The Commonwealth of Massachusetts
Department of Early Education and Care
21 Spring Street, Suite 2, Taunton, Massachusetts 02780
Date: November 1, 2007

INVESTIGATION REPORT

Incident # : 49037 Facility # : 4904051
Name of Facility: JRC - 66 Kevin Clancy Way
Address: 66 KEVIN CLANCY WAY, STOUGHTON, MA 02072-3888

Intake Date: **08/27/2007**

Report Date:

Facility Description: The JRC Stoughton Residence is a single family with two floor levels. There are 7 bedrooms, a living room, recreation room, dining room and 4 bathrooms. The residence has a licensed capacity for 12 boys.

Reason for Investigation: The program notified the Department of Early Education and Care (EEC) that [redacted] Report had been filed with the [redacted] on behalf of a [redacted] year- old resident in the program. A report had also been filed with [redacted] on behalf of a [redacted] year- old placed in the program. Both residents' received unwarranted GED shocks which were administered by staff on the [redacted] shift at the request of an unknown caller.

Investigation Activities: On August 29, 2007 a visit made to JRC program along with Investigator, [redacted] from the [redacted] who is investigating on behalf of the [redacted] year- old resident. Investigator, [redacted] from the [redacted] and Social workers, [redacted] and [redacted] from [redacted] who are investigating on behalf of the [redacted] year old resident. Investigators met with Joseph Assalone, Director of Student Services and reviewed video footage of the night/early morning of 8/26/07. Both Residents [redacted] and [redacted] were interviewed by investigators. Follow up visits were made to the program on 8/30, 8/31, 9/5, 9/6, 9/7 and 9/10/07 by EEC, [redacted] and [redacted] Investigators at which time interviews were conducted with necessary staffs.

Contacts Interviewed:
Joe Assalone, Director of Student Services
Five (5) Mental Health Assistants
Dr. Von Hyem, Director of Clinical Services
Glenda Crooks, Assistant Executive Director
Three (3) Quality Control Staff (DVR Monitors)
Charles Njogu, High Crisis/ Security Specialist
Dr. [redacted] Clinician
[redacted] LPN

Documents Reviewed:
[redacted] Reports
Critical Injury Reports
Three Resident Files
Internal Investigation
Staff Records and Training
DVR Monitoring logs, dated *8/26/07*
GED Policy /Program Rules & Policies
JRC Notification Procedures (past and present)

Roland Porkpah, Quality Control

Determinations:

-The investigation has found sufficient evidence to conclude that staff [redacted] was physically abusive towards two residents placed in the program. [redacted] allegation of physical abuse of the residents [redacted] and [redacted] by staff [redacted] It is the judgment of the Department that staff [redacted] had engaged in conduct which bears adversely upon his ability to provide for the safety and well being of a child.

-The investigation found sufficient evidence to conclude that the Stoughton House staffs were neglectful in the care of residents [redacted] and [redacted] The program staff failed to protect the health and safety of the identified residents. [redacted] the allegation of neglect of the residents by all staff. It is the judgment of the Department that the staff had engaged in conduct which bears adversely upon their ability to provide for the safety and well being of a child.

-The Staff failed to follow JRC policy and training regarding medical treatment and failed to communicate relevant information to nursing regarding residents [redacted] and [redacted] condition. This resulted in delay of medical attention for both residents.

-The Licensee and Administration failed to provide a program that was administratively sound with clearly conceived policies and practices for the services provided to residents. It is the investigation finding that programmatic issues were a contributing factor in the events that took place on 8/26/07.

- The investigation had found sufficient evidence to conclude that staff [redacted] lacked the necessary training and experience to carry out responsibilities of an overnight supervisor.

-The licensee failed to have staff with adequate training on shift to ensure the proper administration of the program policies.

-The staffs failed to follow JRC policies and procedures as it relates to behavior management.

- The staffs used poor judgment and failed to follow resident [redacted] and [redacted] Treatment plan and Daily Recording Sheets.

-The staff failed to monitor the residents in a manner that assured there health and safety. The staff failed to provide a safe environment for the residents in care.

- The staff violated the programs communication policy and neglected their responsibilities as a mandated reporter.

-Staffs [redacted] and [redacted] were neglectful in their responsibilities as monitoring staff thus compromising the supervision and the safety of the residents.

