

**Arizona Center for Disability Law  
Public Findings From August 2006 File Review & Site Visit to  
Vista Care Residential Treatment Center  
Report Dated October 9, 2006**

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**I. INTRODUCTION**

The Arizona Center for Disability Law (“Center”) is the designated protection and advocacy system for persons with disabilities in the State of Arizona. We advocate for the rights of persons with disabilities to be free from abuse, neglect and discrimination and to have access to housing, education, health care, employment and other services in order to maximize independence and achieve equality. Specifically, the Center is authorized by the federal Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act to investigate incidents of abuse and neglect of individuals with mental illness. *See* 42 U.S.C. § 10801 *et seq.*

The Center presents the following findings and recommendations based on a site visit and file review conducted on August 17 and 18, 2006 by two staff from the Center (Michelle Michelson, staff attorney, and Melissa Tubman, staff advocate). This review follows reviews the Center conducted in February 2005 and July 2004. The current review was initiated as a continuation of the Center’s investigation into previous allegations of abuse but also in response to more recent complaints the Center received from former clients and their families as well as concerns that stem from critical incidents that were reported to the Center pursuant to state regulation during 2006.

In order to evaluate the care provided by the facility, the Center looked to federal and state regulations that apply to facilities licensed as level 1 residential treatment centers for adolescents. The Center also looked to requirements established under the Medicaid program for children under the age of 21 (known as the Early Periodic Screening Diagnostic and Treatment (EPSDT) program), as those requirements have been clarified through such law suits as J.K. v. Eden in Arizona and Rosie D. v. Romney, 410 F.Supp.2d 18 (D.Mass. 2006). The Center also relied upon the standards established by the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS). Those DBHS standards are clarified in Performance Improvement Protocols which are binding on residential treatment centers that contract with the public mental health system.

The Center staff reviewed a total of six files: four of the young people were still receiving services at Vista Care or had been discharged shortly before the review, two were female and four were male, three were in the custody of Child Protective Services (CPS) and three were not. The Center chose these six files from a total of 28 adolescents who were at the facility on three different dates between January and April 2006 when the Center requested lists of current clients. In addition to reviewing individual files, the team reviewed the following documents:

- Critical incident reports from January 2006 through August 17, 2006;
- Grievances, responses, and related investigative reports regarding grievances filed at Vista Care for the period January 2006 through August 17, 2006;

- Current Admission Criteria;
- Current Level System Positive Peer Culture (PPC) Manuals;
- Parent Orientation Guide;
- Client Orientation Handbook;
- List of Staff, Titles, and training in the Satori Alternatives to Managing Aggression (SAMA) method;
- Staffing Schedules for Behavioral Health Technicians (BHTs) for August 2006;
- Nursing Staff Schedules for August-September 2006;
- Quality Management Quarterly Site Review Reports by the Community Partnership for Southern Arizona (CPSA) for October-December 2005 and January-March 2006;
- Selected employee coaching notes, morning staffing notes, shift change records for BHTs, BHT Supervisors, and nursing staff;
- Therapist resumes;
- August 2006 Activity Schedules;
- Emergency Safety Response Report to Office of Behavioral Health Licensing (OBHL) for August 2006;
- A sampling of Vista Care's policies and procedures; and
- OBHL investigative reports relating to incidents which occurred on January 2, 2006 and April 30, 2006.

The Center appreciates the assistance it received from Vista Care's staff during the course of this review. The Center acknowledges Vista Care staff's assurances that they are in the process of reorganizing client programming, improving the functioning of the milieu, and emphasizing the use of verbal de-escalation techniques. Center staff are particularly heartened by the fact that Vista Care's management has signaled that it is open to the Center's suggestions for improving care. These findings focus on a select number of issues that relate to safety, treatment, and reporting.

## **II. SAFETY CONCERNS**

### **A. Peer-on-peer assaults**

#### **(1) Additional Baseline Staffing is Needed to Properly Supervise Clients and Implement the Facility's "Eyes On" Policy.**

A number of critical incidents call into serious question the ability of Vista Care staff to ensure client safety with the level of staffing in effect at the time of the visit. State licensing regulatory provisions clarify that clients have the right, among other things, to be free from abuse and neglect. *See* Arizona Administrative Code (A.A.C.) R9-20-203(C)(19). Additionally, agencies that provide behavioral health services to children must ensure that a child is not abused by other children while in the agency's care. *See* A.A.C. R9-20-404(A)(2)(e).

