Monitoring and Investigation of Carlton Palms Educational Center

Results and Recommendations
March 2018
FLORIDA’S ONLY COMPREHENSIVE TRANSITIONAL EDUCATION PROGRAM: CARLTON PALMS

Executive Summary

As Florida’s Protection and Advocacy System for individuals with disabilities, and in a specific effort to protect and advocate for the rights of individuals with intellectual and developmental disabilities, Disability Rights Florida (Disability Rights) maintains the authority to pursue remedies or approaches to ensure the protection of, and advocacy for, the rights of those within the State who are eligible for treatment, services or habilitation.\(^1\) This authorization vests Disability Rights with an ability to investigate incidents of abuse and neglect of individuals with developmental disabilities.\(^2\)

For the past several years Disability Rights monitored Carlton Palms’ corrective efforts after the death of a young resident in restraints in the summer of 2013. Ultimately, multiple allegations of abuse and neglect resulted in several licensure complaints and Settlement Agreements with the Agency for Persons with Disabilities (APD). Our monitoring included review of APD’s election to impose a moratorium on admissions to Carlton Palms, as well as Carlton Palm’s agreement to certain changes in the provision of medical care of residents, oversight of staff, nursing best practices, and surveillance measures intended to ensure compliance with licensing and other measures. We also attended Carlton Palms’ quarterly-scheduled monitoring meetings in conjunction with other interested stakeholders and entities.

As part of its monitoring of use of restraint, Disability Rights documented and advised the Agency for Persons with Disabilities that Carlton Palms had been utilizing approximately thirty-four low-back chairs with restraints that appeared to be constructed “in-house” with bolts in the legs and eyelets in the arms used for restraint. Lacking proper head and neck support, arm padding, and sound engineering, Disability Rights suggested to APD that the chairs did not comply with

\(^1\) 42 U.S.C.A. § 15043(a)(2)(A)(i)
\(^2\) 42 U.S.C.A. § 15043(a)(2)(B)
Florida Statutes$^3$, Administrative Rules$^4$, Carlton Palms’ own corporate policies to use only commercially produced restraints, as well as paragraph eight of the 2014 Settlement Agreement between APD and Carlton Palms$^5$. Rather than discontinue use of the chairs, Carlton Palms obtained commercially-produced restraint chairs and Disability Rights requested the development of a training curriculum and re-training for all staff.

In November, 2016, Disability Rights determined that there was probable cause to believe that incidents of abuse or neglect continued at Carlton Palms. Despite increased oversight from APD and monitoring efforts from Disability Rights, the Department of Children and Families (the Department) had conducted no fewer than 28 adult- and child-protective investigations regarding allegations of abuse or neglect lodged by, or on behalf of, at least 21 individual Carlton Palms residents. Notably, that partial-year total of investigations was already twice the total of all adult and child protective investigations (14) related to allegations of abuse and neglect of residents at Carlton Palms in 2015.$^6$ Of the cases where Disability Rights identified probable cause for abuse and neglect, twenty-one individuals’ files were reviewed for investigation.$^7$ Disability rights identified the following eight findings:

1. Incomplete and Misleading Reporting of Abuse and Neglect
2. Failures to comply with abuse and neglect reporting requirements
3. Inadequate staffing and resident supervision
4. Inadequate staff oversight and compliance with behavior programming
5. Non-compliance with behavior services laws and regulations
6. Lack of Individualization in Behavior Plan
7. Failure to Comply with Resident’s Behavior Plans
8. Failure to comply with restraint documentation requirements

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$^3$ Fla. Stat. § 393.13(4)(c)(8)(h)(2) prohibits inherently dangerous restraint or seclusion procedures.
$^4$ Fla. Admin. Code, Rule 65G-8.009(2) prohibits untested or experimental procedures.
$^5$ Paragraph 8 required revised policies on the utilization of mechanical and physical restraints
$^6$ This does not include reports that were lodged with the Department of Children and Families under a different name than “Carlton Palms.” Other reports are lodged against the parent company, Advoserv or Bellwether Behavioral Health, or a variation of “Carlton Palms Educational Program.”
$^7$ Disability Rights may access the records of any individual with a developmental disability “if such individual, or the legal guardian, conservator, or other legal representative of such individual, has authorized [Disability Rights] to have such access.” 42 U.S.C.A. § 15043(a)(2)(I)(i); see also 45 C.F.R. 1326.25(a)(1). While Disability Rights makes a good faith effort to contact the individual’s legal guardian, conservator, or other legal representative upon the prompt receipt of necessary contact information, see 45 C.F.R. § 1326.25(a)(3); see also 42 U.S.C.A. § 15043(a)(2)(I)(iii), if Disability Rights determines that the health or safety of an individual is in “serious and immediate jeopardy,” no consent from another party is needed. 45 C.F.R. § 1326.25(a)(4)
A Separate, Single, Statutory License for A Single Provider

In 2006, the Florida Legislature statutorily created the Comprehensive Transitional Education Program (CTEP) to serve individuals primarily, though not limited to those with developmental disabilities, who have severe or moderate maladaptive behaviors. The services provided by the CTEP were proscribed as “temporary in nature and delivered in a structured residential setting, having the primary goal of incorporating the principle of self-determination in establishing permanent residence for persons with maladaptive behaviors in facilities that are not associated with the comprehensive transitional education program.”

Though the CTEP license capacity has grown to 230 individuals, it has taken statutory action in order to do so and further the licensure’s goal of transition. In 2010, the statute was changed to add other components and require the CTEP to provide those services in a sequential order in order to result in a setting that is largely unrestricted with less monitoring and supportive of the development of independent living skills. Originally limited to 120 residents, the capacity limit was changed in 2014, when the statute was amended to reflect a restriction of any residential unit to only 15 residents.

There is only one entity that holds CTEP licenses – known as Carlton Palms – which is owned and operated by Bellwether Behavioral Health (Bellwether), formerly AdvoServ. Florida’s Agency for Persons with Disabilities (APD) has licensed a maximum capacity of 230 individuals for Carlton Palms’ residences. The CTEP continued its growth and by February 2016, the CTEP housed nearly thirty percent (30%) of all state residents who are in group homes diagnosed with developmental and intellectual disabilities and having challenging behavior. Its census as of September 2017 was 166 residents.

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8 Fla. Stat. § 393.18 (effective July 1, 2006 to June 30, 2010)
9 Fla. Stat. § 393.18(1)(e) (effective July 1, 2010 to June 30, 2014)
10 Fla. Stat. § 393.18(4) (effective July 1, 2014-June 30, 2016), with the exception of grandfathering in residential units that were previously permitted to operate with more than 15 residents.
11 Florida’s Agency for Persons with Disabilities reviews and grants the licenses for residential settings that provide services through the Individual Budgeting Medicaid Waiver for Floridians with intellectual and developmental disabilities.
12 Provided by Agency for Persons with Disabilities pursuant to a public records request.
The State’s Oversight of Abuse and Neglect Complaints at Carlton Palms

Previous complaints and Settlement Agreements have been entered into between APD and Carlton Palms.15 A licensure complaint from APD against Carlton Palms in 2011 charged physical abuse of three residents and requested a fine of $3,000.00.16 Another case was filed in 2012 alleging abuse to another resident and sought an additional $1,000.00 fine.17 APD settled both cases in February 2012 and waived the fines in return for Carlton Palms’ retraining its staff and maintaining supervisory personnel on premises for all hours of the day and week.18 However, the Settlement Agreement was not filed in the administrative case until June 11, 2014, after APD settled yet another complaint of abuse. In October 2012, APD filed this complaint alleging abuse of another four residents and seeking a finite moratorium on admissions for a year, citing “multiple acts of physical violence to the residents.”19 This later 2012 complaint ultimately resulted in a Settlement Agreement on December 19, 2012, for which both parties proclaimed an intent to “enhance the protection of persons with disabilities” through the following terms: 20