Investigation Findings:

• On the night of August 25-26, 2007, the following six staff was on duty at the Stoughton residence. Two of the staff had worked a triple shift and had been with the residents since 7am on 8/25/07. Three of the staff had worked a double and had been with the residents since 4pm on 8/25/07. Staff [redacted] was the only one that had not been with the residents throughout the day, he had come on shift at 10pm on 8/25/07. The investigation noted that four of the staff had been employed for less than 3 months at JRC.

• The licensee reported that during the early morning hours of August 26, 2007, a former resident, [redacted] (a [redacted] year- old resident who had been AWOL from JRC custody two weeks prior to the incident) had called the Stoughton residence. It was reported that resident [redacted] had posed as one of the quality control monitors, [redacted] from DVR Monitoring System. Over several hours [redacted] gave a series of instructions to the Stoughton residence staff to awaken three residents [redacted] and [redacted] and administer several skin shocks for behaviors that they had exhibited earlier in the evening. The licensee reported that resident [redacted] had intimate knowledge of the students who resided in the home, the staff who worked there as well as how the residence operates. One staff, [redacted] thinking that he was speaking to an authorized person from DVR monitoring began to comply with every direction given. The other staff also followed instructions as directed. [redacted] continued to make a series of phone calls to the Stoughton House between the hours of 2:00am and approximately 4:45am, during which time he continued to portray himself as [redacted] from DVR and made accurate statements about staffs positioning in the house. Resident [redacted] was consequently administered 29 GED applications and resident [redacted] was administered 77 GED applications in a three hour period. Prior to administering GED applications to resident [redacted] the staff called the JRC monitoring directly at which time they learned that they had not been speaking with DVR.

• The licensee reported that both residents [redacted] and [redacted] were evaluated by the JRC nursing staff, JRC's physician, as well as their treating clinician, Dr. [redacted] The students were reported to be found to be in good health. The skin shock devices were removed from the both students and they were relocated to another residence. [redacted] reported that resident [redacted] was further examined at [redacted] Hospital on [redacted] and was reported to have two areas of first degree burn related to the presence of the GED.

• Following the reported incident, The JRC Administrative staff was contacted and an internal investigation was initiated. The license reported that all necessary collaterals and each students' parent/guardian was notified as of the incident as well as and each students' court appointed attorney. A report was also filed with Officer Duke at the Stoughton police station. The licensee reported that six Stoughton staffs and the assigned DVR monitor were consequently suspended pending the outcome of the investigation.

• The licensee reported that they became aware that the caller was resident [redacted] because he called back into the DVR monitoring system and his voice had been recognized by the staff. It was reported that resident [redacted] had admitted to being the person that called the Stoughton residence during the previous night instructing the staff to administer the shocks. During the investigation it was learned that [redacted] had also spoken with his clinician, Dr. [redacted] as well as a resident of the Stoughton House and admitted his actions. The Stoughton Police were updated with this information and provided his family's address and phone number and plan on prosecuting him to the fullest extent.

• [redacted] is a 16 year old male, from [redacted] presently is in [redacted] was admitted to the Judge Rotenberg Educational Center (JRC) on [redacted] current guardian ([redacted]) has signed consent forms for all JRC's treatment procedures. It was reported that since placement [redacted] had not exhibited many major inappropriate behaviors and often performed extremely well. It was reported that prior to the reported incident, resident [redacted] had not received a GED since [redacted] Resident [redacted] was discharged form JRC on [redacted] and had returned to [redacted]

• [redacted] is a [redacted] year- old male, from [redacted] [redacted] was admitted to the Judge Rotenberg Educational Center (JRC) on [redacted] [redacted] had signed necessary consent for all JRC treatment procedures. It was reported that [redacted] knew his program and did not deviate from it. Resident [redacted] had had not exhibited any behaviors that warranted a GED since [redacted]. Resident [redacted] remains in the JRC program but no longer receives GED applications.

• Resident [redacted] ([redacted]), age [redacted] years old. Resident [redacted] is from [redacted] and does not have approved Movement Limitation or Aversive Shock (GEDs) in his Treatment Plan. Resident [redacted]'s clinician and parent are to be contacted for an approval consequence. Resident [redacted] remains in the JRC program.

