November 2021 conduct on **Dogwood**, after he failed to follow the individual’s behavioral plan, which required staff to ask the resident to “stop and think.” Instead, during a dispute about whether the resident was allowed to have his property (a bible) due to his supervision level, the staff got in his face and said, “every time you cannot have your own way, you want to harm people.” In response, the resident escalated, became louder, and eventually ended up in restraints. The resident and the staff only separated during this exchange because another staff intervened. Of note, the allegation

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<sup>21</sup> One of the resident witnesses noted that the abusing staff took away the victim’s toys, told him he was not getting them back, and also told him to “shut up and sit his ass down.” The reporting staff member also heard the abuser speak with the resident in this manner after the resident asked for his toys (which were expensive) and heard the other staff who had failed to intervene tell him he was not getting his “shit back.”

was even more egregious, with multiple residents reporting that they witnessed this staff physically abuse the individual both before and after he was in restraints. OIG was not able to substantiate those allegations.

- In a July 2022 OIG report (2922-0051) a two-year employee mentally abused and neglected a resident in November 2021 by refusing to allow him to use the bathroom when he needed to, which resulted in him urinating on himself. The staff directed him to clean up the urine with a mop and bucket and took the resident's notes and threw them into the bucket.
- In a July 2021 OIG report (2921-0108) a one-year employee provoked an individual resulting in a finding of physical abuse by confronting a resident about "being in other people's business" and aggressively grabbing her by the arm of her sweatshirt, which then resulted in a physical altercation between them. The staff then pulled the resident's hair. The incident occurred on **Dogwood** in December 2020.
- In a February 2022 OIG report (2920-0057) a five-year employee abused an individual by slapping her on the side of her face and telling her to "shut the fuck up" in response to her engaging in self-injurious behavior in January 2020 on **Dogwood**. Three other residents witnessed the abuse, and the resident bit her own arm in response to the abuse.

A comparison of the reports Equip for Equality routinely receives from residents (including in 2023), with the substantiated OIG reports reflects that the current level of verified abuse only touches the surface.<sup>22</sup> The combination of the cover-up culture, both individuals' and staff fear of retaliation, and many individuals with limited or no ability to adequately communicate what they have experienced, ensures that abuse often goes undetected or unsubstantiated. The numbers speak volumes on this front. For individuals who were able to express their desires, during the period of October 21, 2022 through July 5, 2023 ninety-one people told Equip for Equality that they desired to leave Choate, and there were an additional thirty-one individuals already on the community transition list at the time of the Governor's March 2023 announcement. Twenty-three of the ninety-one individuals are on Sycamore Lower, the forensic unit, and as a result have legal barriers to leaving. Thirty-six of the ninety-one individuals were on the three non-forensic units under review – Dogwood, Redbud and Sycamore Upper. Only two individuals, both of whom live on Cypress Lower, expressed a desire

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<sup>22</sup> For instance, the repeated references to "cold showers" in the OIG reports and in one of our individual interviews is of concern, as there have been no substantiated reports in at least the past few years on this topic, yet residents are referring to it as a form of "punishment" that staff are using or threatening to use.



to stay at Choate.

If the facility provides good care and individuals feel supported in a therapeutic environment, why do so many want to leave? Equip for Equality's monitoring activities and OIG's recent report make the answer clear: most residents do not feel safe or supported at Choate and remain at risk of harm, including on the dual diagnosis (Redbud and Dogwood) and Sycamore Lower / Upper units under review for continued use for individuals with developmental disabilities. As a result, these units must be closed – residents there are no safer there than on the Cedar and Cypress units that are closing and, given people's history with abuse at Choate whether directly or witnessed, Choate simply cannot offer therapeutic care given the damage already done.

D. Individuals at Choate Continue to Live in an Environment Where Their Right to Dignified, Respectful and Compassionate Care is Not Recognized or Fulfilled.

