1/20/82

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BEFORE THE
DEPARTMENT OF SOCIAL SERVICES
STATE OF CALIFORNIA

IN THE MATTER OF THE ACCUSATION AGAINST: BEHAVIOR RESEARCH INSTITUTE OF CALIFORNIA 9342 Zelzah Avenue Northridge, California Respondent	NO. L230-1278 FIRST AMENDED ACCUSATION/ STATEMENT OF ISSUES

COMES NOW ANNE BERSINGER, complainant herein, and amends the Accusation in this matter signed on October 20, 1981, and previously served on respondent. This amended Accusation supersedes the original Accusation in its entirety, either restating or amending all parts thereof, so that the parties may conveniently refer to a single document.

This amendment has become necessary for three reason. First, respondent's license renewal application has been denied, and respondent has appealed therefrom and requested a hearing thereon. Second, a number of the allegations made in the original Accusation needed to be clarified, expanded upon, or made more specific for the benefit of respondent. Third, a very limited number of allegations

based on facts which have recently come to complainant's attention has been added.

Complainant now alleges the following as cause for revocation of respondent's license and special permit to operate and maintain a community care facility, and as cause for denial of respondent's application to renew its license and special permit:

I

Complainant is the duly appointed Deputy Director, Community Care Licensing Division (CCL), Department of Social Services, State of California, and makes and files this accusation in such official capacity and not otherwise.

II

Pursuant to Health and Safety Code Section 1525, the Department of Social Services (hereinafter "Social Services" or "Department") is the agency of the State of California responsible for issuance or denial of a license to operate a community care facility or of a special permit, and for the issuance or denial of a renewal of a license or special permit. Pursuant to Health and Safety Code Section 1550, Social Services is authorized to suspend or revoke any license or special permit for violation of statutes or of rules and regulations promulgated pursuant to the Community Care Facilities Act, Health and Safety Code Section 1500 et seq.

III

Prior to July 1, 1978, all functions of Social Services relevant to this accusation were performed by its

predecessor in interest, the State Department of Health ("Health"). Insofar as they are relevant to this accusation, all actions taken by Health prior to July 1, 1978, are to be given the same force and effect as though they had been taken by Social Services.

IV

Respondent was licensed on October 25, 1977 to operate a group home for six children called The Behavioral Research Institute (hereinafter "BRI") at [redacted], Northridge, California ("facility"). On October 25, 1977, BRI was authorized to conduct behavior modification and to utilize negative reinforcers in the treatment of autistic children and adults in accordance with BRI's then existing program. (A true and correct copy of BRI's then existing program of negative reinforcers or aversives is attached hereto as Exhibit A. A true and correct copy of the authorization letter is attached hereto as Exhibit B.) On March 30, 1979 the facility was issued a Special Permit to Provide Aversive Behavior Interventions (hereinafter "special permit"). (A true and correct copy of the special permit is attached hereto as Exhibit C.) Said permit, which superseded all previous authorizations, was conditioned on compliance with the general requirements contained therein; with the special licensing requirements contained therein (hereinafter the "A Standards"); and with the special permit program requirements contained in the February 14, 1979 draft of the "California Guidelines for the Use of Behavior Interventions to Restore Personal Autonomy:

Aversive Behavior Interventions as a Specific Case" (hereinafter the "B Standards" or the "Draft Guidelines"). (A true and correct copy of the Draft Guidelines is attached hereto as Exhibit D.) Respondent is currently licensed under license number 190501621 to care for six children or adults. As used herein, the term "respondent" refers to the licensee and to its agents, consultants, and employees.

V

Complainant seeks revocation of respondent's license on the grounds that respondent has violated or permitted the violation of applicable statutes and regulations, in the manner set forth below.

VI

Complainant seeks revocation of respondent's special permit on the grounds that respondent has violated or permitted the violation of the licensing statutes and regulations; of the general requirements set forth in the special permit; of the A Standards; and of the B Standards or Draft Guidelines in the manner set forth below.

VII

Assuming arguendo that the letter of October 25, 1977 authorizing BRI to conduct behavior modification was not superseded by the special permit, complainant seeks revocation of that authorization on the grounds that respondent has violated or permitted the violation of the licensing statutes and regulations and of the conditions set forth in the authorization letter.