• Both residents [redacted] and [redacted] were interviewed during the investigation and had reported that they had been awoken from their sleep when they received GEDs shocks that were administered by staff [redacted]. Both residents reported receiving additional applications while strapped to the 4-point board in the recreation room. Both residents' reportedly had asked staff [redacted] "what they did" and was told that they were being consequated for behaviors they had exhibited during the 9:00pm hour. The residents had denied having any behaviors during the identified time period. Both residents had complained of pain related to the applications received and requested that the nursing staff be called. The residents reportedly were not seen by the nurse until the following day at which time pictures were taken of their injuries. Resident [redacted] was unavailable during the investigation but was later interviewed by [redacted].

• All Direct care staff were interviewed and had confirmed the incident as reported however there were some noted discrepancies in the staffs' accounts of the reported events. The staff reported that the evening and night shift went well and there had been no issues with any residents. All staff reported that they had not observed either resident exhibit the behaviors alleged by the DVR caller but assumed that DVR had. It was reported that staff [redacted] had administered the aversive application at the direction of DVR monitoring staff (an unknown caller) and did not consult with or pre-verify anything with any other staff. Three staff (sleep aides) reported that they were asleep when residents [redacted] and [redacted] received GED application in their bedroom. DVR revealed that sleep aides were awoken by the commotion and had responded (approximately 2:43am) to the area where staff [redacted] and [redacted] explained what had transpired. Staff [redacted] reported that he had not been aware that resident [redacted] had received GED shocks while sleeping. Staff [redacted] reportedly had been doing assigned chores. Video Surveillance revealed that staff [redacted] had been aware of the events and had consulted with staff [redacted] prior to his administering the applications. Staff [redacted] had also been observed briefly speaking with the caller. Both staff, [redacted] and [redacted] were observed reviewing the resident Recording Sheets, prior to administering any applications.

• All Stoughton staff on shift had acknowledged that they had at some point participated in and/or observed the events occurring with residents [redacted], [redacted] and [redacted]. The staff had not made any individual efforts to assure the appropriate procedures were being implemented. Staff reported that they had followed procedures the same way they received them from the DVR caller. It was reported that staff were not in agreement with the events however followed instructions because they believed that it was DVR on the phone and felt that they could not go against DVR. Reportedly, staff were apprehensive but the caller told them that they would be "Evaluated" if they did not follow instructions. Staff reported that they assumed that they were being watched because the caller seemed aware of staffs actions and accurate positioning inside the house, also because no Quality Control staff had shown up to the house. The investigation noted that the staff observed (on DVR) continually expressing concern and appear reluctant to participate.

• Staff reported that it was unclear as to who was supervising the shift at the time of the events because staff [redacted] had been giving the instructions. The investigation noted that on 8/26/07 staff [redacted] (being the most senior awake staff on shift) was assigned the role of supervisor. Staff [redacted] failed to take control of the shift and direct staff in an appropriate manner. Staff [redacted] did not take any steps to prevent or intervene during the reported events but instead advocated to other people. Staff [redacted] reported that he had only been employed at JRC for 3 months to the day and was not familiar with delayed consequences and had no prior experience with administering aversive treatment. Staff [redacted] acknowledged that he had been flustered and had looked to senior staff for direction.

• The staff failed to meet resident's [redacted] and [redacted]'s health needs. The staff did not evaluate residents [redacted] and [redacted] after they complained of pain, nor did staff notify the on-call nursing. DVR revealed that resident [redacted] had informed several staff on different occasions

his leg was "killing him" and could be heard asking staffs to call the nurse. Three staff had recalled that resident [redacted] had complained of leg pain. One staff reportedly had observed that resident [redacted] was walking with a minor limp. It was reported that staff [redacted] was made aware [redacted]'s complaint and blew it off. Staff [redacted] did not recall resident [redacted] complaining of injury. Staff [redacted] reportedly had attempted to call the nurse later on but got no answer. One staff had recalled the resident [redacted] complained of abdomen pain but had not requested to see a nurse. DVR revealed that (at 4:32) resident [redacted] had told staff [redacted] (who remained with him in the apartment) that he was sweaty, his mouth was dry, blood pressure was racing and he felt as though he was about to have a stroke. The resident had asked and was given water at that time but was otherwise not evaluated by any staff. It was reported that resident [redacted] had complained but he was unsure whether or not he was being truthful. It was reported that it was not unusual for residents to complain after receiving application. Residents [redacted] and [redacted] were not seen by the nursing staff until the following [redacted].