In Equip for Equality's 2005 report, we noted that Choate does not afford individuals with basic dignity, including concerns about their clothing, and concluded: "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."

These concerns continue. In fact, during resident interviews conducted from October 2022 through July 2023, a total of forty-one individuals shared concerns regarding lack of staff attention and assistance (twenty-five of whom are on the units under review), and twenty-five reported feeling disrespected by staff (sixteen of whom are on the units under review). Some examples include:

- People on multiple units stated staff ignore individuals when sharing concerns about peer-to-peer abuse.
- One individual on Dogwood shared "most staff here don't care about my situation or say they are too busy" and an individual on Redbud shared that staff say they are "too busy" when she requests assistance.
- An individual on Sycamore Lower shared "most of the time I feel lonely or depressed."
- An individual on Sycamore Upper said "no one helps," when asked if there was a staff member he likes on the unit.
- Also, we heard from people on multiple units that staff talk negatively about residents openly, including individuals who shared that staff call them names

(gay, retarded, pedophile, cuss words), many of which also constitute mental abuse.

- Individuals reported staff will say “get the fuck in the day room” (Dogwood) and tell people to “shut up” (Cedar Lower), and that staff are otherwise “reckless, out of order” (Sycamore Lower).
- Individuals on multiple units shared that some staff tease people or are rude to people.
- Likewise, on multiple units we heard reports that staff threaten people with write-ups. In one example the individual shared that staff threaten him if he does not **immediately** turn off his television after being asked to do so. Another individual shared that he is written up if he stays up late (until 11:30).
- An individual on Sycamore Lower reported that staff tell him he needs to “obey” them.

Also, during on-site monitoring activities from October 2022 through July 2023, Equip for Equality monitors observed the following issues reflecting on the lack of dignified and compassionate care:

- Individuals disrobing on the unit, or wearing clothes that expose their bodies, without staff noticing or responding.
- An individual wearing clothing that was so large that it created a fall risk without staff noticing.
- An individual wearing a shirt inside out and backwards.
- An individual reporting unmet clothing needs despite previous requests.
- An individual routinely being sent to off-site day programming wearing urine-soiled clothing.
- A 1:1 staff not knowing the individual’s name.
- Failure to consider the emotional needs of the individual who is the victim in the sexual abuse charges filed against a staff member in Spring 2022 by ignoring her transfer request until Equip for Equality became aware of it six months later during a December 2022 unit visit.

- Poor living conditions that do not lend themselves to high quality care and reflect that this population of people is somehow not deserving of something better.
  - Consistent with Equip for Equality’s observations, a February 2023 Illinois Department of Public Health (IDPH) report noted concerning environmental conditions at Choate, including bugs in light fixture boxes, heat vents covered in dust, stained ceiling tiles, missing ceiling tiles, dusty ceiling vents, rust color on the wall above the shower, black colored mold on air conditioner unit, water-stained light fixtures, and peeling paint.
- A newer staff member shared that the units were being cleaned because Equip for Equality was there and it is generally “nasty,” and that staff treat individuals served at Choate poorly.
- A long-term staff member stated that staff members need to be better role models for residents, modeling appropriate behavior through use of respectful language and not using inappropriate language.

OIG reports further showed problems in the areas of dignity and respectful and compassionate care.

- In a January 2023 OIG report (2821-0216) OIG found that a six-year employee engaged in mental abuse in May 2021 when she upset two individuals by stating in their presence: “that individuals were gay retards, jackasses, ni\*\*ers, and liars, and that individuals suck dicks and staff were having sex with individuals.”
- In a February 2023 OIG report (2922-0031) OIG found that an eight-year employee engaged in mental abuse against an individual in September 2021. In this case, the nurse came to perform a COVID test on an individual and the staff (abuser) yelled and cursed at her to get off the floor for her test and then told her to return to the floor when the test was done. This resident was naked throughout the incident. The nurse stated that the staff (abuser) said that the resident had gotten out of hand while the staff was out, and she was attempting to get her back in line. (Like in other cases, this staff further attempted to obstruct OIG’s investigation by intimidating witnesses, saying she would get them fired).
- A September 2022 OIG report (2922-0098) involved an incident discovered in March 2022 on **Redbud** whereby nurses, as a matter of ongoing and long-term practice, required individuals to dig through their own feces for inedible objects they swallowed. This practice caused emotional distress, placed their health and safety at risk, and violated Choate’s policy related to PICA. As a result of these practices, OIG cited Choate for systemically failing to provide adequate medical