VIII

During the pendency of this proceeding, respondent's license and special permit expired (October 24, 1981). On or about June 18, 1981, respondent filed an application for renewal of that license.

IX

Section 1525 of the Health and Safety Code provides, in relevant part, that "[i]f the director [of the Department of Social Services] finds that the applicant is not in compliance with the laws or regulations of...[Chapter 3, Division 2 of the Health and Safety Code, sections 1500 through 1565], he shall deny the applicant a license, license renewal, special permit, or permit renewal."

X

Section 80132 of Title 22 of the California Administrative Code provides in relevant part as follows:

> "Denial of a Renewal License or Special Permit
>
> For purposes of Section 80132, the term license shall also mean and include special permit and the term licensee shall also mean and include holder of a special permit.
>
> (a) The licensing agency shall deny an application for a renewal license when the licensee is not in substantial compliance with applicable law or regulations, as defined by Section 80133(b) at the time of the renewal visit.
>
> (b) The licensing agency shall deny the renewal application when lack of substantial compliance has resulted in the department's

action to suspend or revoke the license or to seek other remedies as provided by law.

* * *

(e) When a renewal application is denied in accordance with this section and the licensee appeals the denial the licensing agency shall, upon written request from the licensee within the 15-day period, issue a license pending adoption by the department of a decision on the administrative action."

XI

Social Services denied respondent's application for renewal of its license and special permit, finding that respondent was not in substantial compliance with applicable law and regulations at the time the renewal application was submitted. The bases for this finding are the acts and conditions described in this Accusation as ongoing, and the acts and conditions noted during the June 5, 1981 and subsequent licensing evaluations.

XII

On or about October 28, 1981, respondent appealed the denial of the license and special permit. Pursuant to Section 80132(e), Social Services has issued respondent a license and special permit which permits it to operate pending adoption by Social Services of a decision in this action.

XIII

Social Services has duly adopted regulations which are applicable regulations within the meaning of Section 1550

of the Health and Safety Code. Said regulations are found in Division 6, Title 22 of the California Administrative Code, beginning with Section 80001. Respondent is subject to the provisions of these regulations. Except as otherwise noted, all sections hereinafter referred to will be from Title 22, California Administrative Code.

XIV

Section 80403(f) provides as follows:

> "Unless approved by the Department or licensing agency, no form of behavioral restraint shall be used in caring for any person served. Such restraint includes the use of any appliance or device to confine a person to a bed, chair, or any other object, or to deprive him of the use of his arms, hands, or feet as a means of controlling his behavior...."

Respondent has violated Section 80403(f) on a continual basis, as follows, by using restraints as a means of controlling the resident's behavior:

1. Respondent kept resident [redacted] restrained by the use of appliances or devices on the following occasions and on other unknown occasions prior to July 17, 1981:

A. On the morning of July 17, 1981 [redacted] was restrained in bed by an arrangement which kept him flat on his stomach in bed. [redacted] died between 9:00 and 10 a.m. on this date while being so restrained.

B. On June 5, 1981 [redacted] was restrained in bed, before getting up at 8:10 a.m. He was restrained on his stomach with a plastic cuff on each leg and on his left hand. The restraints were tied [illegible] bedframe. His

right hand was covered by a sock which was tied at the wrist by a small thin belt. Respondent is informed and believes, and thereon alleges, that [redacted]. was regularly restrained in this or a similar fashion while he was in bed.

C. On June 5, 1981 [redacted] was restrained by the use of foot and hand cuffs. There was an excoriation of the right ankle immediately below the foot cuff. Both hands were swollen. The left hand was bluish in color. There were marks from the cuffs at the level of the wrists. His fingers were swollen and fusiform in shape. Because [redacted] suffered from a circulatory disorder, the type of restraint to which he was subjected was contraindicated.

D. On or about March 10, 1981 respondent caused restraints to be used on [redacted].

E. On or about February 5, 1981 [redacted]. was subjected to restraints by respondent. [redacted]. was restrained by both wrists to a chair with a restraint around his chest.

F. In or about December 1980 and for an unknown period of time after that month, [redacted]. frequently was kept in restraints. Respondent's staff used mechanical restraints in lieu of acceptable procedures to prevent [redacted]. from grabbing people, throwing things, or attempting to gouge at his eyes.

G. In or about December 1980 and for an

unknown period of time after that month, [redacted]. was restrained to a chair by a vest device to prevent him from running around.