Vista Care has itself determined that it is necessary to maintain constant supervision of its clients during waking hours in order to ensure client safety. The facility refers to this as its “eyes on” policy. (There are exceptions made for privacy. For example, clients are not monitored in restrooms.) A review of incident reports and a tour of the facility left no doubt that staffing patterns did not permit Vista Care’s unit staff to implement the existing policy to keep “eyes on” clients. This fact is illustrated by documented incidents in which clients were assaulted by peers when using the quiet room. In a number of incident reports, Vista Care management noted lapses in the “eyes on” policy and suggested that the solution involved staff training and a re-emphasis of the policy. However, it is physically impossible on at least two of the three units for one staff member to simultaneously maintain visual supervision of clients in the day room and the quiet room. Nor did it appear that there were sufficient numbers of staff available at the facility to provide back up as necessary to fully implement the “eyes on” policy, particularly if clients on more than one unit at a time wanted to use a quiet room or if there were some other problem occurring on more than one unit. This deficiency appears to have been directly linked to a number of peer-on-peer assaults and incidents of sexually inappropriate conduct in the quiet room and elsewhere.

The Center appreciates Vista Care management’s openness to the need to increase staffing levels and improve staff-to-client ratios. We look forward to hearing the outcome of talks between Vista Care and its parent organization, Three Springs, regarding increasing the level of staffing on the units.

**(2) Improvement is Needed with Regard to the Communication Among Staff of Client Risks, Measures Taken to Ensure Protection from Identified Risks, and the Assignment of Additional Staff (Over Baseline Staffing) to Address Identified Risks.**

A review of critical incidents strongly suggests that Vista Care needs to improve communication between staff members regarding client risks and precautionary measures to be taken with regard to those identified risks. Vista Care staff told the Center that Vista Care was not provided full information from a referral source which would have placed Vista Care staff on alert for some of the problematic behavior reflected in critical incident reports. Nevertheless, admission assessments suggest that relevant risk factors regarding a client later accused of inappropriate conduct were known early on and could have been considered as part of the client’s treatment planning before the critical incidents occurred much less when the initial allegations of abuse surfaced. Instead, Vista Care staff dismissed initial allegations and missed the opportunity to use the information that had been gathered as part of the intake process.

Regarding precautionary measures, it appears that when allegations of physical or sexual abuse surface the practice is for staff to call the Administrator and obtain an order for a client to be placed on a higher level of supervision. However, orders for higher levels of supervision of clients were not clearly reflected in client files, shift logs, and morning staffing reports. Such orders need to be clearly communicated and documented in client files and shift change logs and in whatever other manner will ensure all necessary staff understand the heightened requirements

for supervising individual clients. Moreover, any orders for increased supervision must be reflected in accompanying orders to increase staffing levels to make increased supervision possible and real. An already overburdened staff member is not likely to consistently implement an order to “shadow” a client. A number of incidents that Vista Care previously handled with orders for “shadowing” would be more effectively addressed with orders for one-to-one staffing.

**(3) All Allegations of Abuse Must be Taken Seriously and Handled According to the Applicable Policies, Protocols, and Reporting Requirements.**

The Center strongly encourages Vista Care staff to handle allegations of abuse more consistently. The allegations of a client with questionable credibility should be taken as seriously as any other allegations and all protocols, procedures, and reporting requirements must be followed for all allegations of abuse. Unfortunately, a client whose credibility has been called into doubt in the past may be even more vulnerable to be targeted for abuse than a client with impeccable credibility.

It is particularly disturbing that a peer-to-peer incident involving allegedly sexually inappropriate behavior in early March was not documented as a critical incident. The only evidence Center staff could find that these allegations were addressed outside the client file was an investigation report in Vista Care’s internal grievance file. There is a notation in the investigation report that reports to outside entities were completed. However, no report regarding this incident was included in the collection of critical incident reports which were distributed to regulatory agencies. It does not appear that there are Morning Staffing Notes that address the incident. Nor is there any notation on the nursing, BHT, or BHT supervisor shift reports regarding the new allegation on the date following the incident (when it was reported that it was a sexual incident).

**[Redacted for public distribution:** There is no mention in the investigation report of the fact that a client alleged sexually inappropriate conduct by the same peer less than a week earlier. It is also troubling that the investigative report suggests the client was encouraged to second-guess his perception of the sexual motivation behind the incident. As it turned out, the client was more than likely correct in his perception that the assault had sexual implications. Moreover, had this incident been reported properly, it should have stood out as the second allegation of sexually inappropriate behavior by a particular client. As such, protective measures and increased oversight should have been put in place whether or not the allegations were substantiated. Unfortunately, sexually inappropriate behavior occurred on at least two more occasions before sufficient preventive steps were taken.]