1. Provide continuous, recorded, video monitoring to be retained for 30 days;
2. Retention of specific incidents if requested by APD, DCF or a law enforcement entity;
3. APD to conduct unannounced inspections of each component center resulting in a brief written report;

15 These complaints were also detailed for Florida’s Legislature through Florida’s House of Representatives Staff Analysis for CS/HB 899 (2017), footnote 16, detailing failed attempts at a moratorium on admissions but receipt of a $10,000.00 fine for allegations of “inadequate training of staff, physical violence, inadequate care, and inadequate supervision of residents.”
17 Agency for Persons with Disabilities v. Carlton Palms, Owned and Operated by Advoserv, Administrative Complaint, Division of Administrative Hearings, Case No. 11-6465.
19 Agency for Persons with Disabilities v. Carlton Palms Educational Center, Owned and Operated by Carlton Palms Educational Center, Inc., Second Amended Administrative Complaint, Division of Administrative Hearings, Case No. 12-003826
4. Written staff acknowledgement by March 1, 2013, to call the Florida Abuse Hotline if they witness or suspect abuse, neglect, or exploitation of residents; and
5. Breach of the agreement will result in the reinstatement of the second amended administrative complaint filed against Carlton Palms on October 22, 2012.

The child’s death in the summer of 2013 was not the only cause for additional complaints of abuse. In September 2014, APD filed another complaint against Carlton Palms that included allegations that a resident in wrist restraints, ankle restraints, and a protective mat had fractured their right humerus.21 This complaint resulted in a Settlement Agreement being approved on March 16, 2015.22 That Settlement Agreement stated, “Over the course of the past few years, there have been a number of incidents that occurred at the Carlton Palms facility, some of which have involved serious injury, and one that involved the death of a resident.”23 APD’s previous efforts at addressing deficiencies at Carlton Palms had been memorialized by letter from APD’s Director Palmer on April 22, 2014, and those requirements were recited in the 2015 Settlement Agreement. They included:

1. Improving the quality of video images and retain videos for 30 days;
2. Add audio recording capability to the video capability and retain those recordings for 30 days;
3. Maintain a back-up storage system for all video/audio recordings;
4. Modify or enhance remote video monitoring;
5. Develop medical protocols to specifically address assessment and treatment of medical issues for on-site and off-site treatment purposes;
6. Develop and implement a revised policy on health-related issues to address inadequate communication between clinical and direct-care staff;
7. Add monitoring provisions for administrative presence for all evening, nights and weekends; modify supervisory training; modify existing video monitoring to ensure that it may occur without detection or knowledge by staff; and update systems to better utilize the data in shaping staff performance and identifying trends/issues across program locations;
8. Participate in quarterly meetings with summaries of incident reports, abuse reports, employee disciplinary actions and other issues of concern;
9. Communicate to senior management all incident reports to the corporate office;

21 That resident also returned to the emergency room following surgery due to inadequate medical care.
22 APD Case No. 14-004853APD, an action brought by APD against the CTEP’s license #13442280A, regarding the Orange Villas component of Carlton Palms.
23 Florida Division of Administrative Hearings, Case No. 14-004853APD, Exhibit A of the Notice of Settlement and Motion for Relinquishment of Jurisdiction.
10. Provide to APD the policy on the utilization of mechanical and physical restraints and conduct re-training of all staff;
11. Develop and submit a plan to APD to achieve compliance with home and community based characteristics;
12. Develop and implement a policy which prohibits the facility from continuing to employ any licensed medical profession whom the Florida Department of Health has suspended or revoked the license(s) of such employees.

The 2015 Settlement Agreement goes on to state that the above procedures were met and the following requirements constituted the ongoing compliance measures by Carlton Palms:

1. A $75,000.00 technology upgrade for video image quality and audio as well as remote monitoring and retention of such recordings for sixty days. The recording also must encapsulate four hours prior and after the event;
2. Continued monitoring of the efficacy of the medical case management protocols developed;
3. Continued monitoring of the efficacy of the policy on health-related issues between clinical and direct care staff;
4. Continuation of additional monitoring including scheduling administrative staff over evenings, nights, and weekends, as well as continuing with supervisory training;
5. Continuing quarterly meetings;
6. Continued monitoring of the efficacy of the staffs’ training on its revised policy on the utilization of mechanical and physical restraints. Included is a requirement that it revise this training as needed in consideration of new or peer-reviewed developments in this area; and
7. Adherence to developed employment policies regarding professional and direct care staff.

Florida’s Behavior Services Delivery System and Restraint and Seclusion Policies

In 2016, the CTEP statute itself was amended to create three components which must provide (1) intensive treatment and education, (2) intensive training and education, and (3) transition. The stated goal of these components is to avoid regression and prepare an individual for transition to a less restrictive environment such as independent living.

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24 Fla. Stat. § 393.18(1)(a)-(c)(2016)
Additionally, in 2016, the Florida Legislature added the provisions now contained in subsections (5) and (6) requiring the CTEP to comply with the terms of any settlement agreement it enters into with APD and permitting the agency to approve the proposed admission or readmission of individuals to Carlton Palms for a period of time and pursuant to a review process.

Indeed these vulnerable Floridians, pursuant to Florida’s Legislature, have the right to be free from harm including unnecessary physical and mechanical restraint. The stated legislative intent for the delivery of services to Floridians with intellectual or developmental disabilities is to “minimize and achieve an ongoing reduction in the use of restraint and seclusion in facilities and programs.” The legislative guidance goes even further, limiting the use of restraint to only times of emergency or to protect the client or others from imminent injury. There are further guardrails imposed prohibiting the use of restraint as punishment, convenience of staff, or as a substitute for a support plan.

APD is tasked with rulemaking authority to establish standards for licensed facilities in the areas of staff training for the detection, reporting, and prevention of sexual abuse, abuse, neglect, exploitation, and abandonment. The rulemaking grant goes further to address minimum standards of quality and adequacy of client care as well as incident reporting requirements.

The rules adopted by APD governing restraint in its licensed homes, including Carlton Palms, are contained in Chapter 65G-8 regarding reactive strategies. Pursuant to rule 65G-8.002(1), each provider must utilize an emergency procedure training curriculum approved by APD. Carlton Palms has such a written Reactive Strategies Policy known as “Safety Care”, Advanced Skills, High Severity Behavior 1, which was customized for AdvoServ, (now known as Bellwether Behavioral Health), for its own “AdvoServ Mechanical Restraint Procedures.” The customization includes the use of restraint chairs and mat wraps for behavior management.

These customized techniques of mechanical restraint are then taught to Carlton Palms staff and incorporated into the residents’ daily lives. However, the program

26 Fla. Stat. § 393.13(3)(g)
27 Fla. Stat. § 393.13(2)(d)8
28 Fla. Stat. § 393.13(2)(h)
29 Fla. Stat. § 393.13(4)(h)
30 Fla. Stat. § 393.067
31 Fla. Stat. § 393.067(7)
32 Rule 65G-8, Fla. Admin. Code
requires the use of de-escalation before the use of mechanical restraint. Relevantly, calling for assistance as early as possible is described as the first appropriate step to incident minimization.\textsuperscript{34} When no other safe alternative exists, the program permits moving to physical management of the resident. Such practices, pursuant to the program, are not to be used for convenience, as punishment, or because de-escalation is prolonged.\textsuperscript{35} This is in keeping with Florida’s statutory statement of Client Rights.\textsuperscript{36} Pursuant to the program, the use of physical management should be brief and “should be used as a momentary or temporary procedure, lasting a few seconds or a few minutes, not tens of minutes or hours.”\textsuperscript{37}