H. During his period of residence [redacted]. was frequently in restraints at other times not specifically known to complainant.

2. Respondent kept resident [redacted]. restrained by the use of appliances or devices on the following occasions and on other occasions not specifically known to complainant before and after those dates:

A. On or about the night of June 4-5, 1981, [redacted]. was made to sleep with handcuffs which restrained his hand and arm movement. The handcuffs were attached to a hard resistant cloth belt with a metal buckle on the back.

B. After arising on or about June 5, 1981, [redacted] was made to wear plastic handcuffs which were attached to a hard and resistant cloth belt with a metal buckle on the back. There was a 2 cm x 2 cm red sore on his back at the level of the metal buckle. There was a red area of 4 cm x 4 cm clearly delineated on the left wrist that was visible when an employee checked the cuffs.

C. On or about April 13, 1981 [redacted]. was made to lie face down with his hands restrained by green plastic cuffs behind his back.

D. On or about April 13, 1981 [redacted]. had a

reddened area the size of a half dollar on his left ankle in the area where the leg restraints would lie. Complainant is informed and believes, and thereon alleges, that this reddened area was a result of the use of leg restraints on [redacted].

E. On or about March 10, 1981 [redacted]. was in restraints.

F. On or about March 1, 1981 [redacted]. was restrained in a large black chair by himself in the kitchen. [redacted]'s hands were tied to the chair, his feet were tied to the bottom of the chair, and a huge box covered his head and torso. He was kept in this position for at least one hour.

G. On one occasion in October 1980 [redacted]. was restrained to a chair with a restraint around his torso and the back of the chair.

H. On or about November 4, 1980 [redacted]. was in restraints with both hands restrained behind his back and both feet bound together.

I. During his period of residence at BRI [redacted]. was frequently in restraints. On numerous occasions his wrists and hands would be bruised and/or blue.

3. Respondent kept resident [redacted]. restrained by the use of appliances or devices on the following occasions and on other occasions not specifically known to complainant before and after those dates:

A. On June 5, 1981 [redacted] was restrained with plastic handcuffs which were attached to a hard and resistant cloth belt at his waist with a metal buckle on the back.

B. On or about April 13, 1981 [redacted] was restrained to a table by both wrists and the right ankle. A representative of respondent told a Department evaluator that [redacted] was restrained in this fashion because he was "a hitter" and "a fire setter."

C. On or about March 10, 1981 respondent was using restraints on [redacted]

D. On occasion during the period from September 3, 1980 through March 1981 and on unknown occasions before and after that period, [redacted] was placed in "distraction elimination" or "isolation-deprivation" or "time-out" (hereinafter referred to as "isolation") for periods lasting up to 24 hours. This procedure was used by respondent as an aversive consequence for [redacted]'s hitting. In isolation, [redacted] was seated in a chair at a table and was restrained to the table by his wrists and ankles. Boxes would then be stacked around him to prevent him from seeing anyone or anything in the room. During that period he either received no meals or was fed lettuce with mayonnaise three times daily and a protein drink once a day as his only food. The bottom of his foot would be pinched every hour. The pinches were severe enough to cause [redacted] to scream. No one was allowed to talk to [redacted]

or to look him in the eye while he was in isolation. On occasion he would not be allowed to go to the bathroom and would urinate in his pants. His restraints would not be loosened whether or not he complained. Employees were instructed not to respond to him during such periods of isolation. Employees were instructed to give [redacted] a water squirt from over the boxes as they passed by. If [redacted] talked to an employee the employee was instructed to administer a water squirt to [redacted].

E. On numerous occasions during 1980 and 1981 [redacted]. was restrained in a special chair that restrained his arms and legs to the chair and restrained him around the chest. [redacted] would be made to wear a helmet. The restraints on the chair were designed so that [redacted] had limited hand movement.

F. On or about February 5, 1981 [redacted] was in restraints. [redacted] was restrained to a chair in the kitchen treatment area by both ankles and both wrists.

G. During his period of residence at BRI, [redacted]. was frequently in restraints. His hands and wrists would frequently be bruised and/or blue because of the restraints.

4. On or about June 5, 1981 respondent recorded a restraint check when restraints had not in fact been checked.

XV

Section 80803 provides as follows:

"All facilities shall be maintained in conformity with the regulations adopted by the State Fire Marshal for the prevention of fire and for the protection of life and property against fire and panic."