**(4) Adequate Steps Must Be Taken to Protect a Client Who is Repeatedly Targeted by Peers.**

There is a failure to respond adequately to situations in which one client is the target of repeated abuse. Incident reports demonstrate that particular clients have endured persistent abuse by peers. Documentation suggests a troubling pattern of blaming a client who was being repeatedly victimized for provoking assaultive behavior. It is incumbent on Vista Care to develop viable solutions that ensure client safety.

## **B. Staff Training Regarding the Use and Mis-use of Emergency Safety Responses**

### **(1) Incident Reports Reflect a Lack of Training on the Part of Staff Regarding De-escalation and the Safe Use of Physical Holds as Well as a Lack of Candor About Events Surrounding One Significant Incident.**

Two incidents which occurred in January 2006 and in April 2006, respectively, strongly suggest that the staff involved lacked adequate training to handle difficult behavioral situations.

#### **(a) January 2006 Incident**

With respect to the January 2006 incident, a BHT violated a client's rights when he engaged in a verbal altercation with the client, grabbed the client by the shirt (or possibly by the neck), and pushed or threw the client up against a wall. The nurse on shift directed the BHT who used physical force to leave the facility. The client reportedly continued to act out and was physically restrained by another BHT. The client de-escalated and was allowed to return to his unit. Once there, the client was not closely supervised and was on his unit with only a maintenance worker present in the immediate area. When the client's behavior escalated again, the maintenance worker attempted to verbally de-escalate the client himself (rather than call for assistance) and then proceeded to physically restrain the client himself. Other staff intervened and calmed the client. The facility called the Sheriff's department, and the client was transported by law enforcement to the hospital for evaluation and then to detention.

Vista Care took the appropriate step of terminating the aggressive BHT's employment following the incident. However, it is troubling that other staff did not intervene to stop the verbal altercation before the BHT placed his hands on the client and the client's behavior escalated further.

The Center also notes with extreme concern evidence of a lack of candor in documentation and reporting regarding this incident. First, the nursing progress note regarding the incident wholly fails to mention that a BHT behaved improperly during the incident (much less violently). The nursing progress note also inaccurately records the actions of the maintenance worker as those of a "BHT." Second, Vista Care failed to include a full description of the series of event in the mandated incident report. The incident report, while containing a more forthright version of events than is included in the nursing progress note, (1) failed to accurately report the severity of the violent conduct of the BHT, and (2) failed to mention that the "staff" who attempted to verbally de-escalate the client on the unit and who performed a

SAMA physical hold was a maintenance worker rather than behavioral health staff. With regard to the failure to fully report the nature of the BHT's use of force, the incident report notes the BHT "pushed non-complaint client toward basketball court" whereas the OBHL investigator was told the BHT grabbed the client by his shirt (or neck) and pushed (or threw) him up against a wall. Moreover, there is no clear documentation in the file that the maintenance worker physically restrained the client.

Such inconsistencies and selective documentation and sharing of facts undermines the trust that is required in a system that relies heavily on self-reporting by facilities. The Center strongly encourages Vista Care to ensure complete and honest reporting in all progress notes and reports.

The Center notes that maintenance workers at Vista Care are listed as being trained in the SAMA de-escalation and physical hold techniques. The Center emphasizes that it violates state licensing regulations for maintenance workers to engage in behavioral interventions. Further, state regulations specify that emergency safety responses can only be used by a "staff member" and the term staff member is defined as "an individual who is employed by or under contract with a licensee to provide behavioral health services to an agency client and who is a: (a) Behavioral health professional, (b) Behavioral health technician, or (c) Behavioral health paraprofessional." A.A.C. R9-20-216 and R9-20-101(152).

The Office of Behavioral Health Licensing found that Vista Care violated A.A.C. R9-20-203(C)(19)(a) when it failed to ensure the client was free from abuse with regard to the BHT's aggressive conduct, assessed a \$500 penalty against the facility, and required an enforcement action plan of correction. OBHL also found, as a factual matter, that a maintenance worker physically restrained a child at the facility. Nevertheless, OBHL did not substantiate a licensing violation with regard to the maintenance worker's improper involvement. The OBHL investigation report states: "A review of the incident report revealed the maintenance worker was not requested to assist in controlling the behavior of the [client]. Instead, he was on the scene attempting to disarm the fire alarm that had been set off by the client."

