***Committee Members Present:***

Mr. Edward Barlow, Chair

Ms. Jean Grim, Vice Chair

Mr. Carlton Starke

Mr. Steve Pories

Mr. Daniel Moore (Absent)

Ms. Sequoya Willis

***Human Rights Advocate***

Taneika Goldman

**Crater LHRC Secretary**

Ms. Fabri D. Claiborne

***Affiliates Present:***

*Adult Activity Services – James Scott*

*Benchmark Residential Services – Clarence Dilworth*

*Dan-Poe-Dil, Inc. – Clarence Dilworth*

*Happy Home Counseling Services – Quinn Wilson*

*JC HomeLife – Keith Blom, Rodarneek Om*

*New Beginning, Inc. – Marilyn Newby*

*Phoenix and Peace – Marilyn Newby*

*Progressive Adult Rehabilitation Center, Inc. – Felecia Daniels*

*Pryor House – Jeronica Page*

*T’Lab – Janine Johnson*

*TruCare Homes, LLC – Simone Johnson, Shawnda Williams*

*DePaul Community Resources – Peggy Ball*

*John Randolph Medical Center – Mark Smallacombe*

*Live 4 Life, Inc. – Jason Jackson*

*Visions Family Services, Inc. – Michael Nichols, Colettia T*

*Lea and Associates – Joy DuVal*

 *Compass Counseling – Chris Ruhlan, Carolyn Ruhlan*

1. ***Call to Order***

A quorum being present, ,Chair, Edward Barlow called the Crater Local Human Rights Committee meeting to order at 5:35 PM at Taylor-Starkewood Enterprises 589 S. Crater Road, Petersburg, Virginia.

1. ***Public Comments:***

None

1. ***Approval of Minutes***

A motion was made and seconded to approve the minutes of the Thursday, October 10, 2013 meeting with amendments. Ayes: Carlton Starke, seconded Steve Pories.

Amendments made to the January 9, 2014 minutes are as follows:

Under Advocate Comments- please add-Annual LHRC Report due to Advocate by 1/15/2014 and Annual Restraint Data due to Mary Clair O’Hara in Central Office also by 1/15/14.

Under TruCare’s Affiliate Report add-“presented proposal for curfew, deferred to subcommittee for review”

\*for the 4/10/14 minutes please be sure to capture that TruCare rescinded their proposed curfew and accepted LHRC counsel about attention to individualized behavior supports vs. general restrictive plans.

Under closed session add- “motion to accept appropriate use of medical/protective devices for 15 named individuals served by DePaul Community Resources. Ayes Carlton Starke, second Daniel Moore. And motion to appoint Next Friend Gloria Greene for two named individuals served by Phoenix-N-Peace. Ayes Carlton Starke, second Daniel Moore.

1. ***Advocate’s Comments***

Mrs. Goldman reviewed administrative changes that occurred within the Central Office. She also reminded the affiliates that the CHRIS Annual Report was due to the Central Office by December 15, 2013. The Annual Report may be submitted using the old form, there is a new form for the Quarterly Report. Lastly, new members are needed for the LHRC.

1. ***Old Business***

The third Quarterly Report for Southside Regional Medical Center was reviewed and approved. Ayes: Carlton Starke, seconded Daniel Moore.

1. ***New Business***

Mr. Edward Barlow has submitted his resignation as Chairperson, effective immediately.

1. ***Program Expansion/Affiliation Request***
	* DuPaul Community Resource

A motion to accept the new sponsored home affiliations of DuPaul Community Resource was made by Sequoya Willis and seconded by Carlton Starke.

* + J.C. Homelife

 A motion to accept the program expansion of J.C. Homelife was made by Steve Pories and seconded by Carlton Starke.

1. ***Event Report Statistics***

Reports from each provider on events occurring during the reporting period of

January 1, 2014 – March 31, 2014

1. **Adult Activity Services** –

No incidents to report

1. **Benchmark Residential Services**

**Carson House**

No incidents to report

1. **Compass Counseling Services of Northern Virginia**

No incidents to report.

1. **Dan-Poe-Dil**

**Wedgewood House**

**Serious Injury/Death Report**: March 21, 2014, client SM returned home from day support and it was noted that he had abrasions on his left leg below the knee. He stated that he had fallen. Day support was contacted and they stated they had no knowledge of the injury. The injury looked like it may need medical treatment; therefore, he was transported by residential staff to the emergency room at Southside Regional Medical Center. His leg was x-rayed and it was determined that nothing was broken. His injury was cleaned and bandaged by hospital staff and he was released that day.