Section 80025(b) defines an "ambulatory person" as follows:

"'Ambulatory Person' means a person who is capable of demonstrating the mental competence and physical ability to leave a building without assistance of any other person or without the use of any mechanical aid in case of an emergency."

Section 80025(c) defines a "nonambulatory person" as follows:

"'Nonambulatory Person' means a person who is unable to leave a building unassisted under emergency conditions. It includes, but is not limited to, those persons who depend upon mechanical aids such as crutches, walkers, and wheelchairs. It also includes profoundly or severely mentally retarded persons and totally deaf persons. A 'profoundly or severely' mentally retarded person is one who is unable, or likely to be unable, to respond physically or mentally to an oral instruction relating to fire danger and, unassisted, take appropriate action relating to such danger."

Regulations adopted by the State Fire Marshal are found in Title 19 of the California Administrative Code, and refer to Building Standards found in Title 24 of the California Administrative Code.

Title 19, Section 3.31 provides as follows:

"Restraint shall not be permitted in any building except in Group I Occupancies constructed for such use in accordance with the provisions of Chapter 2-10, Part 2, Title 24, CAC."

Title 24, Section 2-419 defines "restraint" as follows:

> "Restraint shall mean the physical retention of a person within a room, cell or cell block by any means; or within the exterior walls of a building by means of locked doors unoperable by the person restrained. Restraint shall also mean the physical binding, strapping or similar restriction of any person in a chair, walker, bed or other contrivance for the purpose of deliberately restricting the free movement of ambulatory persons."

Title 24, Sections 2-1001 through 2-1078 relate to "Group I" Occupancies as that term is used in Title 19, Section 3.31. Respondent's facility does not qualify as a Group I Occupancy authorized to house nonambulatory or restrained persons, and it is not of a construction adequate to comply with standards relating to such facilities.

Respondent has failed to maintain its facility in conformity with the regulations adopted by the State Fire Marshal in that respondent had and has in its facility persons who are nonambulatory at least at such time as they are in restraints, although the facility is not cleared by the Fire Marshal for either nonambulatory or restrained persons, and does not meet the building construction requirements for facilities housing nonambulatory or restrained persons.

Pursuant to a request made by Social Services on or about July 28, 1981, the Los Angeles City Fire Department, as a local agent of the State Fire Marshal, inspected respondent's facility for compliance with applicable laws. A fire clearance was issued subject to the following special condition:

"Approved for physically and mentally ambulatory only! The use of restraints is strictly forbidden at all times in this type of occupancy."

In spite of this condition, respondent has continued to use restraints on its residents in violation of Section 80803.

XVI

Health and Safety Code Section 1550(c) provides:

"The state department may suspend or revoke any license or special permit issued under the provisions of this chapter upon any of the following grounds and in the manner provided in this chapter:

* * *

(c) Conduct in the operation or maintenance, or both the operation and maintenance, of a community care facility which is inimical to the health, morals, welfare, or safety of either an individual in or receiving services from the facility or the people of the State of California."

Respondent has violated Section 1550(c) in the manner set forth below:

1. Respondent has misused and abused behavior modification therapy using aversives* in a manner which is inimical to the health, welfare, and safety of the residents of BRI in the following manner:

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*The term "aversive" as used in this Accusation means the application of corporal punishment or other painful or noxious stimuli. It does not include consequences which do not involve pain, discomfort, or humiliation (e.g., verbal disapproval).

A. Frequently during the period of licensure residents received excessive bruises from the administration of excessive and unnecessary aversives.

B. On or about January 31, 1981, and on or about February 7, 9, 21 and 28, 1981, [redacted] had bruises, cuts, and drainage from open wounds on his buttocks as a result of pinches.

C. On occasion during the period from September through December 1980 and on unknown occasions before and after those months, [redacted] had numerous marks, scabs, and scars caused by pinches on his buttocks.

D. On numerous occasions while [redacted] was a resident at BRI, he received bruises on his buttocks and legs.

E. On or about May 8, 1980 [redacted] was badly bruised on his buttocks and legs as a result of aversives administered to him by respondent.

F. On or about March 24, 1980 [redacted] received a black eye while he was being forced into the "spank position" to receive an aversive called a "water squirt II" by respondent. In the spank position, a resident is held with his head between the worker's thighs and his hands behind his back.