Whether or not Vista Care directly requested the maintenance worker to control the client, the conduct constitutes a violation. Moreover, Vista Care had trained the maintenance worker in the use of physical holds, had apparently not trained the maintenance worker that he was not to actually use physical holds, and had left an agitated client in an area where the only staff around was the maintenance worker. It is particularly disturbing that the OBHL investigator referred back to the incident report for proof that Vista Care had not behaved improperly. The incident report lacks credibility particularly on this point because it does not even mention that the maintenance worker performed any behavioral interventions. Furthermore, any situation in which a maintenance worker felt the need to do anything other than maintenance work strongly indicates a serious problem with under-staffing (or at the very least staffing allocation).

The Center hopes that in the future OBHL will not back away from substantiating clear violations of the regulations it is charged with enforcing. In this instance OBHL had an obligation to substantiate a violation with regard to the maintenance worker's use of a physical restraint. If it had done so, OBHL would have been able to address the issue directly in a corrective action plan. Instead, OBHL sent the negative message that the facility was not liable for the violation because it had not directly ordered its staff to violate the regulations. That is not and cannot be the standard. Additionally, the investigator must have been aware of the lack of candor in the nursing progress note and in the incident report. OBHL cannot look the other way when confronted with such inaccuracies.

It is extremely unfortunate that this series of mis-handled interventions ultimately led to the client being discharged to a juvenile detention facility. Such an outcome directly conflicts with ADHS/DBHS's direction to avoid inappropriate uses of law enforcement and the criminal justice system. *See Practice Improvement Protocol (PIP) 14, Out of Home Care Services, Service Guideline No. 11, ADHS/DBHS (effective March 9, 2005).*

#### **(b) April 2006 Incident**

During an incident that occurred in April 2006, Vista Care staff members responded to clients' unruly behavior by violating numerous regulations and guidelines regarding the use of Emergency Safety Responses and physical holds. One staff member, who left the facility immediately after the incident and did not return, dragged a client across the floor by the client's feet, pinned a client against a wall by placing his forearm across the client's neck, placed his hands around a client's neck, yelled obscenities and threats, and assaulted a co-worker in the process. The most disturbing aspect of the incident was that the two other BHTs did not respond appropriately to the misconduct of their co-worker until he assaulted a BHT. In an attachment to the critical incident report, Vista Care's Administrator stated that all staff would be re-trained on removing clients from potentially escalating situations and that all staff would be re-trained on abuse recognition and the use of "tapping out" a co-worker who is behaving improperly. The Center supports this focus on re-training. The severity of the lapses that occurred on April 30<sup>th</sup> suggest that extensive rather than spot training is required. The Center strongly encourages Vista Care to institute frequent, regular and on-going training for all behavioral health staff in abuse recognition, "tapping out" procedures, and situations that require calling in additional staff.

OBHL also investigated the April 30, 2006 incident. Inexplicably, the investigator did not substantiate a violation of A.A.C. R9-20-203(C)(19)(a) for failing to ensure clients were free from abuse. The reason given was that there were no indicators to predict that the worst-offending BHT would display such explosive behavior. However, there were numerous regulatory violations wrapped into this one extreme incident and they were not all committed by the assaultive BHT. For example, another BHT also admittedly used an improper physical hold and did not intervene or call for help when he witnessed the first BHT using extremely dangerous physical methods, including placing his arm against a client's throat. OBHL was

obligated to substantiate regulatory violations in this instance and to work with the facility to resolve the multiple problems that set the stage for this event.

**(2) Vista Care Should Document the Use of Emergency Safety Responses More Clearly in Client Files.**

Center staff did not find clear documentation of the use of Emergency Safety Responses in client files. With regard to the client file, it appears that ESRs are mentioned in progress notes; however, client files do not appear to contain the type of information that Vista Care is mandated to maintain regarding each ESR. Of course, Vista Care appears to be submitting Emergency Safety Response Reports to OBHL as required by A.A.C. R9-20-216. Nevertheless, from the perspective of treatment teams, parents and guardians it would be helpful to maintain and track such information in the client file. Moreover, Vista Care staff could include greater detail and depth regarding the precipitating factors and outcomes of particular incidents in client files than is currently being done in the OBHL report. The Center recommends that Vista Care adopt a form for documenting each ESR, maintain those forms in client files, and address the use of ESRs with the child's CFT.

It is very positive that Vista Care has reduced its use of Emergency Safety Responses. The Center urges Vista Care to continue to reduce its reliance on hands-on interventions. With regard to clients who have experienced numerous Emergency Safety Responses, the Center strongly recommends that Vista Care bring in a behavioral specialist to review clients' treatment plans and develop constructive behavioral plans. Additionally, Vista Care must direct all non-behavioral health staff to refrain from performing Emergency Safety Responses. Non-behavioral health staff should never be alone with clients and must be trained to call for help immediately if they become aware of a client in crisis.