These mechanical restraint procedures developed for Carlton Palms, were meant to be used only when the individual is displaying behaviors that place themselves or others at risk of injury.\textsuperscript{38} As part of the use of mat wraps, procedures indicate timelines for opening the mat, doing circulation checks, wellness checks, and attempts to safely release the individual from the restraint.\textsuperscript{39} Of all the mechanical restraints devised, only the Restraint Chair has a code of “RCH” required.\textsuperscript{40} Oddly, the six steps detailed in the QBS Trainee Manual for procedures during use of the Restraint Chair, all reference a “Wrap Mat” and are not specific to a “Restraint Chair.”\textsuperscript{41}

Carlton Palms’ Behavior Programming Guidelines, which governs the use of interventions in its programs from routine interventions, moderate interventions, and restrictive interventions, states they are to be used “only in the most intractable cases and with the most dangerous and disruptive behavior problems, notably self-injury, aggression or property destruction that poses an imminent risk of injury.”\textsuperscript{42} These interventions are only to be employed until the risk is resolved. The Guidelines further require de-escalation as “always the first intervention” and all staff are to be trained in Safety Care’s techniques in the de-escalation of dangerous situations.\textsuperscript{43} Bellwether has previously stated that the use of restraint “has been and will always remain a last resort” when there is imminent danger to the individual, peers or staff.\textsuperscript{44}

\textsuperscript{34} Safety-Care Trainee manual, page 21.
\textsuperscript{35} Id. Trainee manual, page 51.
\textsuperscript{36} Fla. Stat. § 393.13(4)(h)
\textsuperscript{37} Id. safety-care trainee manual page 58.
\textsuperscript{38} “Safety-Care TM Advanced Skills; Advoserv Mechanical Restraint Procedures” Customized for Advoserv, Trainee Manual, QBS, Inc. p.1
\textsuperscript{39} Id. p. 11.
\textsuperscript{40} Though many behavior plans reviewed use ROM (Range of Motion) or PWB (Protective Waist Belt) to code the same type of restraint.
\textsuperscript{41} Id. p. 24
\textsuperscript{42} Advoserv Behavior Programming Guidelines, September 2014.
\textsuperscript{43} Advoserv Behavioral Programming Guidelines, September 2014, p.6.
\textsuperscript{44} Advoserv statement to Heather Vogell, ProPublica for “Unrestrained”
Disability Rights’ Review of Carlton Palms Files

In our review, we first started by reviewing the behavior plan of each individual. Notations were made to indicate when restraints were used without de-escalation, in an emergency coding, for prolonged periods of time, or out of the sequence prescribed by the individual’s behavior plan. We then reviewed the Incident & Injury Reports that are required internal documents for when residents sustain injuries, including when those injuries are obtained during a restraint procedure. We also reviewed outside reporting to APD for when incidents involving injury or calls to the abuse hotline are made to determine if inconsistencies existed.

Some instances involved piecing together timelines for reports of abuse and neglect days after it is alleged to have occurred. Disability Rights’ review of the allegations of abuse and neglect was not done in a vacuum but in conjunction with corresponding reporting from the hours or days surrounding the incident. Through corresponding behavior data sheets, internal incident and injury reports, and required reporting to APD, a clearer picture of deficiencies permeating throughout the culture of the program emerges.45

Disability Rights’ Findings

1. Incomplete and Misleading Reporting of Abuse and Neglect

When considering the documentation involving incidents that were identified as being called to the Department’s abuse hotline, we looked for inconsistencies between the allegation, the behavior data sheets, internal Incident & Injury reports, and outside reporting to APD. Instances of incomplete and misleading reporting of suspected abuse and neglect involved the prolonged avoidance of complying with reporting requirements and staff’s self-serving dilution of incidents when they were reported or relayed to proper authorities.

Client E was the subject of an internal Incident and Injury report completed in May 2016 noting the client woke up with scratches on their neck and that the incident was unobserved by anyone46 even though the incident was called in to the Department by an anonymous caller. During the investigation it was revealed that the previous day Client E had been aggressive and the behavior plan was not

45 Many of the examples cited could be examples of more than one Finding and the examples cited are not exhaustive.
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followed by staff. The staff member could be seen on video pointing fingers and scolding Client E, which is not a de-escalation technique, before the staff attempted to hold Client E while they both “fall onto [the] sofa.”47 It was then that staff can be seen and heard, according to the video and the Department’s investigator, slapping Client E in the face.48

The staff later admitted to the slapping and was discharged, however, the documentation completed by the staff prior to the Department’s involvement, included Carlton Palms’ own behavior data sheets and Incident and Injury reports. Both are deficient. The entire event was recorded in behavior data sheets, and signed off by supervisors, as showing use of redirection, gloves, emergency helmet, emergency protective waist belt, emergency chair with hand restraint, and emergency chair foot restraint.49 However, there was no use of a helmet indicated by the video even though the data sheets record self-injurious behavior as the reason for the helmet. Secondly, the behavior data sheet’s entire narrative fails to describe the altercation accurately and instead generically describes staff as “asking [Client E] to stop but [Client E] continued walking towards staff in an [sic] aggressive manner.”50 Further, the incident was not reported to APD until four days later, in violation of APD Operating Procedure 10-002, after the Department’s investigator arrived and initiated the video review for investigation purposes.51

Even the narrative of the staff from Carlton Palms misleads by stating staff “physically guided [Client E] to an adjacent couch” which is a marked departure from the description of the video provided by the Department which describes the staff and Client as falling onto the couch.52 Finally, prior to the Department’s involvement, the next morning when Client E awoke with scratches on the neck, the staff completed the Incident and Injury Report noting that the injury was “unobserved” and the cause was unknown.53 Even if the morning staff thought the scratches were inflicted without anyone seeing, they should have reported the injury to APD in accordance with the Operating Procedure as an injury. As it turned out, other staff witnessed the underlying incident with Client E and failed to promptly and accurately describe the incident in internal documentation and report it to the Department and APD.

Client M was the subject of an abuse and neglect complaint when Client M complained of being punched in the eye by staff and the eye showed bruising.54

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Client M’s allegations changed as the Department’s investigation continued and eventually Client M blamed the bruising on striking a metal pole in the bedroom. Another staff member was allegedly in the room when the incident took place but saw nothing until Client M was on the floor. Per staff, Client M was being aggressive and a physical hold was used when both fell to the floor. However, in reviewing the behavior data sheets, only two behaviors are documented for that particular day. One involved only the loss of an interval due to disrespect. The later behavior data sheet is described by the staff member as only “inappropriate behavior” on the part of Client M and jumping behind staff with an aggressive posture. Staff failed to note that they used a physical hold on Client M or that Client M fell to the floor. Staff also did not check either box to indicate if there were visible signs of injury. However, the involved staff indicated to the Department during its investigation that Client M threatened to say they punched his eye, yet this was not indicated on any of the supposed contemporaneous documentation required by Carlton Palms.

2. Failures to Comply with Abuse and Neglect Reporting Requirements

Carlton Palms’ Abuse and Neglect policy contains definitions of abuse and neglect and the appropriate staff response. Abuse, per the policy, is any non-accidental infliction of physical or psychological injury or any other act as deemed by the members of the Senior administration. All residents are to be free from verbal abuse, degrading remarks, profane language, teasing and sarcasm. Neglect is defined as non-compliance with listed basic care requirements or any lack of them as deemed by the members of the Senior Administration. The listed requirements focus on hygiene, personal care, medical care, and safety. Per the policy witnesses to violations are required to report them and investigations are required. We found instances that were not called in to the Department’s abuse hotline but violated the Carlton Palms’ Abuse and Neglect policy in that witnesses are to report allegations of abuse and neglect, and according to APD policies, within certain timeframes.