G. In or about December 1980, [redacted] fell while his hands and arms were restrained as a part of his behavior modification program. [redacted] received a cut on his chin which required stitches.

H. In or about January or February 1981, [redacted], respondent's employee, postponed a doctor's appointment for [redacted]. because he was excessively bruised by the administration of aversives.

I. On or about February 5, 1981 [redacted]. was bruised on his inner thighs as a result of the administration of aversives by respondent.

J. On or about Feburary 5, 1981 [redacted] had scar marks on his back and inner thigh. Complainant is informed and believes that these marks were caused by the administration of aversives by respondent.

K. In January or February 1981 respondent caused or allowed [redacted] to become excessively bruised by the administration of aversives.

L. On occasion during the period September 3 through December 15, 1980 and on unknown occasions before and after that period, [redacted] respondent's employee, wrestled [redacted] to the floor to restrain him. On some of these occasions [redacted] received bruises and/or cuts on his mouth. Such action should not have been necessary in an adequately administered program.

M. On one occasion during the period September 3 through December 15, 1980 [redacted]'s tooth was chipped while BRI employees were wrestling with [redacted].

N. On occasion during the period September 3 through December 15, 1980 and on unknown occasions before and after that period, [redacted] picked [redacted] up

and banged him against the wall. On some of these occasions, [redacted] was restrained and was wearing a helmet that bumped against his mouth, causing his lips to be cut. Such actions should not have occurred in an adequately administered program.

O. On one occasion during late April or early May 1980 [redacted]. had bruise marks on his buttocks that were caused by respondent.

P. On or about May 10, 1980 [redacted] had extensive welts and bruises on his buttocks that were caused by respondent.

Q. During his residence at BRI, [redacted].'s behavior deteriorated unnecessarily due to improper treatment and unprofessional use of aversives.

R. During the period January 1980 to July 18, 1980 [redacted]'s behavior deteriorated unnecessarily due to improper treatment and unprofessional use of aversives.

S. In or about May 1980 and for an unknown period of time before and after that month, there was no adequate system of monitoring the number of aversives administered on any given day.

T. In or about January through May 1980 an excessive number of aversives were administered, as evidenced by the following:

(1) On April 24, 1980 [redacted]. was administered 77 spanks for hitting himself, 33 spanks for crying and 6[illegible] for other behavior. In

addition [redacted] received 100 water squirts.

(2) On occasion during the above period [redacted] was spanked up to 60 times a day.

(3) In May 1980 [redacted] received 15 spanks on one day and 17 spanks on another for scratching other children.

U. In or about January and February 1981 as many as 30 pinches were administered to [redacted] on his buttocks in a single day. In addition, he received on occasion as many as 30 spanks a day on his buttocks.

V. During the period September through December 1980 and for an unknown period of time before and after those months, respondent threatened to fire employees for not leaning hard enough on residents who were bent over to be spanked or for not giving an effective spank or pinch. This procedure was unnecessarily punitive and humiliating for the residents.

W. On one occasion during the period September 3 to December 15, 1980 [redacted] consultant for respondent, instructed [redacted], a staff member, to grow his fingernails longer so he could give an effective pinch. Such pinches were administered with the fingernails and caused excessive and unnecessary cuts and bruises.

2. Respondent has misused and abused behavior modification techniques in a manner which is inimical to the health, welfare, and safety of the residents of BRI and to the

residents of the State of California as follows:

A. On occasion during the period from September 3 through December 15, 1980 and on unknown occasions before and after that period, respondent's employees administered "behavior rehearsal lessons" to the residents. The lessons would be devised and scheduled by [redacted] to be administered hourly, and did not constitute proper or ethical use of behavior modification principles. These lessons included the following:

(1) [redacted] would be prompted to throw a task and then an aversive would be administered. [redacted] was not permitted to demonstrate behavior which would allow him to escape the application of an aversive.

(2) [redacted] would be prompted to destroy property, then would be water squirted for destroying property, without being given the opportunity to escape the aversive by appropriate behavior. To administer these lessons to [redacted], respondent's employees would interrupt his performance of a task, an event that would generally cause [redacted] to receive an aversive, thus confusing [redacted]'s ability to discriminate between approved and unapproved behavior.