• The staff did not verify that the caller was actually a DVR monitoring staff. Staff reported that they had tried to talk to the caller but he only wanted to speak with staff [redacted] It was reported that there was only one phone line into the house and staff [redacted] was afraid to hang up the phone because he thought he would be evaluated. It was further reported that staff could not identify where the call was coming from because there was no caller ID on the phone in the kitchen and cordless phone was not fully charged and kept shutting off. Reportedly, the internet had been down as well therefore staffs did not have access to personnel or emergency contact information. Staff further reported that attempts had been made to call DVR when the phone was clear but the person would call right back on the other line. It was reported that staff [redacted] had attempted to call DVR from his cellular phone but could not get service. Reportedly staff [redacted] had eventually took the phone from staff [redacted] and called the real DVR directly at which time it was learned that they had not been speaking with DVR. .

• The investigation noted that there were several opportunities and options staff could have taken to verify that they were receiving instructions from DVR Monitoring. Staff [redacted] could be observed on video surveillance in the kitchen by the phone, while the caller was on the line and did not take the initiative to speak with or question the caller. At least three other staff were observed briefly speaking with the caller at different times throughout the night but would always return the phone to staff [redacted]. There were at least two other occasions when the phone was not in use and staff did not attempt to call at those times. The investigation noted that the phone numbers of program administration, caseworkers and clinicians were available in the house and were accessible to staff. DVR video surveillance showed staff [redacted] removing the list from the kitchen wall.

• The investigation found that the Stoughton staff did not follow resident [redacted], [redacted] and [redacted]'s Treatment plan or Recording Sheets. Staff reported that they had not followed JRC pre-verification process as trained because the caller had insisted that he had approval from Sue Parker and Glenda Crookes, who is the chief administrator. The staff had administered unwarranted GED applications to two residents. The staff unnecessarily

restrained residents [redacted] and [redacted] on the 4-point board. Review of video surveillance revealed that both residents [redacted] and [redacted] were cooperative and compliant at the time they were placed on the board. Resident [redacted] was restrained to the 4- point boards and was not approved for this "movement limitation" treatment. The investigation further noted that resident [redacted] remained in transport restraints (waist and legs) while he was in bed. DVR revealed that resident [redacted] had remained in transport restraints for approximately 45 minutes. The investigation noted that staff [redacted] denied that he had administered the GEDs to the residents while they were sleeping. Video surveillance revealed that staff George entered both resident [redacted] and [redacted] bedroom while they were sleeping and administered GED applications, which startled him out of his sleep.

• Staff acknowledged concerns of a possible crisis and stated that other residents had woken up and were looking into the hallway. It was reported that residents were told not to get involved and to go back to bed. It was reported that students had continually expressed concern and had told staff that the identified residents did not have behaviors. The residents had pleaded with staff to call and make sure that it was really DVR on the phone. Staff reportedly did not respond to the residents request and stated that they (residents) would lie to avoid consequences. Staff [redacted] had reported that at one point residents appeared ready to aggress. DVR revealed that most residents were awake during most of the events and could be heard yelling that it was a prank and that staff should verify it with DVR.

• All staff reported that they had continually checked on the other residents to make sure they were safe. DVR revealed that the staff were not appropriately monitoring the residents throughout the shift. There had been one staff upstairs with the residents during the events while 5 others had been dealing with the identified residents. DVR further revealed two occasions when all staff could be observed standing in the kitchen area talking amongst them and residents on the fist floor were not being monitored at all during that time.

•Staff reported that they take directions from DVR or the resident's clinician however did not know that they could call the clinician or case manager directly. Staff reported that DVR was watching at all times and would call staff if a resident was observed "breaking contract". Staff reported that DVR would instruct them to consequate a resident for a behavior if it was on the residents Recording Sheet. Staff reported that they had never, nor had they ever known any staff person to wake up a sleeping resident to give GEDS. Staffs reported that it was specifically stated in the training that residents were not to receive GED application when sleeping.

• The Stoughton staff acknowledges that although staff were informed that the authorization came from [redacted], staff did not follow each and every step of the GED procedure as trained. The staff reported being were unfamiliar with the use of aversive treatment, delayed consequences or reporting abuse and/or neglect. Staff [redacted] acknowledged that he did not really evaluate the situation because of the confusion. Staff [redacted] stated that he assumed that it was a test from Quality Control (QC) to find out if he was following procedure. Other staff reported that they thought that it was a "Program

OP". It is the investigations findings that the staff's inexperience and insufficient training (as it relates to the care of the residents) contributed to the reported events.