Client N suffered a black eye after being placed into mechanical restraints in the mat. The internal Incident and Injury Reports completed by staff show one report

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60 APD Operating Procedure 10-002 requires Critical Incidents to be reported immediately and followed up with written reports and Reportable Incidents, including consumer injuries, even if by accident, within one business day.
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being completed within an hour of the alleged restraint, listing the three employees involved in the restraint (no report of injury was filed by any of the three involved employees), and states that during the restraint staff noticed swelling of the face, redness in the eyes, and that Client N complained of an abrasion to the knees.\textsuperscript{62} Yet, the next morning an additional Incident and Injury Report is completed by a separate staff member stating that staff walked into the room and noticed Client N had a swollen and black eye.\textsuperscript{63} It is unknown why the staff arriving the next morning were not made aware of the incident involving injury the night before even though the supervisor signed off on the previous night’s report.\textsuperscript{64} But the truly perplexing part are the two overlapping behavior data sheets for the incident prepared by the same staff member. One data sheet encompasses the time from 20:30 hours to 20:45 hours and includes documentation that six staff members were involved in the mechanical restraint of Client N.\textsuperscript{65} The second data sheet, for the same night by the same staff member, begins at 20:20 hours and also concludes at 20:45 hours and documents the use of seven staff involved in Client N’s restraint this night.\textsuperscript{66} For both data sheets, however, neither is marked showing there were visible signs of injury despite the separate internal Incident and Injury Report detailing the swelling of the face, redness of eyes and abrasion to the knee.\textsuperscript{67}

Both narratives of what gave rise to the aggression and the actions of Client N differed significantly as well.\textsuperscript{68} When the Department investigated the incident, they spoke with the nurse that saw Client N the morning after the incident who then alleged that Client N had a long history of making up allegations.\textsuperscript{69} However, lying is not noted in Client N’s behavior programs of April and November 2016. When Client N was eventually seen in a clinic away from staff, Client N told the physician that a “man punched his eye.”\textsuperscript{70} The clinic physician notated that Client N was told the incident will be reported.\textsuperscript{71} These medical notes were apparently obtained by Carlton Palms and produced to the Department during its investigation.\textsuperscript{72} On October 3, five days after the restraint event, Client N was seen by a different nurse than the one that was notified the morning after the event.\textsuperscript{73} This nurse stated the injuries were not consistent with the face hitting the floor as alleged by

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staff. Later, the original nurse that saw Client N the morning after the event, noted in Client N’s medical records, “I do not think there was abuse but since nature of injury not clear, Dr. Clark wants called in.” And so the Department’s abuse hotline was called on October 3, 2016, by the Carlton Palms’ staff nurse and not by any of the staff involved in the original restraint procedure.  

Client N’s black eye and restraint led to visits to an outside physician, yet Carlton Palms did not report the incident to APD until five days later despite having behavior data sheets, internal Incident and Injury Reports, and notifications to supervisors and the on-site nurse. The restraint that allegedly caused the black eye occurred in the late evening of a Wednesday, the supervisor was supposedly notified that night, and the on-site nurse saw Client N on Thursday morning, yet the report to APD was made the following Monday in contravention of APD’s policies for reportable incidents.

Client S sustained abuse when being physically redirected back to the group area. A staff member placed both hands on the mid back area of Client S and pushed Client S into the group area causing Client S to fall. However, more concerning was the report of the witnessing staff member who described the incident merely as “[Client S] fell in Annex group (3) causing redness on both elbows and knees.” There was no mention of the push from the other staff member, despite the fact that the witnessing staff member had followed both Client S and the offending staff member to the hall when Client S had left the group area. The witnessing staff member that completed the misleading Incident and Injury Report is the same staff member that was involved in the procedure where Client N reported being punched in the face.

On one particular day and night, Client C was placed in the mat wrap with ankle and wrist restraints when attempting to leave the group area to use the telephone to call the abuse hotline. Client C became aggressive when staff intercepted the attempt and was “flinging his body on staff.” The total amount of time in the restraint mat wrap for Client C on this occasion was forty-two (42) minutes. On the same day, only fifteen minutes after coming out of the procedure, Client C attempted again to call the abuse hotline again and was placed in the restraint mat wrap for another thirty-eight (38) minutes though the duration of the episode was not recorded and had to be estimated based on the times of the circulation checks.

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that were allegedly conducted.\textsuperscript{82} For both of these incidents, two separate documents exist to notate a correction that the attempt to use the phone was to call 911 and not the abuse hotline – a change from the original narrative that should have required closer scrutiny.\textsuperscript{83} Finally, the evening ended with another procedure only six minutes after coming out of the last mat wrap when Client C allegedly engaged in self-injurious behavior and was placed into an emergency use of the chair restraint with ankle and wrist restraints. Though maladaptive behaviors are expected, there is no narrative associated with this use of emergency restraint, and yet, a supervisor signed off on it, which ultimately violates the reporting requirements of Safety Care.\textsuperscript{84}

3. Inadequate Staffing and Resident Supervision

We also found from reviewing the abuse and neglect complaints, shortcomings with particular staff, staffing supervision, or even compliance with the behavior plans. In some instances, the reports given by staff seemed improbable given the resident’s respective behavior plans for line of sight supervision.

Client I was the victim of abuse from another resident and the abuse was brought to light because Client I had bruises of unknown origin despite the fact that Client I is to be in line of sight of staff at all times.\textsuperscript{85} The investigation raised questions about the frequency of skin checks and medical attention since Client I had other alleged bruising that looked more like a boil or infection.\textsuperscript{86} The Program Director and Staff stated the resident that hurt Client I had never shown aggression towards others and that it was prohibitive to restrain the offending resident in any way.\textsuperscript{87} However, the investigation reviewed the offending resident’s behavior plan which included use of arm splints or staff remaining within arm’s reach of the offending resident.\textsuperscript{88} Further, the offending resident was said to require line of sight at all times due to “aggression”\textsuperscript{89} and was precluded from visiting other’s bedrooms due to severe behavior problems.\textsuperscript{90} The offending resident was also noted to have past aggression towards others.\textsuperscript{91} The statements from the Program Director and staff

\textsuperscript{82} Disability Rights Document 69 of 334
\textsuperscript{83} Disability Rights Documents 73 & 77 of 334
\textsuperscript{84} Disability Rights Document 71 of 334
\textsuperscript{85} Disability Rights Document 1, 8 of 224
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\textsuperscript{88} Disability Rights Document 38, 41 of 224
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about the offending resident not displaying forms of aggression before was clearly inaccurate.

Furthermore, the response by staff at the time of injury should have raised alarms for Carlton Palms’ administration. At the time of the incident, the other resident entered the room while being followed by a staff person.\(^{92}\) That staff person then turned and left the other resident.\(^{93}\) After the resident hurt Client I, the staff looked at the injuries to Client I and then “pushed the Victim’s wheelchair out of camera range.”\(^{94}\) It is unknown why a staff member would deliberately move a resident out of the view of the camera range or, more importantly, why this was not addressed by supervisors. Client I’s injury was not reported to APD until four days after the incident when the Department’s abuse hotline was called. The Carlton Palms staff did not call the abuse hotline nor did they report the injury to APD by the next business day.\(^{95}\) Yet, inexplicably the event is described as the offending resident “throwing a tantrum” though such actions by the resident are not described by the investigator viewing the video.\(^{96}\) The Incident & Injury Report further fails to state that staff broke with the offending resident’s behavior plan and was not within arm’s reach.

Client B informed staff that while they were preventing another resident from eloping, Client B had swallowed half of a pencil. The behavior documentation notes that a supervisor was immediately notified.\(^{97}\) Client B’s behavior plan requires environment sweeps to ensure no items are within reach of Client B to swallow. Despite, this requirement Client B had had at least three incidents that the Department verified findings of inadequate supervision in the past. In 2016, there were multiple incidents of ingesting objects before the behavior plan was updated to require body checks and use of preventable clothing. Yet, Client B was still able to swallow half a pencil after the behavior plan was updated.

4. Inadequate Staff Oversight and Compliance with Behavior Programming

We found instances of abuse and neglect complaints consist of recurring patterns of neglect or abuse that contradicts Carlton Palms’ behavior program and reactive strategies.