(3) [redacted] would be asked what happens if you hit or if you pinch and would be threatened with receiving a pinch if he did not answer appropriately. It was not demonstrated that [redacted] was able

to relate these "lessons" to his hitting or pinching behaviors.

B. On occasion during the period from September 1978 through October 1980 [redacted] and [redacted] would threaten residents with a pinch if they did not respond to statements or to questions in the appropriate fashion. These threatened actions were not called for by the residents' programs and did not constitute a proper use of behavior modification principles:

(1) [redacted] would pinch the underarms of [redacted] and make [redacted] repeat phases.

(2) [redacted] would ask [redacted] in various tones of voice whether [redacted] wanted a pinch.

(3) [redacted] would make [redacted] repeat phrases, threatening a pinch if [redacted] did not repeat the phrase.

(4) [redacted] made [redacted] stand with his feet flat, his hands in his pocket and his lips shut tight.

(5) [redacted] threatened to squeeze [redacted]'s hand if [redacted] did not respond properly.

(6) Respondent's employees and/or consultants threatened to pinch [redacted] if he did not respond appropriately.

C. On occasion during the period from

September through December 1980 and on unknown occasions before and after that period, respondent would prompt residents to become aggressive for the purpose of showing how bad the child was before treatment at BRI. For example, in or about December 1980 [redacted] was prompted to grab an employee's hair so it could be filmed. Food was scattered around the room by respondent's employees and the scene was filmed to make it appear that [redacted] has thrown the food.

3. Respondent acted in a manner which was inimical to the health, morals, welfare and safety of [redacted]. and of the people of the State of California by failing to design and implement an adequate program for [redacted]., a deaf child, as follows:

A. During the period from acceptance of [redacted]. at BRI through in or about February 1980, [redacted] was suspected to be a deaf child; during this period, respondent permitted its staff to use aversives on [redacted] under circumstances where it was not certain he could understand the behavior he was required to exhibit to avoid punishment. This constituted an unacceptable use of behavior modification techniques.

B. In or about February 1980, it was confirmed that [redacted]. is a deaf child, and his parents so notified respondent. Respondent failed to modify [redacted]'s program, and continued to inflict water squirts and corporal punishment upon Willie in contexts where it was unlikely if not impossible that [redacted] could understand the behavior he

was required to exhibit to avoid punishment. For example, [redacted] received water squirts for not responding to verbal commands to keep his eyes closed while in bed.

C. While at BRI, [redacted] was regularly punished for crying, without any effort being made to eliminate the possibility that [redacted]'s crying reflected his frustration at not understanding what was expected of him, or how to escape punishment. This constituted an unacceptable use of behavior modification techniques.

D. During the period that [redacted] spent at BRI, respondent failed to teach [redacted] to communicate by means of sign language or any other means of communication for the deaf.

4. Respondent acted in a manner which was inimical to the health, morals, welfare and safety of residents of BRI and of the people of the State of California when respondent discontinued its program for residents, including but not limited to the program of [redacted], before scheduled medical or family visits. Respondent did this not for the benefit of residents, but to allow bruises to subside for public relations purposes.

5. Respondent has misused and abused the use of restraints in a manner which is inimical to the health, welfare, morals and safety of the residents of BRI as set forth in paragraph XIV. Respondent used restraints for the convenience of staff and as a substitute for effective treatment procedures, and continued to do so in spite of repeated demands

that it cease violating applicable law.

6. Respondent has acted in a manner which is inimical to the health, welfare, morals, and safety of the residents of BRI and/or the people of the State of California in that respondent attempted to cover up the effects of its behavior modification therapy using aversives as set forth in paragraphs XVIII, XXIV, and XXVII; in not providing sufficient food for residents as set forth in paragraph XIX; in denying the residents their personal rights as set forth in paragraphs XVII and XVIII; in retaliating against persons who complained about the BRI program as set forth in paragraph XXI; in denying employees of the Department of Social Services the right to inspect and investigate complaints as set forth in paragraph XX; in not providing a consistent program as set forth in paragraphs XXVI, XXVII, and XXVIII; and in other inappropriate actions as set forth in this accusation.

XVII

Section 80341(a) provides in relevant part:

"All facilities. Each person receiving services from a community care facility shall have rights which include, but are not limited to the following:

(1) To be accorded dignity in his personal relationship with staff and other persons.