• ***Resident*** [redacted] stated that he was resident [redacted] roommate at the time of the reported incident. Resident [redacted] recalled that he had woken up to his roommate [redacted] screaming and reported that [redacted] had received a GED application while he was sleeping. Reportedly [redacted] had been screaming loud enough for everyone in the house to hear. He reported that resident [redacted] had told staff that his leg was killing him. Resident [redacted] recalled that resident [redacted] had also received GEDs while he was sleeping and had complained about his stomach. Resident [redacted] expressed that he was worried about his roommate but did not get involved. Resident [redacted] reported that he did not believe that was DVR on the phone and had told staff this. Resident [redacted] reported that he had never seen anything like what had happened with residents in the Stoughton House. Resident [redacted] stated that he then thought that it was a "Program OP" and went on to describe incidents that would be considered a JRC "program op". Resident [redacted] reported that residents are familiar with their own Program Sheet but do not have access to others. He continued to report that residents know each others behaviors because they hear when staff pin point other residents.

• ***Resident*** [redacted] reported that he had been resident [redacted] roommate at the time of the incident. He stated that he had been woken up by the commotion. He reported that [redacted] was upset and yelling because he had received GEDs while sleeping. Resident [redacted] stated that he did not observe resident [redacted] get any GEDs however had recalled that resident [redacted] had complained to staff that his leg was hurting and requested that the nurse be called. Resident [redacted] reported that he had never seen other student's Recording Sheet but that it was accessible when left unattended.

• [redacted] is a LPN at JRC and reported that nursing was not notified about either resident's [redacted] or [redacted] concerns during the early morning of 8/26/07. It was reported that both residents were seen by nursing the day following the incident. Staff [redacted] reported nursing became aware of the reported events from another resident who was being seen. It was reported that DVR had later called nursing and explained what had happened and sent residents to be medically evaluated. Resident [redacted] had reported that he was shocked on the abdomen and was observed to have marks on his upper body related to the GED but nothing severe. It was reported that the area was observed to be red and irritated. Mr. [redacted] reported that the GED application can cause friction if moved around. It was reported that nursing should have been contacted when resident [redacted] complained of racing blood pressure and feelings of a possible stroke.

• Staff [redacted] reported that resident [redacted] was not limping or complaining of pain when seen but was observed to have fresh marks on the middle lower area of his left calf. It was reported that the skin was off of the area which he diagnosed as a stage two ulcer. It was reported that the area identified was the same area where resident [redacted] had received shocks. It was reported that the electrode device was removed from [redacted] leg because the area on was too bad to keep the device on. Mr. [redacted] reported that he had never seen a bruise from the GED device like resident [redacted] had and stated that nursing should have

been called for such an injury. [redacted] was also observed to have older marks on each deltoid area that were large and irregular looking that were possibly from the GED.

• It was reported that nursing staff is on duty until 11:00pm daily and the Nursing Director available 24 hours a day for emergency calls. Staff [redacted] reported that it is not a typical for a resident to say that they have injuries following a GED application. It was reported that typically staff would not call a nurse when a resident voices that he is in pain from a GED application and described it as a pinch.

• ***Dr.*** [redacted] reported that he is the clinician assigned to residents [redacted] and [redacted] Dr. [redacted] reported that the students at the Stoughton residence are high functioning students and do know their treatment plans. It was also reported that some students are high risk students and have a tendency to try to manipulate staff. Dr. [redacted] reported that staff are to maintain professionalism when dealing with the students. It was reported that staff can not socialize with the students but it is fine for staff to listen to the students. Dr. [redacted] reported that he had never seen anything happen like this before at JRC. He reported the events were outside of the norm and should have raised questions for staffs. Dr. [redacted] reported that the GED procedure was explained to staff in training and reported that the Stoughton staff had done things contrary to the teachings and training experiences at JRC.

•Dr. [redacted] reported that he is available 24 hours and all residences have his contact information. Dr. [redacted] stated that he is usually contacted by DVR with resident concerns but that direct care staff can and have paged him as well. Dr. [redacted] reported that at no time on 8/26/07 did the staff at the Stoughton house call him questioning DVR directions or with any other concerns. Dr. [redacted] expressed concern that staff did not know to call the clinician and stated that they call him frequently about trivial things. Dr. [redacted] reported that resident [redacted] had called him on that following [redacted] and had admitted that he had called the Stoughton residence and had staff administer GED to residents.