**C. Vista Care Should Ensure that Clients on All Units Have Access to a Telephone That Allows for Private Communication.**

Center staff were concerned that only one unit had a current arrangement that would allow clients to make private telephone calls. Clients are afforded the right to privacy in communication pursuant to A.A.C. R9-20-203(C)(29)(c). State regulations also afford clients the right to reasonable access to telephones to make and receive confidential calls. *See* A.A.C. R9-20-203(B) (incorporating the rights set forth in A.R.S. § 36-514). *See also* Practice Improvement Protocol 14, Out of Home Care Services, Service Guideline No. 12, ADHS/DBHS (effective March 9, 2005). The Center recommends that Vista Care take the necessary steps to equip each unit with a telephone that will allow clients to make private calls rather than calls from the nurses' station.

**III. TREATMENT ISSUES**

**A. Prescribers and Nursing Staff**

At the time of the review, Vista Care was understaffed with regard to behavioral health prescribing clinicians. The only prescriber employed at Vista Care at the time of the Center's visit was Kim Greenwood, a nurse practitioner who is on-site Mondays and Fridays. Fortunately, Vista Care recently hired a board certified child and adolescent psychiatrist to be the new Medical Director at the facility. The Center congratulates Vista Care on this hire and welcomes the new Medical Director.

CPSA noted in its quality management report dated April 5, 2006 that the clinical records CPSA staff reviewed did not demonstrate collaborative efforts between the psychiatric nurse practitioner and the medical director (prior to the medical director's resignation). CPSA's Action Plan required Vista Care to formulate a definition of behavioral health prescribing clinician collaboration. Vista Care formulated a Standard Operating Procedure for Prescribing Practitioners which calls for oversight by a Medical Director and which states that a Child and Adolescent Psychiatrist will review the competencies, collaborate and discuss medication management and rationale with the prescribing psychiatric practitioner on a bi-weekly basis. The Center is hopeful that Vista Care will now be able to meet its requirements for collaboration and oversight.

The Center nevertheless urges Vista Care to remain mindful of the need to ensure that there is sufficient coverage by prescribing clinicians to meet client needs in light of the fact that Vista Care is steadily increasing its census. It also appears that Vista Care may be approaching a number of clients that will require additional nursing staff. The Center strongly advises Vista Care to avoid increasing the census of clients at the facility without ensuring a commensurate increase in medical staff.

#### **B. Client Files Reviewed Lacked Adequate Crisis Plans and De-escalation Plans.**

In a letter dated August 7, 2006, CPSA's quality management team recommended that Vista Care complete a real-time crisis plan for each client based on the individual's needs and behavior. The Center concurs that individualized, real-time crisis plans are needed. Such individualized plans are required by the J.K. v. Eden Settlement Agreement, the corresponding Arizona Vision and Twelve Principles, and the practice improvement requirements that flow from the Settlement.

The Center emphasizes that a generic plan which instructs clinicians or family members to call law enforcement in a crisis is not an individualized crisis plan. In the files reviewed, the Center either found no crisis plans or crisis plans which failed to present alternatives to calling 911. This conflicts with the specific requirements set forth by ADHS/DBHS:

“The [Child and Family Team] CFT should work with the provider to anticipate crises that might develop, and devise specific strategies to prevent and address them. In recognition of the behavioral health system's principled commitment to

avoiding delinquency, inappropriate uses of law enforcement and criminal justice systems must be avoided, and policies must be developed to inform all decisions to engage them.

***Service expectation for providers: All service plans will include a crisis plan that will address alternatives to law enforcement involvement and the avoidance of restraints and seclusions. Provider policies will be reviewed to align with this expectation. If an out of home placement is interrupted by hospitalization or arrest, the provider will pursue every opportunity to ensure the child's return to that same residence."***

Practice Improvement Protocol 14, Out of Home Care Services, Service Guideline Nos. 11, ADHS/DBHS (effective March 9, 2005)(emphasis in original). *See also* PIP 14 at Service Guideline 12. The PIP implements the requirements outlined in the J.K. v. Eden Settlement.

Thus, the Center strongly encourages Vista Care to develop individualized crisis/de-escalation plans that identify an individual's triggers, helpful self-care activities, the types of support a specific individual finds helpful to avert crises, mental health crisis resources, and the types of approaches by behavioral health staff that clearly do not help the individual in a crisis situation.