(2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment.

(3) Not to be subjected to corporal or unusual punishment, humiliation, mental abuse,...or punitive interference connected

with the daily functions of living, such as eating or sleeping.

(4) To be informed by the licensee of the provisions of law regarding complaints and of procedures for registering complaints confidentially, including but not limited to, the address and telephone number of the complaint receiving unit of the Department and licensing agency."

Section 80341(c) provides in relevant part:

"All persons admitted to facilities or their parents...shall receive a copy of the rights enumerated in Section 80341 upon admission to the facility."

Respondent has received limited permission to use specified punishments as a part of its behavior modification program. However, respondent has violated those portions of Section 80341(a) and (c) with which it is required to comply, as follows:

1. Respondent punitively interfered with the residents' daily functions of living, such as eating, sleeping, elimination, and bathing in the following instances and for an unknown period of time before and after these instances:

A. In or about June or July 1981 [redacted] received no breakfast or lunch on one day. [redacted] received no dinner on that day.

B. On or about June 9, 1981 [redacted] received no dinner. [redacted] received no breakfast on that date.

C. For an unknown period of time during June and July 1981, respondent did not provide [redacted] with

three meals a day.

D. During the period from June 30 to July 8, 1981 [redacted] was deprived of sufficient food to the extent that he lost 7 pounds.

E. On or about February 27, 1981 respondent did not allow [redacted] breakfast, lunch, or dinner because of inappropriate behavior. He received no food for 21 hours. On this date the records showed that he had lunch but staff at the facility said he had eaten nothing.

F. In or about February 1981 [redacted] was deprived of meals up to three times a week.

G. On or about December 12, 1980 respondent refused to allow [redacted] to sleep in his bed.

H. During November and December 1980 and for an unknown period of time after that period, respondent did not allow [redacted] to sleep in his bed. He was made to sleep on the floor with one arm tied to a desk and the other arm tied to a board with a blanket thrown over him. Employees were instructed to keep an account of how often he chanted and to administer a water squirt each time he chanted during the night.

I. On or about November 5, 1980 respondent withheld breakfast from [redacted]

J. On occasion during the period from September through December 1980 and for an unknown period of time before and after that month, [redacted] was placed in the back yard of the facility by himself while in

restraints. Respondent fed [redacted] when he was in the yard by placing a plate of food on the ground with no eating utensils. [redacted] would have to eat with his arms restrained to his sides.

K. On occasion during the period from September 3 through December 15, 1980 and on unknown occasions before and after that period, [redacted] would be taken into the back yard and hosed down with the garden hose to "consequate" an inappropriate behavior. If [redacted] hit more than one time a day, his shower privilege would be taken away and he would be hosed down.

L. The personal rights of [redacted] would be violated while he was in isolation as follows:

(1) On one occasion during the period from September 3 through December 15, 1980, while [redacted] was in isolation, [redacted] was fed lettuce and mayonnaise, with protein powder sprinkled on top of the mayonnaise. On other ocassions he would receive lettuce and mayonnaise three times a day and a glass of milk with a protein additive as his only food.

(2) When [redacted] was placed in isolation respondent would not allow anyone to speak to [redacted] for 24 hours. He would be restrained in the classroom behind the boxes until 11:00 p.m., then he would be tied to a piece of furniture in the living room in a kneeling position to sleep. On these occasions he would be deprived of a bed, pillow, and

blanket.

(3) On several occasions during the period from September through December 1980 and on unknown occasions before and after that period, [redacted]. was not allowed to go to the bathroom, was deprived of his meals and deprived of his bed.

M. On numerous occasions during the period from September through December 1980 and for an unknown period of time before and after that period, mini-meals were served. The food for a meal would be divided into portions that could be earned by appropriate behavior. The residents would be deprived of portions of their meal for inappropriate behavior. When the serving of food was delayed, certain foods such as french toast, cold cereal, and fried eggs would become rubbery and unappetizing. Some residents were unable to exhibit sufficient appropriate behaviors to earn an adequate amount of food.

N. On numerous occasions during the period November 20, 1978 through July 18, 1980 respondent did not allow [redacted]. to sleep in his bed but required him to sleep on a mat on the living room floor for the convenience of staff.