•***Monitoring Staff,*** [redacted] had been employed at JRC since [redacted] and had been working as a Quality Control Staff for 5 about months. Staff [redacted] reported that he had worked the 12am to 8am shift on 8/26/07 and worked along side staff [redacted] and [redacted]. Staff [redacted] stated that he had been assigned to monitor the Stoughton residence and had placed a call into the Stoughton house at the beginning of his shift. Staff [redacted] reported that he was in charge of monitoring a total of 11 houses and reportedly would rotate consistently through the screens throughout the night, checking for concerns in each house. Staff [redacted] stated that he had gone on a break from 3:30am to 4:15am and staff [redacted] was in charge of monitoring his assigned houses during that time. Staff [redacted] reported that he had checked on the Stoughton house prior to taking his break and had observed no unusual behavior. He further stated that no one from the Stoughton residence had contacted DVR regarding any concerns prior to his break. It was reported that staff [redacted] was also responsible for monitoring assigned houses and the students on [redacted] constant watch list while he was on break (2:30am until 3:15am).

• Staff [redacted] reported that all monitoring staff had observed the events at the Stoughton House at the same time and had responded accordingly. All monitoring staff had reported that a resident was appeared to be improperly restrained on the board. Reportedly, staff [redacted] had called the residence several times before finally getting through and explaining to the staff that they were not giving the restraint properly. It was reported that staffs seemed distrustful and confused. It was reported that staff could be observed (on DVR) arguing amongst each other and refused to speak to the monitoring staff. It was reported that there appeared to be a communication issue amongst the staff at the Stoughton House. The call reportedly was disconnected at which time staff Tarlue left to go see what was going on at the program and she called the Stoughton House.

• The investigation noted that staffs [redacted] and [redacted] account of the events were consistent with that reported by staff [redacted] with the exception of the reported time of observance. The investigation noted that staff, [redacted] had worked as a Quality Control staff at the Stoughton house from 4:00pm until 11:00pm and reported that there were no concerns at the Stoughton residence that night. Staff [redacted] reported that he had covered for staff Tarlue when he went on break. Staff [redacted] reported that he did not check on the Stoughton Residence because it was not a house of concern.

• It was learned that staff [redacted] had not been monitoring the Stoughton residence as required therefore compromising the supervision and the safety of the residents. Review of the DVR log for the overnight shift on 8/26/07, indicted that the communications to the Stoughton house had been disconnected from 12:45am until 4:41am. In addition, staff [redacted] failed to contact each residence at the start of the shift and inform the staff that he was assigned to monitor their residence. Further, staff "Fire" failed to follow the JRC policy and neglected his job responsibilities. The monitoring staffs' failure to intervene during the events led the Stoughton staff to believe that they were in direct contact with DVR.

• ***The Quality Control Program Director, Roland Porkpah*** reported that DVR supervises the overnight shift but the most experienced person is expected to run the shift. It was further reported that all DVR monitoring staffs are equal and no one is directly in charge of the shift. It was reported that it is the assigned DVR monitoring staff's responsibility to view all assigned houses to assure that staff were awake and performing their duties. It was reported that it is the expectation that staff cover each other during breaks at which time that staff person must monitor their own houses as well as the ones they area covering.

• Mr. Porkpah reported that DVR monitors use video monitoring and watch live footage; they reportedly do not cover previous footage from the day. Ms. Porkpah reported that at the time of the existing JRC policy DVR staff could be a verifier and if they saw an incident they would speak and verify the behavior with the direct care staff. It was reported that the direct care staff have the students Recording Sheets and can question DVR if they disagree. It was further reported that direct care staff could contact the resident's clinician directly. Mr. Porkpah reported that DVR staff should not be giving a delayed consequence and must contact the resident's case manager or clinician.

• It was reported that there were no students from Stoughton House watch list on 8/26/07, however the Stoughton House is a high crisis residence and should have always remained open. It was reported that Administrative staffs are available 24 hours for all DVR concerns and staffs have list of who notify for various incidents. It was reported that staff are to immediately report if they are unable to access a house due DVR failure. It was reported that there were no technical difficulties with the monitors that staff [redacted] was utilizing.