### **C. Client Files Raised Concerns Regarding Uneven Trauma Treatment.**

A history of trauma was evident in all of the client files reviewed. However, notes in the files suggest that the level and quality of treatment for trauma were uneven. The Center recommends that Vista Care place a greater emphasis on identifying individual clients' need for trauma-related therapy and on matching clients with such a need with a therapist that has a specialization in the area. As ADHS/DBHS' Performance Improvement Protocol 14 states, treatment and therapeutic interventions must be highly individualized to the individual child's needs. *See* Practice Improvement Protocol 14, Out of Home Care Services, Service Guideline No. 7, ADHS/DBHS (effective March 9, 2005). Moreover, under the EPSDT Medicaid program, each Title XIX-eligible child at Vista Care is entitled to the medically necessary services that will provide the maximum reduction of a mental disability and restoration of that individual to the best possible functional level. *See Rosie D. v. Romney*, 410 F.Supp.2d 18 (D.Mass. 2006). The provision of a type of counseling that is not targeted to the child's needs does not meet this mandate.

More generally, of five therapists on staff, four are masters level clinicians. One employee functioning as a therapist does not have a masters-level degree. The Center encourages Vista Care to ensure that all therapists have masters-level credentials.

### **D. The Center Encourages Vista Care to Clearly Document the Communication of Discharge Criteria to Clients as Well as Whether Identified Goals Were Achieved.**

The Center recommends that discharge criteria should be concrete, understandable to the child, and stable, not changing throughout the child's stay. Each child should know from the beginning what they are expected to achieve in order to successfully leave Vista Care. There was little evidence in the files reviewed that clear individualized discharge criteria had been communicated to clients. Nor did a number of files contain clear information regarding which goals a client had accomplished by the time of discharge. Similarly, some treatment plans in files reviewed were not signed by the client or parent which suggests a lack of a collaborative approach to treatment planning. Clearly identified goals and discharge criteria are required by the EPSDT Medicaid program, the J.K. v. Eden Settlement, and specifically by Performance Improvement Protocol 14, Out of Home Care Services.

#### **IV. REPORTING**

##### **A. Reportable Incidents**

The Center recognizes that many Vista Care staff members make a strong effort to report incidents in a consistent manner. However, the examples of incidents that were not reported properly suggest the need for improved training regarding reporting requirements and, specifically, the need to strongly emphasize the point that staff must report all allegations, whether or not Vista Care staff believe the allegations have merit.

In Section II(B)(1) above, the Center sets forth its serious concerns regarding the lack of candor in both the nursing progress note and the incident report that document an incident that occurred in January 2006. All incident reports must contain a full and forthright description of the events surrounding the incident. Additionally, Vista Care should identify in its incident reports each staff member involved in the incident.

An incident which occurred in late February 2006 that involved an allegation of sexual harassment of a client by a staff member (the staff member admitted to making an inappropriate statement) should have been reported to the Center. On a positive note, the incident report appears to have been sent to CPSA, OBHL, the Sheriff's Department, CPS, and the case management agency. Nevertheless, pursuant to A.A.C. R9-20-202(B)(2), a level 1 RTC must report "[s]uspected or alleged abuse, neglect, or exploitation of the client or a violation of the client's rights under R9-20-203(B) or (C)" to the Center within one working day. An allegation of sexual harassment by a staff member constitutes both an allegation of abuse and an allegation of a rights violation.

Another incident that occurred in late February 2006 involved peer-to-peer sexually inappropriate behavior. This incident was reported to OBHL and CPS but not to the Center. In light of recent problems addressing peer-to-peer inappropriate conduct, the Center requests that Vista Care provide incident reports to the Center regarding all peer-on-peer allegations of sexual abuse. At a minimum, Vista Care must report incidents of peer abuse to the Center when either the alleged victim or alleged perpetrator is involved in a second allegation of peer abuse.

An incident that occurred in early March 2006 involved allegations of sexually inappropriate conduct. The incident was documented only in the grievance file though it should have been documented as a critical incident and the reports should have been distributed accordingly. Vista Care should have sent a copy to the Center because it represented an allegation of repeated peer abuse. It was not sufficient that Vista Care investigated the incident internally as part of its grievance procedure. This is a significant reporting error.

The Shift Log for a date in late April 2006 reflects an incident that involved self-harm by a client which led Vista Care staff to call the Sheriff's Department and the Fire Department. It appears that this incident should have been reported, at the very least, to OBHL and the Center pursuant to A.A.C. R9-20-202 as a suicide attempt or self-inflicted injury that required immediate intervention by an emergency response team. However, Center staff did not locate a critical incident report regarding this incident.