\(^{92}\) Disability Rights Document 4 of 224
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\(^{94}\) Disability Rights Document 4 of 224
\(^{95}\) Disability Rights Document 2 of 230
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\(^{97}\) Disability Rights Documents 206 of 297
Client H was the victim when a staff member lunged at them when the client was engaging in maladaptive behaviors.\textsuperscript{98} Other staff members had to pull that staff member away. Client O, whose behavior program only includes interruption and redirection, which may require some physical blocking but not holding\textsuperscript{99} due to the nature of the self-injurious behaviors, nonetheless had bruises in the shapes of fingerprints in inconspicuous places on the thighs that was consistent with physical abuse.\textsuperscript{100} For both clients, the use of physical contact was not in keeping with Carlton Palms’ behavior programming and reactive strategies.

Client L was the aggressor towards another resident resulting in an injury that required treatment in the emergency room of a local hospital. However, on the particular day that Client L allegedly caused this injury to another resident, there is one sheet, for the same date and time, indicating only that Client L stood up and pushed the resident, and was merely redirected by the staff.\textsuperscript{101} However, in the approximately two weeks leading up to the incident, Client L had aggressed in the same manner towards two other people and was placed in range of motion restraints for approximately ten to fifteen minutes each time.\textsuperscript{102} There is no indication Client L’s behavior plan was changed after these incidents and Client L’s requirements for supervision remained only line of sight.\textsuperscript{103}

Client R exhibited a frequency of punching and hitting walls and the floor but suffered a fractured wrist after one procedure.\textsuperscript{104} Client R alleged staff caused the injury during the physical direction to the mat by pulling back the fingers.\textsuperscript{105} Staff alleged that Client R caused the injury by punching the floor.\textsuperscript{106} Video shows Client R flipping over from prone to supine position and the injured hand striking the floor which could account for the injury and ultimately the investigation was closed with no findings.\textsuperscript{107} However, during the investigation, the Behavioral Specialist stated that use of mechanical restraints for wrists was added to the behavior program in response to the injury.\textsuperscript{108} However, mechanical restraints, including the use of wrist restraints in the mat, were a part of the behavior program for Client R as early as five months prior to the wrist fracture.\textsuperscript{109}

\begin{footnotes}
\item[98] Disability Rights Document 4 of 402
\item[99] Disability Rights Document 9 of 242
\item[100] Disability Rights Documents 7 & 9 of 242
\item[101] Disability Rights Document 2 of 235
\item[102] Disability Rights Documents 4 & 6 of 235
\item[103] Disability Rights Document 236
\item[104] Disability Rights Document 11 of 269
\item[105] Disability Rights Document 2 of 270; 3 of 260
\item[106] Disability Rights Document 4 of 260
\item[107] Disability Rights Document 3 of 270
\item[108] Disability Rights Document 5 of 260
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\end{footnotes}
5. Non-Compliance with Behavior Services Laws and Regulations

We also found instances focused on whether or not the restraint procedure was implemented without de-escalation attempts, as punishment, as a substitute for an implementation plan, or for the convenience of staff.\textsuperscript{110} Many of the irregularities consisted of unusually prolonged use of restraints.

Client C spent two hundred five (205) minutes in a protective waist belt while “calm the entire time.”\textsuperscript{111} If Client C was indeed calm, the procedure should have ended. Client C’s entire incident was captured by video and investigated by the Department. Before being placed in the protective waist belt, Client C was in the mat wrap with restraints and reported by the Department’s investigator to be “no longer squirming around but raising [their] head and speaking to staff.”\textsuperscript{112} Yet, Client C is then released from the mat wrap and put into the protective waist belt and then clipped to the chair in the room. During the three hours and forty minutes Client C is restrained to the chair, the investigator notes that client C brings their legs up while talking to staff sitting next to them and at one time attempts to stand. Even when Client C is released from the restraint chair, the Department’s Investigator notes that Client C “continually fidgets in the chair” until being released.\textsuperscript{113} Despite this, the Behavior Analyst found the staff followed Client C’s behavior plan. Client C, however, also alleged the staff made a threat during this time frame that the client should sleep with one eye open. The Department’s Investigator reviewed the video and saw the staff member lean over Client C and say something about going to sleep, but the Investigator accepted the staff’s version that he told Client C to take the night and sleep on it and think about what he had done despite the reactive strategy prohibiting talking to the resident while in restraints.\textsuperscript{114} It wasn’t until three months after the incident, Client C’s behavior plan was updated to define the criteria and duration of calm behavior more clearly.\textsuperscript{115}

Client P reported to multiple authorities that the reason for Client P’s elopements were due to abuse at Carlton Palms where staff beat the residents “behind the cameras.”\textsuperscript{116} Although Client P expressed multiple times the desire for a different residential placement, there was no indication that one was located for Client P,

\textsuperscript{110} Fla. Admin. Code Rule 65G-8.006(2)
\textsuperscript{111} Disability Rights Document 1 of 340
\textsuperscript{112} Disability Rights Document 6 of 340
\textsuperscript{113} Disability Rights Document 6 of 340
\textsuperscript{114} Disability Rights Document 7 of 340; Safety Care also prohibits speaking to clients while in restraints.
\textsuperscript{115} Disability Rights Document 17 of 335
\textsuperscript{116} Disability Rights Document 5 of 256; 8 of 251
even after the Department raised the concern in one of their investigations of Client P’s elopement from the facility.117

Client A was coming out of a procedure and was told by staff to sit on the couch. Client A, however, requested to walk around and was told no by the staff. This led to Client A displaying more maladaptive behavior and the staff reacted by placing Client A in the protective waist belt for ninety-five (95) minutes.118 The incident is an example of a lack of an appropriate behavior plan and use of restraint as convenience for the staff.

Client A was returning to bed when staff instructed Client A to lie down at which point Client A came out of the room. Staff reacted by placing Client A in emergency protective waist belt and then emergency chair restraint with ankle cuffs due to alleged aggression while being placed in the waist belt. First, Client A was described as returning to bed and it is unknown why staff needed to give further instructions to lie down. Second, no de-escalation techniques were used. The whole incident reads as if there was an argument between Client A and staff that resulted in Client A being mechanically restrained.119

Another abuse and neglect complaint for Client A was reported to the Department regarding a bite mark without a clear statement of when the bite occurred. Review of restraint logs for the time in question, a period of eleven days from the date it was alleged to have occurred to the date reported, revealed one significant incident in which Client A was placed in the Restraint Chair and became aggressive with hitting and kicking and biting.120 The very next day, Client A was seen by the nurse for eye pain. The nurse notes redness and a raised area above the bridge of the nose. When asked what happened, Client A stated the supervisor hit Client A.121 The nurse notified her supervisor. Seven days after that incident, Client A informed a nurse that staff bit Client A’s shoulder and the staff present interrupted and redirected Client A for ‘lying’.122 There were no nursing notes corresponding to Client A’s later statement to the nurse that staff bit Client A. Yet four days later, the alleged bite was reported to the Department. The Department interviewed the staff who allegedly bit the client and the staff member not only denied biting the client but also specifically denied “hitting the client on the head with a radio.”123 On the day that the Department’s investigator visited, beginning at approximately five o’clock in the evening, Client A was suspiciously placed in prolonged emergency

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restraints lasting approximately two and a half hours. The first series of the procedure involved a protective waist belt for sixty (60) minutes, followed by restraint chair with ankle and wrist cuffs for twenty-nine (29) minutes, restraint chair without limb restraints for another twenty-nine (29) minutes, and the restraint chair again for another twenty-four (24) minutes.124

In another instance, Client A was in the restraint chair after being aggressive with staff and continued to kick at staff and the wall so ankle restraints were placed on Client A. This was not the only incident where the justification for restraining Client A’s ankles was due to kicking at staff.125 What is not indicated is why staff and the wall were within reach of Client A’s legs. Client A spent forty-five (45) minutes in the most restrictive restraint on a day that is described as Client A being aggressive towards staff “all evening.”126 The only de-escalation used for this incident was ignoring and redirecting. When those techniques did not work, the staff utilized emergency protective waist belt and the chair restraints.127 Safety Care and Carlton Palms’ behavior programming also prohibit the use of restraint due to lengthy de-escalation measures.