• ***The Assistant Executive Director, Glenda Crookes*** reported that she had interviewed all involved staff and all staff insisted that the person on the phone had been watching them. It was reported that both [redacted] and [redacted] felt that they were being watched by someone who knew what was going on in the house at the time. Ms. Crookes stated that the JRC utilizes state of the art security systems which outside sources are unable to hack into. It was reported that no person is able to log onto the house from an outside agency. She reported that the JRC program administration were able to log on however it would be documented on the DVR log. It as reported that the logs were reviewed and showed no record that any JRC administrative staff had logged on to the Stoughton house on 8/26/07. Ms. Crookes further reported that DVR monitoring system themselves had not been logged into the house the entire night of 8/26/07. It was reported that monitoring staff had called the Stoughton residence at 4:52am and phone calls were consistently made to the home thereafter. The investigation noted that DVR staff arrived to the Stoughton residence about one hour after viewing the events on the monitoring screen.

• Based on the actions and expressed opinions of the staff it can be ascertained that the JRC program polices were set up in such a way that it took decision making away from the staff. The staff were unclear on who was the responsible person(s) for the administrative supervision of the program and failed to exercise any independent judgment in the matter. Staff reported that DVR was in charge and therefore they did not "step up". The program staff did not feel empowered enough to intervene or question the actions of DVR. The staff's philosophy that "DVR is in charge and makes all the decisions" caused an unsafe environment and potential crisis situation.

• The licensee reported that every staff member who is responsible for implementing a student's treatment plan undergoes a two-week intensive pre-service training period, which included but was not limited the use of on Limited Movement and the GED, how to follow a residents recording sheets as well as [redacted] report writing. The investigation noted that all staff at the Stoughton Residence had a completed the required JRC requirements and training.

• The licensee reported that staff are required to view each resident Recording Sheet daily and sign off that they have read the student's current status. The investigation noted that the Recording Sheet clearly states that if staff should have questions regarding the students plan to speak with the shift supervisor, DVR monitoring, the clinician or case manager. Review of the recording sheets for residents [redacted] and [redacted] (dated 8/26/07) noted that at least 4 staffs had signed that they had viewed it.

• According to JRC policy, the overnight supervisor is responsible for a variety of duties relating to the implementing of the students treatment plan and educational program at the residential homes and to ensure that all overnight duties are carried out. It was reported that the scheduled supervisor had called out therefore the person with the most seniority takes the lead. The licensee reported that any phone calls into the house are supposed to come through the supervisor who would then instruct staff accordingly.

• An interview was held with the JRC Administration on 9/28/07. The licensee reported that the actual DVR monitor assigned to observe the Stoughton residence was not doing his job by viewing the cameras at the residence therefore DVR monitoring system failed to detect and intervene in the events in a timely manner. The monitoring staff [redacted] was consequently terminated from the JRC program. It was reported that staff [redacted] had also been terminated and others were pending.

• The licensee had reported that given the recent events it had self identified issues, and the program has revised identified policies and procedures to assure that the program is well structured to meet the needs of all residents as well as to assure their comfort and safety. The licensee reported that they have taken the necessary steps to assure that staff are appropriately trained and capable of providing adequate care. All current direct care staff are being re-trained on JRC policies and procedures. The licensee had assigned two new supervisory staff to for the overnight shift. In addition, video review of the DVR room and random spot checks will occur to assure that monitoring staff are doing their jobs. The licensee further reported that a new phone system screening process had been put in place and all phone calls will be transferred to each residence through the school.

• The licensee reported that Delayed Consequences involving skin shocks are no longer permitted, instead, an alternative consequence will be employed. The licensee reported that most residents have been faded from the GED with the exception of those who had self injurious behaviors. The JRC program has suspended the use of the GED in all but 8 residences and has implemented an in house monitoring system for those residences that continue to administer application. A monitoring staff will physically sit in the house and supervise restraints and socialization. It was reported that if students start regressing they will be moved to a residence with in house monitoring. The licensee reported that in the event that a student requires a GED application or restraint the overnight supervisor will immediately respond to that residence.