care to four individuals living on this unit. That this practice existed demonstrates an inherent lack of concern and compassion for the individuals being served at Choate.

- In a March 2023 OIG report (2922-0110) involving an April 2022 incident on **Sycamore Upper**, OIG found that a nurse engaged in neglect by failing to properly assess an individual before ordering that he be placed in restraints, in that she did not see him after he was removed from the dispute (which involved the nurse) and brought to his room to calm. The investigation revealed that the resident's dispute with the nurse arose after he asked the nurse about medications with which he was not familiar, and nurse became aggravated and said "now, you pissed me off." This upset the resident, who then overturned the med cart and attempted to attack the nurse. His assigned direct staff blocked him and escorted him to his bedroom, yet the nurse ordered that he be placed in restraints even though she had not gone in his room to determine if restraints remained necessary. Per his plan, there are multiple procedures they were supposed to employ before resorting to restraints. The resident's assigned one-to-one staff as well as another staff reported that the resident was calm as the staff removed him from the dispute and walked down the hall towards his bedroom. The resident also said that when staff came in his room to apply restraints, the team leader asked why they were putting him in restraints when he was calm, and staff responded that the nurse wanted him in restraints. This was confirmed by the team leader, the lead worker, and yet another staff. Another nurse and three other staff, however, provided completely different accounts, citing behaviors to justify the use of restraints. (Note, OIG did not resolve the conflict between the staff statements, as its finding was based on the fact that the nurse did not observe him before ordering mechanical restraints be applied). In the end, it not only appears that the restraints were used in a retaliatory manner, but also that the whole incident could have been avoided if the nurse had respected his right to ask questions about his medication.

The reports Equip for Equality regularly received from individuals, as well as substantiated OIG reports, reflect a culture where individuals' rights to be treated with respect and dignity, and receive compassionate care, are not paramount. Here too, the control-based treatment practices at Choate dehumanize individuals resulting in harm. Also, as the examples above show, the dual diagnosis (Redbud and Dogwood) and Sycamore Lower / Upper units were not spared from these problems.

E. Choate Continues to Fall Short in Meeting Individuals' Medical, Monitoring and Communication Needs.

Equip for Equality's 2005 report detailed concerns related to systemic treatment failures that resulted in preventable deaths and serious injuries, including failure to

protect individuals with PICA and failure to protect individuals from sexual assault. Likewise, DOJ cited similar concerns in its 2009 report, noting that Choate's medical care was reactive and uncoordinated, treatment records were incomplete, and when one treatment option was not appropriate others were not explored. Though there has not been a notable frequency of deaths in the past few years, these problems otherwise persist.

Our October 2022 through March 2023 review of twenty-five charts revealed multiple concerns, including:

- In five of the charts there was no indication that nursing or other medical staff followed-up after individuals refused on-going medical monitoring services such as diabetic foot checks, dressing changes for wounds, insulin tests, and/or ordered procedures such as a colonoscopy.
- In seven charts there were concerns regarding dental care, including in the areas of dental hygiene, lack of documentation to support timely appointments for dental care, and/or delays in needed dental services. Regarding the latter, for instance, in one chart the individual was noted to need a tooth extracted and a root tip fixed, yet it stated Choate would wait to address this issue until it started to bother him. In another file the oral cancer screening showed a white patch on the individual's inside lower lip related to tobacco use, but the recommendation was for him to be reevaluated in another six weeks.
- In three charts there were concerns about whether the individuals were receiving adequate services related to their dietary needs. One individual diagnosed with obesity and diabetes had gained thirty pounds in the past year but was on a regular diet and did not have a fitness program. Another individual with weight gain also did not have adequate follow-up. A third individual, who had diabetes, had inconsistent records as to whether she was on a diabetic or regular diet, and there were concerns about staff improperly giving her sugary drinks as a reward.
- In two charts there were concerns about individuals' communication needs not being addressed. For instance, one individual has bilateral hearing loss, but his individual service plan does not include any assistance beyond amplification even though the individual can read and write simple words and phrases. In another file, it was not clear whether an ordered audiological exam occurred.
- Finally, in five charts there were concerns about lack of follow-up on medical issues. For instance, two individuals had no documentation suggesting that they had cardiology referrals despite annual medication reviews stating that their QT intervals needed to be monitored due to their prescribed medications. Another individual had an abnormal ECG, but there was no documentation suggesting

that there had been a referral or other consultation even though this individual had a history of heart problems. Yet another individual was referred twice for an endocrinology consult, but it was unclear from the file whether it ever occurred. For a fifth individual, he was supposed to have a HBA1C test every three months, but results for the last two tests that should have occurred (October 2022 and February 2023) were not in his file.

As part of the above problems, the charts themselves were disorganized, missing information that should have been present, and included outdated and/or inconsistent information. In addition to the above individual concerns, multiple charts included a draft individual service plan as well as service or behavior plans that did not have guardian approvals. There were multiple monthly reviews missing, and when present the monthly reviews often involved copy / paste of the prior months' information often leading to outdated and/or inaccurate information in the monthly reports. In all the charts, progress notes were sparse, with no information from multiple shifts sometimes weeks at a time, often leaving the individuals' day-to-day status undocumented. This information is important for the treatment team to identify trends and medical needs, yet no one appears to be enforcing the need for consistent documentation. Reviews of injury reports also showed on-going problems with individuals experiencing incidents of self-harm, ingesting inedible objects, as well as peer-to-peer incidents, raising concerns about the adequacy of supervision and programming. Finally, multiple charts reflected that people were not consistently working on the goals in their treatment plans.

With regard to the units under additional review for continued use, 75% of the twenty OIG cases substantiated for neglect since September 2019 arose on Redbud, Dogwood and Sycamore Lower / Upper. Some examples of the neglect findings that reflect on-going issues with meeting individuals' medical and monitoring needs include:

- In a July 2022 OIG report (2919-0102) involving a May 2019 incident on **Redbud / Dogwood**<sup>23</sup> a staff was found negligent for not supervising a resident who was showering (a requirement for his supervision level) and further allowed another individual with known maladaptive sexual behaviors go to the shower room unsupervised (also contrary to his supervision level). This was followed by the first individual alleging that the second individual raped or tried to rape him. Although the rape allegation could not be verified, the two individuals were alone together in the shower room and had conflicting stories about the nature of the sexual contact and who was the aggressor.

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<sup>23</sup> The OIG report referred to the applicable unit in this combined manner.