Client C was also placed in emergency protective waist belt despite the plan’s requirement for a non-restrictive strategy of resetting accumulation of good days to zero. Client C was alleged to have stolen a staff’s belongings and hid them. Though Client C’s behavior plan specifically notes stealing as a behavior to decrease by resetting the client’s accumulation of good days to zero, staff placed Client C in an emergency protective waist belt restraint and when Client C became aggressive, Client C was placed in emergency chair restraint with ankle and hand cuffs defying Safety Care’s prohibition against the use of restraint as punishment.128

Client Q’s behavior program required verbal redirect and physical redirects to the mat for supine relaxation in the case of aggressive threats or elopement. However, Client Q displayed these behaviors and was immediately placed into mechanical restraints into the mat for thirty-one (31) minutes.129 During the time in the mat, Client Q was reportedly uncooperative with circulation, temperature, and respiration checks.130 At 0755 hours, Client Q became calm and was released.131 However, only ten minutes later staff initiated emergency procedures because after Client Q was released from the previous procedure, “staff were moving [Client Q] to the chair for

124 Disability Rights Documents 72-79 of 276
125 Disability Rights Document 176, 184 of 278
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[protective waist belt]” and Client Q became aggressive again. If Client Q was calm and released from the previous procedure, there would have been no need to continue with a restraint in the chair with the protective waist belt. Yet the restraining continued and Client Q became agitated again and was restrained to the chair with wrist and ankle restraints for twenty (20) minutes and with the protective waist belt for seventy-five (75) additional minutes defying Safety Care’s prohibition on the use of restraints as punitive and relegated only to the time necessary to alleviate the imminent harm to the resident or others.

6. Lack of Individualization in Behavior Plan

Each behavior plan is required to be reviewed and signed off on by a physician. Despite the need for individualization, almost all of the behavior plans reviewed contained a comprehensive statement including all forms of restraint available at Carlton Palms. Therefore, it’s not really known if the physician actually sees the individualized behavior plan. The comprehensive statement included in all but three of the behavior programs reviewed reads:

“I understand the management of this individual’s behavior may include the use of verbal direct, physical direct, personal restraint, mechanical restraint supine, mechanical restraint prone, wrap mat, protective waist belt in chair, restraint in chair (wrist and ankles), range of motion (wrist and ankles), helmet (with and without face shield), Posey Mitts and splints.”

Client G’s behavior program contained this blanket acknowledgement by the physician even though Client G’s program specifically states the supine mat wrap could not be used due to vomiting and the restraint chair should not be used due to extreme continued agitation and so the prone wrap mat was included in their place.

For the three clients, whose behavior plan did not incorporate the blanket statement in full, two included the blanket statement with the addition of a jumpsuit and the remaining client only listed “verbal direct, physical direct, and personal restraint.”

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134 Disability Rights Document 15 of 420
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7. Failure to Comply with Resident’s Behavior Plans

When reviewing the behavior data sheets for compliance with the residents’ behavior plans, we noted times when the sequence was not followed, when prolonged periods of restraint were used, and when de-escalation was not recorded. Other irregularities involved use of the wrong restraint, use of restraint in place of de-escalation techniques, and inappropriate use of the restraint procedure.

On one particular day, Client A was placed in an emergency chair with limb restraints without staff ever utilizing the appropriate behavior plan’s de-escalation strategies. Client A’s behavior was agitation, which according to the behavior plan, required the use of ignoring, contingent observation, verbal direction to lay on the mat, and then physical direction to lay on the mat until calm. However, there were no indications that such techniques were used. Instead the staff went from redirect to an emergency protective waist belt then to the emergency chair restraint with wrist and ankle restraints for forty-nine (49) minutes. During the emergency chair restraint, Client A’s agitation continued such that the staff resorted to an emergency helmet for thirteen (13) minutes.137 Two hours later, a similar emergency use of the protective waist belt and chair restraints was utilized on Client A without proceeding first through verbal redirection and physical redirection to lay down until calm in the supine position.138 That restraint lasted fifty-five (55) minutes. Approximately two hours after that, six staff utilized the protective waist belt and the chair and limb restraints for ninety-five (95) minutes on Client A, though not marked as an emergency, without following the behavior plan to first interrupt and verbally or physically redirect to the mat for calming.139 On this day, beginning around six o’clock in the evening, Client A spent approximately three hours in mechanical restraints, without staff ever utilizing or documenting the de-escalation techniques identified in the behavior plan.

These were not the only incidents of emergency use of the chair restraints on Client A. Other instances of non-emergency use of restraints were utilized for known maladaptive behavior. For instance, Client A displayed a behavior and was redirected and then “quickly” put into the chair restraint with wrists and ankles restrained.140 This incident was not coded as an emergency. In another instance, Client A was coming out of a procedure and having dinner but was making threats to staff such that staff removed the meal to try and get Client A to calm down. After removing Client A’s meal, self-injurious behavior occurred and Client A was then

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21
put into the protective waist belt and then the chair with ankle and wrist restraints.\textsuperscript{141}

Client J spent an hour restrained in the chair without any indication of the prescribed de-escalation techniques identified in the plan.\textsuperscript{142} On the same day, the same staff member put Client J in the chair restraint for another fifty-two minutes without ever attempting de-escalation.\textsuperscript{143} On a different day, with different staff, Client J was again put into the restraint chair for another fifty minutes without ever attempting de-escalation.\textsuperscript{144} On one day, Client J was placed into range of motion restraint for sixty (60) minutes, which includes being restrained in the chair with the protective waist belt but also having the client’s wrists restrained as well. This violated Client J’s behavior plan which states that when in range of motion, Client J will be mandatorily released after thirty minutes so that Client J is only restrained in the chair with the waist belt. The supervisor signing off on the procedure did not indicate if Client J’s procedure was implemented correctly.\textsuperscript{145} A similar occurrence resulted in Client J being in range of motion restraint for forty-five (45) minutes without the mandatory release.\textsuperscript{146}

Client C also spent prolonged time in restraint. On one instance of elopement and aggression towards staff, which would normally require redirection and token forfeiture and use of the mat wrap and restraints if aggressing, Client C went from sixty-five (65) minutes of the mat and mat restraints to two hundred five (205) minutes of protective waist belt restraint.\textsuperscript{147} Another incident of agitation that requires use of the mat wrap and restraints led to sixty-two (62) minutes of emergency chair restraint with the protective waist belt.\textsuperscript{148}

Client M specifically had de-escalation and non-restraint methods built into their behavior plan for aggressive threats which were set apart from physical aggression. For threats, Client M was to be verbally directed to lay in the supine position, then physically directed to do so, then a loss of token. However, Client M went straight from aggressive threats directly to the mat for eleven minutes.\textsuperscript{149} Similarly, Client E required implementation of gloves before proceeding to mechanical restraints with the mat. Yet, when Client E began scratching, staff merely tried to redirect, then

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\textsuperscript{142} Disability Rights Document 120 of 288
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\textsuperscript{149} Disability Rights Document 42 of 309
skipped the implementation of gloves, and proceeded directly to the mat and mechanical restraints.\textsuperscript{150} Client N was also placed in emergency prone restraints despite Client N’s behavioral program specifically stating that prone restraints were removed more than seven months ago.\textsuperscript{151} Despite this, the supervisor marked the data as all procedures being implemented correctly.\textsuperscript{152} Client N suffered visible injuries due to this restraint.\textsuperscript{153} Client E displayed a reemergence of maladaptive behaviors and the response was to add the use of supine relaxation and mechanical restraints to the behavior plan.\textsuperscript{154} Despite this dictation of procedures, there were times when the mat and mechanical restraints with the mat were replaced by the protective waist belt and restraints to the chair.\textsuperscript{155} In one instance, Client E spent fifty-eight minutes in an emergency protective waist belt (chair restraint) without any attempts at release.\textsuperscript{156} Client G had four incidents that resulted in the use of the mat and mechanical restraints and all four involved transitions to “the annex” for meals and a denied request for some type of food or drink.\textsuperscript{157} Ultimately, the transition to the annex proved to be detrimental as Client G was left unattended after failing to be included in the transition and was found sometime later, unattended.\textsuperscript{158} The responsible staff was terminated but the investigation revealed that the staff was dealing with another resident prior to transitioning. It is possible that Client G being left behind was a preventable accident if residents were not required to transition to another location for meals.\textsuperscript{159} Due to the lack of home-like settings, the residents are required to transition in groups for meals.