The grievance file also reflects that a client reported that he had been abused by a staff member in mid-June 2006. Vista Care staff investigated the allegation, concluded that no abuse actually occurred, and submitted the report to Vista Care's ethics committee. However, the reporting regulations require Vista Care to report alleged abuse. Whether or not Vista Care staff substantiate or do not substantiate the allegations, allegations of abuse by staff members need to be reported to all the appropriate outside entities, including the Center.

Finally, A.A.C. R9-20-202 requires Vista Care to provide the Center with incident reports within one working day of the occurrence of the incident. Many incident reports document that Vista Care does not regularly adhere to this time frame and that, in fact, there has often been a time lapse between the time when incident reports are submitted to other outside agencies and the time when reports are submitted to the Center.

## **V. REVIEW OF CLIENT MANUALS AND ORIENTATION GUIDES**

### **(1) The Positive Peer Culture (PPC) Manuals and the Level System Require Revision**

#### **(a) Permission to Speak with Staff Other than Floor Staff**

With regard to the Positive Peer Culture Manuals, the Center recommends that Vista Care remove the "Daily Living Norm" that states: "We will ask permission of our floor staff to speak with all other staff." See page 6 of the PPC. Such a policy could potentially inhibit a client from approaching the staff member with whom he or she is most comfortable to share sensitive information.

#### **(b) Clarify "Time Out" Consequence in Manual**

Regarding the "Time out" consequence described on page 11 of the PPC, the Center requests an explanation regarding how Vista Care ensures that such a consequence is applied in

accordance with A.A.C. R9-20-215.

### **(c) Allow Children to Personalize Environment and Wear Personal Clothing**

The Center also recommends that Vista Care revise the part of the level system that requires clients to earn the privilege of displaying pictures and decorative items in their rooms. Such a policy violates the state licensing regulation that gives clients the right “[t]o maintain, display, and use personal belongings, including clothing, unless restricted by court order or according to A.R.S. § 36-507(5) and as documented in the client record.” A.A.C. R9-20-203(C)(29)(e). Additionally, the practice violates the requirement adopted by ADHS/DBHS that out of home settings must provide as natural and home-like an environment as possible. *See* PIP 14, Out of Home Care Services, Service Guideline No. 12, ADHS/DBHS (effective March 9, 2005). The Out of Home Care Services PIP states that “experiences that reflect normalcy should not have to be earned, and should not be restricted unless there is a clear clinical justification and strategic goals outlined in the service plan for doing so.” Specifically, the PIP states: “Children should be able to appropriately personalize their environment to reflect their tastes, culture, preferences and interests.” Under the current level system, clients on the Orientation level are prohibited from displaying any pictures or decorations, clients on the Peer level are allowed to display only one picture (preferably of family), clients on the Community level are allowed an additional picture or small poster and two decorative items, clients on the Trust level are allowed additional decorative items, and clients on the Honors level “[m]ay decorate room tactfully.” In accordance with ADHS/DBHS policy, all clients should be allowed to decorate their rooms with the only limits being tact and safety unless there is some well defined, documented, and individualized clinical justification for a limitation. Likewise, Vista Care should not require children to earn the privilege of wearing a watch or small religious necklace unless there is some individualized clinical basis for doing so.

Similarly, the Center recommends that Vista Care revise its policy requiring clients to wear clothing issued by Vista Care. As noted above, A.A.C. R9-20-203(C)(29)(e) gives clients in residential facilities the right to wear their personal clothing and references A.R.S. § 36-507(5) which also states that a client “[m]ay wear the person’s own clothing” unless the director of the agency makes a written, individualized determination in the client’s record to the contrary for the purpose of protecting the safety of the client or others.

## **(2) Parent and Client Orientation Guides**

### **(a) The Center Requests that Vista Care Include Information for Parents Regarding the Center’s Monitoring Activities.**

First, the Center requests that Vista Care include the following paragraph in the Parent Orientation Guide:

“The Arizona Center for Disability Law (Center) is the designated protection and

advocacy system for persons with disabilities in the State of Arizona. The Center is authorized by the federal Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act to monitor conditions in psychiatric facilities and investigate incidents of abuse and neglect of individuals with mental illness. *See* 42 U.S.C. § 10801 *et seq.* It is possible that during your child's stay at Vista Care, staff from the Center may visit the facility. According to federal law, Center staff may talk with children in facilities without the consent of a parent or legal guardian. However, the Center will not look at your child's clinical records, take any formal action on behalf of your child, or initiate a formal attorney/client relationship without consent from a parent or guardian. The Center may only review a child's medical record without the consent of a parent or guardian if the child is a ward of the state or if there is an emergency situation."