Non-compliances:

See Attached Statement on Non-Compliance

Investigator
Angela Goss

Statement of Outstanding Compliance Issues

Complaint Number:	**49037**	Date of Report:	**11/1/2007**

Program Information: Tel: 781 828-2202

Program #: **4904051**

Program Name: JRC - 66 Kevin Clancy Way
66 KEVIN CLANCY WAY
STOUGHTON, MA 02072-3888

Licensee Information: tel: 781 828-2202

Licensee ID: **1472144**

Licensee name: Judge Rotenberg Educational Center, Inc.
240 TURNPIKE ST
CANTONMA 02021-2359

REGULATION	STATEMENT OF NON-COMPLIANCE	CORRECTION PLAN (Describe how, when and by whom, e.g., correction has been / will be made. Please be specific)	DATE	STATUS OF COMPLIANCE (EEC USE ONLY)
1.05(02)(a), 3.07(01), 3.07(07)(g)01	The investigation has found sufficient evidence to conclude that staff [redacted] was physically abusive towards residents [redacted] and [redacted] allegation of physical abuse by staff [redacted]. It is the judgment of the Department that staff [redacted] had engaged in behavior that bears adversley upon his ability to to provide for the safety and well being of a child.			
1.05(02)(a), 3.07(01), 3.07(07)(g), 3.07(07)(g)05, 3.01(c), 3.01(d), 3.01(e)	The investigation found sufficient evidence to conclude that six direct care staffs at the Stoughton residence were neglectful in the care of residents the three identified residents. [redacted] the allegation of negelct by all staff. The program staff failed to protect the health and safety of the identified residents. It is the judgment of the Department that the staff engaged in conduct which bears adversely upon their ability to provide for the safety and well being of a child.			
1.06(03)	-The investigation found that [redacted] and [redacted] Staff [redacted] gave false and misleading information to investigators.			
3.01(a), 3.04(03)(a), 3.01(c), 3.01(d), 3.01(e), 3.03(01), 3.03(01)(a)07	The Licensee and Administration failed to provide a program that was administratively sound with clearly conceived policies and practices for the services provided to residents.			

REGULATION	STATEMENT OF NON-COMPLIANCE	CORRECTION PLAN (Describe how, when and by whom, e.g., correction has been / will be made. Please be specific)	DATE	STATUS OF COMPLIANCE (EEC USE ONLY)
3.01(a), 3.06(04)(a), 3.03(01)(a)18, 3.03(01)(a)19	The Stoughton House Staff failed to communicate relevant information to nursing regarding residents [redacted] and [redacted] condition following the GED application, resulting in delay of medical attention for both residents.			
3.03(01), 3.01(c)	The program staff were not monitoring residents in an manner that assured their health and safety. The staff failed to provide a safe comfortable enviorment for all residents in care.			
3.03(01)(a), 3.07(07)(a)	It is the investigation finding that certain program policies such as delayed consequences and program Ops were contributing factors for staff not responding appropriately on the night of 8/26/07.			
3.04(02)(b), 3.04(08); 3.07(01)	The investigation had found sufficient evidence to conclude that staff [redacted] lacked the necessary training and experience to carry out responsibilities of an overnight supervisor.			
3.04(03)(e)03	The investigation found sufficient evidence to conclude that the Stoughton staff neglected their responsibilities as a mandated reporter. The staff made no efforts to report the unwarranted use of force to Administration or file a report with the appropriate authority.			
3.04(07)(a), 3.04(07)(f), 3.07(01)	The Stoughton residential staff failed to follow established JRC policies and standard program procedures as it relates to the residents Treatment Plan and Recording Sheet.			
3.04(07)(a), 3.04(07)(f), 3.04(02)(c), 3.03(01)(a)04	The licensee failed to have staff with adequate training on shift to ensure the proper administration of the program policies and standard program procedures.			
3.07(01), 3.07(07)(g), 1.05(02)(a), 3.04(02)(b), 3.04(08)	-Staffs [redacted] and [redacted] were neglectful in their responsibilities as monitoring staff thus compromising the the safety of the residents.			

REGULATION	STATEMENT OF NON-COMPLIANCE	CORRECTION PLAN (Describe how, when and by whom, e.g., correction has been / will be made. Please be specific)	DATE	STATUS OF COMPLIANCE (EEC USE ONLY)
3.07(07)(a), 3.07(07)(h), 3.07(07)(i), 3.07(07)(j)01a, 3.07(07)(j), 3.07(07)(j)07	The staffs failed to follow established JRC policies and standard program procedures as it relates to behavior management.			

Angela Goss

Licensing Specialist

I have reviewed the above non-compliances and have specified my plan and date of correction for each non-compliance.

LICENSEE'S SIGNATURE: _____ DATE: _____