**Church Road House**

No activity to report

**Fairway House**

No incidents to report.

1. **DePaul Community Resources**

On March 23, 2014, the client was taken to the emergency room due to having seizure, coughing, vomiting and breathing a little fast. The physicians indicated he had a touch of pneumonia. Blood work, x-ray and an exam was conducted and he was sent home after breathing was stabilized.

On March 24, 2014, there was an error in administering medication due to individual being treated at the ER 7:00pm to 4:00am. The client displayed physical aggressive behavior toward the care providers and destruction of property. After hours of aggression, the client was finally stabilized in order to be safely transported to Southside Regional Medical Center.

1. **Happy Home Counseling**

No activity to report.

1. **JC Homelife**

No activity to report.

1. **John Randolph Medical Center** –

**Occurrence 1**: VERBAL ABUSE: March 14, 2014, a male consumer got into verbal altercation with male staff member who used inappropriate language and called the patient expletives during the argument. This was confirmed by other staff members. Upon investigation it was determined that the abuse was founded due to the employees own personal admission. This Staff member was terminated.

**Occurrence 2:** Physical Abuse: March 14, 2014, a male consumer was standing near elevator combing his hair and talking to a female staff member who was on the elevator waiting for the door to close. While talking to the female staff member, another staff member (male) came up to the consumer and wrapped an arm around the consumer taking him to the floor (unprovoked). It was determined that the abuse did in fact occur and this employee was terminated.

**Occurrence 3:** Sexual Abuse: March 13, 2014, a female consumer reported that a male staff member inappropriately touched her. She stated that she was in the solarium and he asked her to leave and touched her shoulder and back. Upon investigation the consumer was in a verbal altercation with another peer in the day room when the male MHT asked the female consumer to leave the room. At that time the staff member grabbed a box of crayons and carried them out for her. According to eye witnesses to the event, the staff member never touched the female consumer at any point. This allegation was unfounded.

**Occurrence 4**: Neglect (medication error): March 13, 2014, it was discovered that the physician ordered Tramadol 25mg. The pharmacy entered the order in the computer as Tramadol 50mg in error. The nurse noted the medication off after it was entered in the system as correct. As a result, the consumer received 6 doses of the incorrect strength before it was discovered by the physician. The nurse who noted this order was placed on a final written warning for unsatisfactory work performance. The nurses who gave each incorrect dose received verbal corrective action regarding this event.

JRMC also provided a copy of their Policy on Surveillance of patients. At the advisement of the committee members, JRMC with the necessary changes of informed consent by the patients and remove remote access.

1. **Lea and Associates –**

No activity to report.

1. **Live 4 Life** –

No activity to report

1. **Low Ground Visions, Inc**.

As of March 31, 2014 services have been closed.

1. **New Beginning, Inc.**

**Residential**

**Abuse #: 20140002 - 1/14/2014**

Individuals were going downstairs to get morning medications and one Individual attacked another for no apparent reason and in his defense the Individual attacked retaliated and began to fight back. Both of the Individuals received scratches. One received 3 scratches in his face and the other received 1 scratch on his bottom lip. The peer to peer occurred as a result of the individual's behavior for no apparent reason. Staff intervened immediately and separated the 2 and kept them separated throughout their waking hours. No other incidents occurred. The individual who attacked the other individual has been referred to see his psychiatrist for this behavior.

Unsubstantiated

**Abuse #: 20140003 - 1/15/2014**

The Individual was sitting at the table drinking a cup of water. He became agitated and started calling the DSP out of her name when asked to move away from the table. He started cursing, yelling and stood up and got in the personal space of the DSP. The DSP verbally redirected him to step back and he continued this behavior. One of his peers heard him speaking to the DSP in this manner and hit the individual. The DSP intervened immediately and separated him from the other individual until he calmed down. As a result of the altercation the Individual received some scratches to his face. First aid was administered immediately.

Individual responded when he was not being addressed after overhearing a conversation with the other individual and the staff. Staff intervened immediately and counseled the individual about not reacting when staff and other individuals are having conversations. The individual apologized and stated he would not do it in the future.

Unsubstantiated

**Abuse #: 20140005 - 3/10/14**

When the oncoming staff went in to awaken the individual the staff noticed that there was blood in his head and dried blood on the side of his neck. The staff showed the incident to the Program Director and the staff who had worked the overnight shift and the overnight staff said when the individual got up to use the bathroom she did not notice any injury and when she went in the room to check on him she didn't see an injury. The staff contacted the on-call supervisor and reported the injury who reported it to the Quality Assurance Director who instructed the on call supervisor to have the individual taken to the emergency room to be seen because it was an injury to his head.