- In a December 2022 OIG report (2921-0126) involving a December 2020 incident on **Redbud**, a nurse engaged in neglect by failing to respond appropriately after a resident and a staff informed the nurse that the resident swallowed two nail clippers, with the nurse taking the position that the resident could not have ingested them. In response to the nurse's reaction, the resident became upset, was physically aggressive towards staff, engaged in self-injurious behavior, and was restrained. The nail clippers had to be removed surgically 46 days later. The individual was on visual observation when she ingested this object and had a history of PICA disorder. Among other things, OIG recommended that Choate do a "Focused Professional Practice Evaluation for [the doctor]" due to "non-existent documentation and failure to do proper assessments."
- In June 2021 and August 2021 OIG reports (2921-0141 and 2921-0135) involving two January 2021 failures to adequately supervise the same individual on **Dogwood**, the individual successfully ingested inedible objects (a zipper tab and paper clips) within three days of each other. Choate was substantiated for neglect in the first case and a staff was substantiated for neglect in the second case. In both cases, the individual with known PICA behaviors was able to access items that should not have been within her reach. OIG recommended that Choate review its PICA sweep procedure to determine if its procedures were sufficiently thorough. Choate's failure to adequately address the needs of individuals with PICA is a long-standing problem at the facility that continues.
- In a December 2021 OIG report (2921-0228) involving a June 2021 incident, a staff was substantiated for neglect after encouraging an individual to punch a chair when she was frustrated, leading to her obtaining a screw from the then broken chair that she later ingested. This incident was not handled in a manner that was consistent with her personal plan, which provided that staff were to prompt her to complete an "expressing emotions" worksheet when she shows signs of agitation. Further, encouraging an individual to punch a chair does not prepare them to move to a less restrictive setting, and is an inappropriate way to teach an individual to manage stress.
- In a December 2022 OIG report (2922-0062) involving a December 2021 incident on **Redbud**, a staff was substantiated for neglect after he left his backpack unattended and unsecured, allowing an individual with PICA to take two bottles containing three prescription medications. Although OIG was not able to determine whether she ingested the medication, this incident left her at risk of harm as she had an extensive history of PICA disorder and self-harm. The individual did, however, report that she had ingested the medications (three different prescriptions), yet the doctor did not deem it necessary to contact poison control.

- In a July 2022 OIG report (2922-0063) involving a December 2021 incident, a staff was cited for neglect for not providing required supervision to an individual who eloped from the unit undetected. The individual was later found outside at 3:45 a.m., naked, in December. This was a known behavior and he required special supervision as a result, yet it was unknown when he left the building. In addition, OIG noted that the facility had not followed its radio policy, with the assigned staff not having a radio to call for assistance.
- In an October 2022 OIG report (2922-0068) involving a January 2022 incident on **Redbud**, a staff was cited for neglect after he fell asleep when he was supposed to be monitoring an individual who had a history of behaviors that left her at risk. One staff and the resident, who initially confirmed that the staff was sleeping later tried to recant, but the consistent statements of another staff as well as other objective evidence supported that the staff was sleeping.
- In a December 2022 OIG report (2922-0094) involving a March 2022 incident, OIG found a staff engaged in neglect for failing to provide adequate supervision resulting in the individual using a metal paint brush to cut her wrists and ankles.
- In another December 2022 OIG report (2922-0100) involving a March 2022 incident, OIG found that a staff failed to provide required supervision while an individual who is blind and deaf was using the bathroom. As a result, the individual sustained a bruise to her left knee, a knot on her shin, a swollen left outer ankle, and a bruise on top of her left foot. Of note, although the personal plan stated that “once staff has placed her near the toilet” she “can navigate from the bathroom on the east hallway to the group room independently,” her QIDP staff said this was incorrect and that the personal plan would be revised immediately. Instead, staff were to assist her to the toilet, leave her for a few minutes, and help her back to the designated location when she is done. Of further concern, OIG recommended that the facility address falsified documentation on the bedtime check sheet, which suggested that the resident was in bed when she was actually in the bathroom where she was left unattended for about 45 minutes.
- In a June 2022 OIG report (2922-0104), involving an April 2022 incident on **Sycamore Upper** staff failed to provide required 1:1 supervision. While the individual was without supervision he assaulted another individual, resulting in a knot on the victim’s forehead and a bruise to the left corner of his eye. Also, as part of this incident, the two involved contractual staff did not have radios which contributed to supervision failure, as the staff was unable to call for relief in order to use the restroom. Choate administration was aware of the unavailability of radios before this incident occurred but did not address the problem. Specifically, OIG’s investigation noted: “Security has brought this to the attention



of Facility Director [] and the administration in the past but there has not been a response. Security also advised to Administration that radios should be assigned to each MHT upon hire and that MHT should be accountable for that radio. They were told that this process would cost a lot of money.” As a result, both Choate and the staff were cited for neglect. (Issues surrounding staff not having adequate communication abilities, then pagers, was also a problem in EFE’s 2005 report on Choate).