For Client K, on the day in which the abuse hotline was called for an incident of PICA, Client K had earlier lost intervals, twice for refusing to clean up and prepare “for move to living/dining room for breakfast”.\textsuperscript{160} Client K also lost intervals, a positive reinforcement, on three separate days for refusal to attend the day program although no such requirement is contained in the plan, and in fact, Client K was permitted in the plan to refuse to attend activities and have choice in activities.\textsuperscript{161} On one occasion, when Client K refused to come back to the group

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\textsuperscript{151} Disability Rights Documents 22 of 324; 8 of 317  
\textsuperscript{152} Disability Rights Document 23 of 324  
\textsuperscript{153} Disability Rights Document 23 of 324  
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\textsuperscript{155} Disability Rights Document 80, 92 of 217  
\textsuperscript{156} Disability Rights Document 92 of 217  
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area, they were placed into emergency chair restraint with wrists secured.\textsuperscript{162} When staff attempted to release Client K, they refused to be released, denying they were calm, and remained restrained for a total of sixty minutes.\textsuperscript{163} Also of note, there were no attempts at de-escalation noted, no verbal direct, and no loss of interval first. Client K also lost an interval on two other days because they would not get up and get ready so that breakfast set up “could be done on time.”\textsuperscript{164} Client K also lost an interval one day when they refused to go outside with the group for water day.\textsuperscript{165} Client K again was denied the choice of activity for the day and was punished for not proceeding with the group of residents and the planned activity and was on the facility’s scheduled meal times. Finally, Client K was also placed in emergency prone restraints despite such procedures not being provided for in the plan.\textsuperscript{166}

In stark contrast, there were instances that showed positive results when de-escalation identified in the behavior plan was utilized to interrupt behaviors.\textsuperscript{167} For instance, for Client A, a known maladaptive behavior was displayed and the behavior plan was followed from verbal direction, to physical direct, to use of the mat with wrist and ankle restraints. The total time involved was only twenty-two (22) minutes and only ten (10) of those minutes were spent in the most restrictive restraint.\textsuperscript{168} This was typical of other timelines when the behavior plan was followed. On one day, Client A’s behavior plan invoked twenty-five (25) minutes of staff time and only sixteen (16) of those were spent in the most restrictive restraint of the mat.\textsuperscript{169} Of the thirty instances found in which Client A’s behavior plan was followed, Client A usually spent anywhere from six (6) to twenty-eight (28) minutes in the most restrictive procedure identified on the behavior plan - the mat wrap - either with or without ankle or wrist restraints.\textsuperscript{170} The longest incident when the behavior plan was followed was fifty-nine (59) minutes.\textsuperscript{171}

8. Failure to Comply with Restraint Documentation Requirements

\textsuperscript{162} Disability Rights Document 80 of 384
\textsuperscript{163} Disability Rights Document 80 of 384
\textsuperscript{164} Disability Rights Document 162 & 110 of 384
\textsuperscript{165} Disability Rights Document 200 of 384
\textsuperscript{166} Disability Rights Document 242 of 384
\textsuperscript{167} Disability Rights Document 94 of 276
\textsuperscript{168} Disability Rights Document 108 of 276
\textsuperscript{169} Disability Rights Document 116 of 276
\textsuperscript{170} Disability Rights Documents 230, 236, 238, 242, and 246 of 278; Documents 38, 48, 50, 54, 60, 146, 138, 152, 154, 156, 158, 160, 164, 168, 172, 176, 178, 182, 188, 195, 207, 211, 234, and 276 of 277
\textsuperscript{171} Disability Rights Document 70 of 277
We also found non-compliance with Carlton Palms’ behavior programming and guidelines regarding documenting the restraint procedures. The policy requires all staff utilizing reactive strategies to be trained and requires documentation of four elements: (1) the behavior that necessitated a reactive strategy; (2) the reactive strategy used; (3) the date and time the reactive strategy was started and ended; and (4) the person who initiated, applied, authorized, and terminated the strategy.

In all uses of mechanical restraints, the post-restraint procedure requires a supervisor or staff who was not involved in the intervention to check the individual for any sign of injuries and for the staff involved to complete an incident report describing how the individual received the injury if any. Finally, the supervisor, staff, and clinician should then review strategies to prevent injury in the future.

Client A was immediately placed in emergency protective waist belt, then chair restraint, then ankle restraint, then use of the helmet. Though the circulation checks were documented for every 15, 20 and 25 minutes, there was no indication as to how long Client A was in each portion of the procedure. This is required documentation per the reactive strategy. The only notation is that the start of the whole procedure was at 2145 hours and that it ended at 2213 hours. Supervisors signed off on this documentation despite its deficiencies.

Client D similarly had an incident leading to an emergency use of the protective waist belt with no indication of the length of time for any part of the procedure. The only time noted was the start time, but not the end time. Yet a supervisor signed off that all procedures were implemented correctly. Another time, Client D was aggressive towards staff, placed in a mat wrap with restraints for twenty-one minutes and no notations of circulation checks or attempts at release were noted.

For Client G, one emergency use of the mat and restraints and one non-emergency use failed to contain any narrative at all, though a supervisor signed off.

Similarly, Client E was in mechanical restraints and it proceeded to go on with Client E on the mat voluntarily and with gloves on for another two hours and forty minutes. The narrative states confusing information that “while in [mechanical restraints]” the client continued to “be upset and reach for staff” resulting in the

172 Id. p. 18
173 Id.
174 Disability Rights Document 194 of 278
175 Disability Rights Document 42 of 343
176 Disability Rights Document 302 & 303 of 343
177 Disability Rights Documents 190, 206 of 395
178 Disability Rights Document 140 of 217
use of protective gloves.\textsuperscript{179} There is no indication how Client E would be able to reach for staff if the client’s arms were restrained while in the mat. Ultimately, Client E complained of back pain and so the procedure continued for another seventy-five (75) minutes with Client E in the protective waist belt and restrained to the chair.\textsuperscript{180}

Client M’s behaviors led to the use of mechanical restraints while in a mat for forty-two (42) minutes followed by restraint in the chair for one hundred (100) minutes. However, while in the restraint chair, staff noted that Client M refused checkups and temperature checks. Yet staff continued to mark that an attempt at release was made every fifteen minutes.\textsuperscript{181} A similar occurrence had Client M in an emergency chair restraint by the waist belt for seventy (70) minutes and staff indicated that no circulation or temperature checks were made because Client M did not want to be touched, yet they documented an attempt at release every fifteen minutes.\textsuperscript{182}

Pursuant to behavior data sheets, Client M was noted to have visible signs of injury after a restraint involving use of a helmet.\textsuperscript{183} However, there were no corresponding Incident and Injury Reports in the file.\textsuperscript{184} Client O’s allegation of abuse and neglect also revealed confirmation that Incident and Injury reports were not filed for Client O’s injuries as reported by family.\textsuperscript{185}

Client Q alleged they were punched and choked by staff after an elopement which caused documented injuries to the anterior neck, axilla, upper arms and upper back, and two lacerations to the lower lip requiring sutures inside and out.\textsuperscript{186} Staff stated Client Q fell several times during the elopement causing the injuries.\textsuperscript{187} However, during subsequent interviews Client Q changed the story two more times, stating first that the staff’s tackling caused the injury, then later stating the trip and fall caused the injury.\textsuperscript{188} Yet, at no time did Client Q corroborate multiple falls during the elopement as alleged by staff. The investigations were closed as unfounded. There were no internal Incident and Injury Reports or reporting to APD for Client Q’s injuries from the elopement, despite our request for all related and pertinent records of the alleged abuse.