After interviewing all staff and reviewing their responses it is determined that there was no neglect however the individual may have struck his head on something and did not indicate any pain to staff. When the staff made rounds to check on the individual she did not observe any injury until individual was approached to get up. He could have obtained the injury in between the time of the last check and the time he was awakened.

**Abuse #: 20140007 - 3/12/2014**

The individual was being seen at the John Randolph Medical Center Emergency Room and when the doctor asked how she obtained the scratches she said the staff assaulted her last night. The doctor called the Police to report the information and the police after getting the information contacted the home and spoke with the residential program director. The program director informed him of the incidents that occurred the night before and that START had been notified and the behaviors went on for quite some time. The individual had attempted to abuse self, staff, individuals, and she attempted to elope. The police officer indicated that was all he needed to know and called and reported it to the doctor who informed the staff that that the individual was discharged and they could return back to the home. The Individual had several incidents the day and night before and the scratches and bruises were self-inflicted and some of the statements were also stated to the staff person from START and after talking with the START staff person the individual admitted that no one had assaulted her or touched her and that she had tried to hurt them. During the night before on 3/11/2014 she had asked to use the phone to call her boyfriend and was told that this was not her scheduled night but if her boyfriend called her they would get her to the phone. She went to her room for approximately 20 minutes and came back downstairs and grabbed the phone. When the staff redirected her she climbed over the black rail in the kitchen. The staff tried to keep her from hurting herself on the rail and she began kicking and striking at them and fell to the floor rolling on the floor and hitting against the rail. She grabbed staff pants and tried to bite staff on the leg. Staff verbally redirected her.

The Individual had several incidents prior to going to the Emergency Room and was targeting anyone who came into her presence. The individual admitted that she did the things that she stated staff did and no one had hurt her.

**Day Support**

 **Abuse #: 20140001- 1/2/2014 Unsubstantiated**

After arriving home on Tuesday afternoon (December 31, 2013), after being asked about a bruise Individual reported to his group home staff that he was teasing other individuals and a staff person made physical contact with him to stop when he did not respond to the verbal request. He had a small bruise on the corner of his left eyelid as reported by his staff. The individual did not state at that time that it happened at the Day Support or did he identify who had done it. Each time he was asked, he stated “I don’t know.”

It is believed the abuse did not occur because the individual's story kept changing and every time he was interviewed his responses were different. The injury observed also did not reflect the type of slap or hit the individual stated he obtained to his face.

**Abuse #: 20140004 - 3/5/2014**

On 3/5/2014 it was reported to the Executive Director that an allegation of sexual abuse had been reported that involved the individual and a staff member of our day support services. It was reported one of our day support staff reported to the residential staff where the individual resides, that he had inappropriately touched a staff person at day support and when the staff person was reporting the individual, the individual stated to the residential staff a staff person at the day support had touched him in his private area.

Abuse Case#20140008

Individual obtained a head injury when he was returning from the rest room. Something fell from his pants. It appeared to be feces and when he bent down to see what it was he bumped his head on the table and it immediately began to swell and some bleeding occurred. He was taken to the emergency room of John Randolph Medical Center to be examined. He was discharged from there with a diagnosis of abrasion and head injury (minor).

When the Executive Director saw the injury and asked what occurred he said he fell and when she asked where was his walker he said it was in the van. The individual is a fall risk and is to have his walker with him at all times.

Staff failed to assure that the individual’s walker was in arms reach so that he could use it to ambulate from place to place and because he is high fall risk due to his unsteady gait the assigned staff did not provide proper supervision to assure his safety.