- In a February 2023 OIG report (2923-0015), involving a July 2022 incident on **Redbud**, OIG found staff failed to provide a resident with required same-room supervision, during which the individual managed to elope to the basement. OIG noted that a mitigating factor was that the staff was assigned to provide same-room supervision to two individuals, one of which had PICA which necessitated that she conduct a 360-degree visual observation of the room to remove any items that could be swallowed.

IDPH has also cited the facility on multiple occasions for issues involving quality of care. In its May 2022 Annual Certification Survey, IDPH had the following findings (among others):

- Failure to ensure that staff were trained on supervision levels and received ongoing training on residents’ behavior intervention programs and supervision levels to perform duties competently, negatively impacting resident care in the following situations: incident involving sexual encounter between two individuals, an individual’s suicide attempt, and an individual’s elopement.
  - As part of the peer-to-peer sexual encounter, IDPH further found Choate did not thoroughly investigate the encounter, failed to notify IDPH, there was no evidence their guardians were notified, did not complete a nursing assessment for either individual following the incident, did not update their behavior plans or supervision levels in response, and did not conduct staff training following the incident.
- Failure to implement adequate supervision and assistance during meals. For instance, one individual’s dietary orders require that she take small sips of liquid during meals (alternating sips with bites) and to take smaller bites of food. IDPH observed during an April 2022 breakfast that she placed a large amount of oatmeal on her spoon. After she finished the oatmeal, she then drank her milk. A staff was sitting at her table but provided no prompts to slow down or to take sips of milk between bites. Likewise, another individual is on a “supervised pacing program” requiring staff to encourage him to take small bites of food and chew slowly. IDPH observed two meals in April 2022, and in neither of those instances did staff prompt him to take small bites and chew slowly. Note,

complying with these types of dietary orders is essential to preventing choking, including choking deaths.

- Failure to implement an individual's behavior plan, which notes if she is engaging in self-harm staff are to determine if anything in her environment is causing increased agitation and redirect her attention to a sensory item / activity that will keep her hands busy. During the April 2022 survey, IDPH observed that the individual would slap her ears every few minutes. The staff approached the individual only twice during the almost one and one-half hour observation period and removed the individual's hands from her ears but did not offer her any type of sensory activity.
- Failure to consistently and accurately document data for active treatment programs for eight of the eight treatment files reviewed. The file reviews show inconsistencies in staff members documenting progress towards their goals, with some data missing.

IDPH's May 2022 findings were a repeat of recent findings, as well as repeated in later findings.

- For instance, in 2021, IDPH also cited the facility for multiple concerns regarding individuals' dietary needs, including failing to follow plans regarding orders dictating food consistency and dietary adaptive equipment, and failing to ensure dietary orders were easily accessible.
- A September 2022 IDPH survey found that Choate failed to take adequate action in relation to yet another peer-to-peer sexual encounter, this time involving an allegation of sexual abuse. IDPH found that Choate once again failed to conduct a thorough investigation or address one of the individual's behavior plans. In addition, it failed to ensure a physician performed a physical exam of the victim per facility protocol.
- Likewise, a May 2023 IDPH survey again found that the facility failed to take appropriate action to address inappropriate sexual behavior.

Once again, the failures in meeting individuals' medical, monitoring and communication needs are a repeat of past concerns, as verified by Equip for Equality's monitoring activities, OIG's investigations and IDPH's surveys. The people living on the units under review are not exempt from these problems and, given this long history after repeated efforts to correct them, there is no reason to believe that there can be meaningful and lasting change.