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\textsuperscript{184} Disability Rights Document 7 of 313
\textsuperscript{185} Disability Rights Document 9 of 242
\textsuperscript{186} Disability Rights Document 5 of 424
\textsuperscript{187} Disability Rights Document 4 & 6 of 417
\textsuperscript{188} Disability Rights Document 6 of 417
Conclusion

What is undeniable is that there exists a small population of individuals with intellectual or developmental disabilities that require intensive behavior treatment and that due to those behaviors, treatment is often not successful at home. While residential habilitation, including intensive behavior and behavior focused programming, is provided in small group homes throughout the state, there is only one CTEP, Carlton Palms, in the state of Florida, whose rates per resident exceed all of the other rates provided to group homes throughout the state. While APD’s administrative complaints could not be resolved fast enough due to subsequent findings of abuse and neglect for Carlton Palms’ residents, there were and are few options for individuals that require the kind of intensive and focused behavioral interventions as the residents at Carlton Palms. When options are lacking, tolerance becomes an acceptable or necessary trait.

Disability Rights Florida remains committed to advancing the quality of life, dignity, equality, self-determination, and freedom of choice of persons with disabilities. Ongoing monitoring of the quality of services and reporting of abuse and neglect at Bellwether’s facilities will continue. The Agency for Persons with Disabilities must continue to identify new and innovation models of support for individuals with developmental and intellectual disabilities so that their needs can be met, in their home communities, near their loved ones if not in their loves one’s homes, and in a homelike setting.

Disability Rights’ recommendations are:

1. Strengthen review and investigation of abuse and neglect allegations.

At one point, Bellwether (formerly AdvoServ) “welcomed strong oversight and clear standards because they help us deliver the highest quality care.” Yet, review of the Carlton Palms’ own reporting through behavior data along with reporting to the Department and APD reveal misuse of restraint procedures, prolonged use of restraint procedures, inadequate documentation of restraint procedures, and staff’s outright avoidance of reporting accurate accounts of restraints and injuries to the

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189 Although, there is at least one former Carlton Palms resident that is residing with the family and has successfully petitioned for variances to the limitations placed on behavioral services provided in the home.

190 Vogell, Heather, “Unrestrained” ProPublica December 10, 2015
residents. During a time when APD’s personnel were on site and staff were allegedly reporting all possible incidents of abuse and neglect, there were multiple examples of delayed and inaccurate reporting by staff that should have been captured by Carlton Palms’ own procedures and investigation.

2. Enforce home and community-like characteristics and exclude settings that tend to isolate individuals from the broader community.

Several incidents discussed as examples were at times the individual was transitioning to or from one place to another and usually for a meal. A lack of a home-like setting prevents individuals from choice in activities and meals, and inevitably requires the use of reactive strategies to gain compliance from the individuals. While the federal community settings rule has been stated as a reason for transitioning individuals out of Carlton Palms, it should not carry the burden alone as the allegations of abuse and neglect stem from staffs’ use of restraint procedures and Carlton Palms’ actions in reporting and supervising the staff during and after these restraint procedures.

3. Amend Florida laws regarding use of restraint to be in line with best practices evidenced in other States.

Pursuant to the Behavior Programming Guidelines, there are variations between the different states in which Bellwether operates. For instance, in New Jersey and Maryland, prone restraint is not permitted. However, in Florida prone restraint is permitted unless the person has Down syndrome, obesity, or any other condition which a physician determines may place an individual at risk in prone restraints. For those in Delaware, no form of mechanical restraint is permitted. Whereas in Florida, mechanical restraints are considered a valid reactive strategy for control of behaviors that create an emergency or crisis situation.

In New Jersey, if an emergency personal control technique is used three or more times in any six-month period, the interdisciplinary team must meet within five

191 42 C.F.R. § 441.301 defines settings that are presumptively institutional by having the effect of isolating Medicaid recipients from the broader community. Carlton Palms meets two of the definitions of inappropriate settings that have the effect of isolating per Florida Legislative House of Representatives’ Staff Analysis for CS/HB 899 (2017).
192 Fla. Admin. Code Rule 65G-8.001(15)
days and conduct a functional assessment of the behaviors and techniques. Further, in New Jersey, Bellwether only operates group homes and these group homes do not utilize mechanical restraints as they have phased them out in favor of personal restraints when necessary.

As stated at Carlton Palms’ quarterly meeting in November 2017, if Bellwether’s facilities in New Jersey can be run successfully without mechanical restraints there’s little reason to doubt the same models could be successful here. As early as January 2017, Bellwether began phasing out mechanical restraints at Carlton Palms and by November 2017, fifty-two percent (52%) of the residents are no longer subjected to mechanical restraints. From March 2016, when mechanical restraints far exceeded personal restraints, Carlton Palms has been able to reverse that so that there are fewer mechanical restraints than personal restraints. As part of the programming, Carlton Palms stated they have implemented a lot of teaching of redirection and de-escalation. The program also switched from eight hour shifts to twelve hour shifts to provide more consistency in staffing for the residents. At the day training program, of the eighty-four participants, only five are subjected to restraints.

4. Create more options for individuals needing similar services so that services could be provided in their home communities in the least restrictive setting.

Not only does the State need to enforce the laws regarding the appropriate provision of reactive strategies, transitions to the least restrictive settings, and adoption of home and community based characteristics for the delivery of waiver services to Florida’s most severe and challenging individuals; it should do so throughout the state by providing a wide array of smaller settings that are fully capable of meeting the changing needs of such individuals in their home communities. Current circumstances force families to move loved ones away from their families, a natural support, to one large congregate setting where all of the residents have challenging behaviors. It is achievable since Carlton Palms has, at the behest of APD’s transition efforts, transitioned a total of forty-four individuals to community settings since the concerted effort for transition began with the last Settlement Agreement.

193 Todd Papa, November 3, 2017, Carlton Palms quarterly meeting
194 Id.
195 Bellwether Behavioral Health’s Behavior Analyst from Bellwether New Jersey, November 3, 2017, Quarterly Meeting
196 Id.
197 See March 3, 2018 letter from Barbara Palmer, APD Director, attached as appendix.
5. Ensure sufficient funding for APD’s proposed Enhanced Intensive Behavioral Rate.

APD’s efforts at establishing an Enhanced Intensive Behavior rate and setting is one option and more should be developed to ensure that those who do not wish to leave the family home are afforded the opportunity to receive sufficient supports at home. Individuals with intellectual or developmental disabilities may have changing needs and should be able to receive those services close to home with little disruption to their lives and the lives of those that support them.
March 3, 2018

Ms. Mary Ellen McDonald
Disability Rights Florida
2473 Care Drive, Suite 200
Tallahassee, FL 32308-9803

Re: Disability Rights Florida – Carlton Palms Education Center report

Dear Mary Ellen:

Thank you for sharing the above report with the Agency. Management and I have reviewed the report and do not disagree with its findings. However, we would like to make one correction to the number of people who have transitioned from Carlton Palms to the community; that number as of our February 2018 report is 44.

I appreciate your giving me and my management team the opportunity to review the report before release. If I can be of any further assistance, please feel free to contact me directly.

Sincerely,

Barbara Palmer
Director
Agency for Persons with Disabilities