**(b) The Center's Toll Free Number Should be Included in the Orientation Guides.**

Where the Parent and Client Orientation Guides list the Center's telephone number, please include the toll-free number for the Center's Phoenix office, (800) 927-2260.

**(c) Vista Care Should Revise Language That Suggests Parents Should Disregard Clients' Reports of Feeling Unsafe.**

The Center is happy to see that Vista Care no longer limits contact between adolescents and their family members during the initial period after admission. However, the Center is still troubled by the following language: "During your first call your child may...tell you he/she feels unsafe, in an attempt to get out of treatment. This may be very difficult for both you and your child."

The Center reiterates the recommendation made in March 2005 that client reports of feeling unsafe should be viewed as providing important information to families and to Vista Care staff. Parents should be advised to treat such reports seriously and to follow up on their children's stated concerns. Whether or not such reports are unfounded, they present an opportunity for clients (many of whom have trauma-related issues) to see their parents take their concerns seriously and take steps to ensure their safety. It bears repeating that not all client reports of feeling unsafe are unfounded. Incidents discussed in this as well as in earlier findings report underline that fact. Rather than suggest that parents should ignore reports that their children feel unsafe, the Center suggests that Vista Care take the opportunity in this section of the Parent Orientation Guide to advise parents of Vista Care's policy for dealing with Parent/Guardian Concerns, refer to the Client Grievance Process (mentioned elsewhere in the Parent Orientation Guide), and refer to the list of outside entities that can investigate complaints (including the Arizona Center for Disability Law).

**(d) Vista Care Should Revise and Clarify Information Regarding Grievance Procedures.**

First, the Center recommends that Vista Care include information regarding filing complaints with ADHS/DBHS as well as with OBHL on page 12 of the Parent Guide and page 10 of the Client Guide. Second, within this section of each guide, Vista Care suggests that parents and clients can contact state regulatory agencies “if they are not satisfied with Vista Springs’ grievance decision(s).” The Center recommends that Vista Care clarify for both parents and clients that they are free to file grievances directly with OBHL, can file complaints with DBHS, and can file appeals or grievances with AHCCCS without waiting for a decision from Vista Care. While Vista Care may choose to encourage parents and clients to file complaints internally, the facility should not in any way suggest that the internal procedure must be utilized first.

## **VI. SUMMARY**

In summary, the Center makes the following recommendations:

1. Increase the staffing and staff-to-client ratios on the units and increase the number of staff members available to provide back up as needed.
2. Improve communication among staff regarding information about potential risks of peer abuse.
3. Improve communication among staff and documentation regarding heightened staffing expectations to address identified risks.
4. Re-train all staff to consistently report all allegations of abuse consistent with regulation and policy, not only those allegations that Vista Care staff deem to have merit. Ensure that all documentation of allegations of abuse are complete and contain a full description of the events surrounding the alleged incident and identify all staff involved by name and title.
5. Ensure that adequate steps are taken to protect clients who are being repeatedly targeted by peers.
6. Continue to train all behavioral health staff regularly and frequently in de-escalation techniques, abuse recognition, “tapping out” procedures, and recognition of situations that require back-up staffing.
7. Document the use of Emergency Safety Responses more clearly in client files and continue to decrease the use of these hands-on responses. Bring in behavioral specialists to create constructive behavioral plans for those clients that have repeated Emergency Safety Responses. Instruct non-behavioral health staff not to perform Emergency Safety Responses and do not place non-behavioral health staff in settings where they are alone

with clients.

8. Ensure that each unit is equipped with a telephone that can be used for private communication.
9. Ensure that the required collaboration and oversight takes place for all clinical prescribing staff and that the coverage of prescribers and nursing staff keeps pace with the client census.
10. Develop individualized, real-time crisis and de-escalation plans for each client that do not rely on law enforcement interventions.
11. Improve the process of determining whether clients need trauma-related treatment and ensure that clients have access to masters-level therapists with training and experience in treating trauma.
12. Revise client manuals, parent and client orientation guides, and the level system policies as noted in the pertinent section above.

The Center looks forward to receiving Vista Care's response to these recommendations.

Finally, the Center encourages ADHS/DBHS to either direct CPSA to continue to conduct quarterly site reviews of Vista Care's program or to undertake quarterly reviews itself. The Center is informed that CPSA has requested permission from DBHS/ADHS to reduce its site reviews from a quarterly basis to an annual basis. The Center believes it is not advisable to reduce oversight at this time, especially in light of the fact that Vista Care is steadily increasing its census. The Center proposes that DBHS pay increased attention to patterns in incident reports, client supervision, staffing levels and ratios, and staff training.