### III. Conclusion and Recommendations

Equip for Equality has engaged in intensive monitoring at Choate Developmental Center, two decades ago and the past two years, and has not seen meaningful or positive change – all to the detriment of individuals who deserve better. In our recent monitoring we heard from almost one hundred individuals who want to leave Choate and become part of their communities – mostly consisting of individuals who are not court-ordered to be there – yet they are institutionalized without being offered community options or even the opportunity to explore them.

The Department of Human Services has undertaken many efforts to address the problems raised, both back in the early 2000s and in recent years. Yet, the history of Choate, like the history of other large institutions generally, reveals that such efforts are not effective or sustainable. In addition, the SIU School of Medicine’s July 14, 2023 Phase One report does not provide an analysis of why the units subject to review should remain despite the facility’s long troubled history, nor why any individual with a developmental disability should be required to stay in a setting that has not met their needs over a long period of time and has operated in a manner that is directly contrary to their well-being. Individuals should not have to wait to see if meaningful change can occur and be sustainable – they deserve so much more.

We remain committed to working with the Department to ensure that all individuals who want to transition to the community from Choate have meaningful options consistent with their wishes, and to help ensure resident safety while repurposing efforts are underway. This must include the dual diagnosis (Redbud / Dogwood) and Sycamore Lower and Upper units. Those living arrangements have not and cannot provide therapeutic care, both due to the history of abuse and neglect on those units and the lack of specialized services being provided. Many of these individuals have significant, severe trauma histories and deserve compassionate and necessary services. Like Cedar and Cypress, the people on these units need a fresh start, with intentionally and individually designed care in the least restrictive setting possible.

Moreover, Choate administration’s response to concerns brought to their attention have often not been timely, robust, or thoughtful, and have failed to demonstrate the ability to right the ship and keep individuals safe. There is a lack of urgency, with on-site managerial and supervisory staff failing to observe the problems Equip for Equality regularly observes and receives complaints about when on the units. All of this creates the impression that there is inadequate commitment to the welfare of individuals who live there and further justifies that no units serving people with developmental disabilities remain on the Anna campus.

Equip for Equality further recommends that the Department of Human Services take the following steps:

- Immediately end new placements in all units other than Sycamore Lower (the forensic unit, and only until such time as the forensic unit can be opened in another location).
- Develop a plan to create a forensic and step-down unit in a safe environment where the individuals' service needs, including their psychological needs, can be fully addressed.
- Continue and intensify efforts to transition people from Choate to the least restrictive environment of their choosing, including individuals on the dual diagnosis units (Redbud and Dogwood) as well as individuals on the step-down unit (Sycamore Upper) who do not have legal barriers preventing their transition from an institutional setting.
- While individuals remain at Choate, implement meaningful programs and individualized treatment to ensure the provision of supports and services to both meet individuals' needs and ensure their success in the community.
- Implement OIG's recommendations as detailed in its June 9, 2023 Report, which includes the installation of security cameras, a top to bottom analysis of all processes relating to reporting abuse and neglect, review the facility's staffing levels to ensure there are an adequate number of staff to meet individual needs, comply with directives related to root cause analysis, and address resident care needs in an individualized fashion.
- Maintain on-site monitoring at Choate during this transitional period, including Equip for Equality's current monitoring activities and oversight by the Department's Division of Developmental Disabilities' SODC Operations staff and the Chief Resident Safety Officer. The Department's oversight role must include ensuring Choate administration is effectively addressing problems and implementing solutions to ensure resident safety and rights. (Our recommendations purposefully do not take a position on replacing facility leadership. While additional oversight at the facility is necessary, Choate's current problems are not new and are reflective of a culture problem that developed over the course of decades. Taking time to appoint new leadership could serve as a distraction that only delays the timely transition of all individuals with developmental disabilities away from Choate.)
- Monitoring and oversight must also include the Illinois Department of Public Health, the Centers for Medicare and Medicaid Services' state survey agency. They have previously played this role when state-operated centers have experienced problems but have not yet done so at Choate in recent years.