**INVESTIGATION SUMMARY:**

During the interview of the investigation the individual was asked about the incident that supposedly took place on the 26th of February, 2014. The individual was asked if he could tell us what happened. He stated he was not going to talk with us and nothing happened and to leave him alone. He was told no one had said he had done anything but we wanted to make sure no one had done anything to him that was not right. He further stated nothing happened to him and he was not going to talk with us. The staff person who indicated she had been inappropriately touched was interviewed and she stated the individual came up from behind her and put his hand around her waist, she hollered and he turned her loose and laughed and ran to the other side. There was one witness who indicated he was in the kitchen and when he looked up he saw the individual with his hand around the waist of the female staff and he told him to stop and that he was being inappropriate and the individual laughed and turned around and went to the other side. Two other staff were interviewed and the male staff stated he heard the female staff holler and he went to see what was going on and she told him the individual had touched her inappropriately but when he got there the individual was not in the area and it appeared to be calm so he went back to his assigned duties. The supervisor stated she responded when she heard the staff holler also and when she asked what was wrong the female staff said the individual had displayed an inappropriate behavior and the supervisor said she told her ok to write it up and she returned to her area because everything appeared to be calm and the staff was not acting as if it was a big deal or serious. The female staff indicated when she took the individual to his residence and when the residential staff came out to accept the individuals as usual she told the staff at the home what the individual had done. When asked why she did not properly report the incident at the day support where it occurred she said she did not know she just didn't. When the Executive Director received the call about the incident she was told that the residential staff also indicated an individual had also been inappropriately touched by the male individual but no one at the day support had ever witnessed this. It was also reported to the Executive Director that the male individual indicated a staff person had inappropriately touched him and in the first interview when the male individual asked who had done that he indicated by pointing to the alleged abuser. The staff who work in the area with the male individual and the alleged abuser were interviewed and each one of them stated the alleged abuser stays in her training room with her assigned individuals and usually only comes out when there is an activity that her individuals are engaged in or to go to lunch, etc. They were asked if they had seen her in the training room where the male individual is assigned and all the responses were "no." They were also asked if they had seen the individual in the accused staff's room and they stated "no." After all the interviews and responses it is believed the act of inappropriate sexual behavior from the accused alleged abuser (female staff) did not occur. However it is believed that the female staff who was inappropriately touched by the male individual failed to follow the proper procedure in reporting the incident when it first occurred and as a result of this she will receive disciplinary action and re-training in documentation of incidents and behaviors.

1. **Phoenix-N-Peace, Inc.**

**Residential**

No activity to report.

1. **Progressive Adult Rehabilitation Center, Inc. (P.A.R.C.) –**

Agency conducted Annual Human Right training on March 11, 2014 with all staff, which included requirement for reporting allegations of abuse and neglect and human rights complaints.

**P.A.R.C Osage House**

 No activity or changes to report

**P.A.R.C Day Support**

No activity to report.

**P.A.R.C Supported Living Services**

No Activity or Changes to Report

1. **Pryor House**

On January 9, 2014, a call from the licensing specialist stating that they (licensing and human rights) were at the facility due to a complaint that they received. The complaint was that the individual had marks on his body, no orthopedic shoes, the individual’s clothes were old looking and no Christmas decorations were up. After licensing and human rights investigated, they stated that there was no evidence of abuse or neglect. This resulted in the individual’s mom moving him to another facility.

On February 25, 2014, staff was exiting out of the office and the individual grabbed staff by the collar and scratched her neck. He was redirected and calmed down momentarily. As soon as staff started to walk away he kicked staff and the individual was lowered to the floor by using TOVA techniques, given a PRN and staff asked the individual to start his counting techniques and he counted up to 10 and he laid on the floor until he calmed down. When asked why he did that, he just stated that he was mad.

1. **Southside Regional Medical Center, Inpatient Services**
2. **T’LAB, Inc**.

No activity or changes to report.

1. **TruCare Homes, LLC.**

**Butternut Home**

**McilWaine Home**

Nothing to report.

1. **Visions Family Services -**

**` Day Support**

**Intensive In Home**

No activity or changes to report.

**Residential**

**Mental Health Support**

No incidents to report.

**Therapeutic Day Treatment**

No Activity to Report.

A motion was made by Cartlon Starke to approve third quarter reports and to table and refer the Butternut Home – Resident Handbook-Curfew addendum proposal to a subcommittee and seconded by Daniel Moore.

1. ***Closed Session***

A motion was made and passed that the Local Human Rights Committee go into Closed Session pursuant to the Virginia Code 2.2-3711-A.15 for the protection of the privacy of individuals, their records in personal matters not related to public business. Ayes Carlton Starke, Jean Grim .

A motion was made to reconvene back to open session. Ayes Carlton Starke and seconded by Daniel Moore.

1. ***Announcements / Updates (Chairperson’s Closing Comments)***

The next regular scheduled meeting will be held Thursday, July 10, 2014,

5:30 PM at Starkewood Counseling Services, 589 S. Crater Road, Petersburg, VA.

Clarence Dilworth will provide refreshments during the next scheduled meeting.

Thank you to Carlton Starke for providing the meeting location.

1. ***Other Actions***

None

1. ***Adjournment***

There being no further business, the meeting was adjourned .

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Edward Barlow, Chair (Date)