O. During the period from January through July 1980, and for an unknown period of time before that period, respondent practiced a procedure of waking [redacted] once every three hours every night to bring him to the bathroom, thus preventing him from sleeping for a

basis. A Water Squirt II is administered to a bent-over resident by an employee who is holding the resident's neck between his or her thighs, with the resident's hands forced up above the resident's back, and the water squirted at the resident's face in that position. It is not a proper behavior modification technique to use humiliation of involuntary subjects as an aversive consequence.

3. Respondent failed to accord the residents of BRI dignity in their personal relationships with staff and other persons in the instances alleged in paragraphs XIV and XVI and in parts 1 and 2 of this paragraph.

4. Respondent failed to accord the residents of BRI safe, healthful, and comfortable accommodations, furnishings, and equipment in the instances alleged in paragraphs XIV, XVI and XIX and in parts 1 and 2 of this paragraph.

5. Respondent has consistently failed to inform the parents of its residents of their right to complain to Community Care Licensing.

XVIII

Section 80341(b) provides in relevant part that:

> "In addition to (a) above, each person provided services by a residential facility shall have and may exercise the following rights:
>
> * * *
>
> (2) To have his family or surrogates regularly informed by the facility of activities related to his care or services including ongoing evaluations, as appropriate to his needs.

(3) To have communications to the facility from his relatives, guardian or conservator answered promptly and appropriately.

(4) To have his close relatives or persons responsible for the resident visit at mutually agreed upon hours but without prior notice, and to be allowed other visitors through mutually agreed upon arrangements.

Respondent has violated Section 80431 as follows:

1. On occasion during the period from May through December 1980 and on unknown occasions before and after that period, respondent instructed its staff not to talk to parents of the residents of BRI.

2. On or about July 18, 1980 respondent refused to allow [redacted]'s parents and their counselor to look at [redacted]'s records.

3. On or about July 18, 1980 [redacted]'s records were removed from the facility and made inaccessible to his parents, the placement agency, and Community Care Licensing evaluators.

4. On occasion during the period from September 1980 through February 1981 and on unknown occasions before and after that period, respondent instructed its staff to discontinue the administration of aversive therapy, to put away restraints and water squirt bottles, and to remove bruised residents from view if relatives or other visitors came to the facility.

5. On occasion during the period from September

through December 1980 and on unknown occasions before and after that period, respondent instructed its employees to administer pinches and spanks to the buttocks, inner arm, inner thigh, and/or the soles of the feet, and to dress residents in long pants and long-sleeved shirts to prevent relatives and other visitors from seeing the bruises and abrasions resulting from pinches and spanks.

6. On or about September 17, 1980 respondent informed Mr. and Mrs. [redacted] that if their son was to remain in BRI they (Mr. and Mrs. [redacted]) would be prohibited from visiting [redacted] for three months.

7. On or about September 17, 1980 respondent informed Mr. and Mrs. [redacted] that any inquiries they had about their son had to be made to [redacted] between 4 and 5 p.m. on weekdays.

XIX

Section 80407 provides in relevant part:

> (a) Facilities Providing Meals. Where meals are served, the total daily diet shall be of the quality and in the quantity necessary to meet the needs of the residents and shall meet the Recommended Dietary Allowances of the Food and Nutrition Board of the National Research Council, adjusted to the age, activity and environment of the group involved. All food shall be stored, prepared and served in a safe and healthful manner.... The following should apply:
>
> (1) Where total food service is provided, arrangements shall be made so that each resident has available at least three meals per day....

//

* * *

(3) Nourishment or snacks shall be provided to all persons as needed.

(4) Meals on the premises shall be served in a designated dining area suitable for the purpose and residents encouraged to have meals with other residents....

* * *

(10) Procedures which protect the safety, acceptability and nutritive values of food shall be observed in food storage, preparation, and service....

* * *

(17) All persons involved in food preparation and service shall observe personal hygiene and food services sanitation practices which protect the food from contamination.

(18) If residents participate in food preparation and service as part of their planned program they shall comply with the same policies and procedures as those required of food service employees.

* * *

(22) There shall be one or more dining rooms or similar areas suitable for serving persons at a meal service, in shifts where appropriate. The dining areas shall be convenient to the kitchen so that food may be served quickly and easily and shall be attractive and promote socialization among the diners.

* * *

(30) Pesticides and other toxic

substances shall not be stored in food storerooms, kitchen areas, or where kitchen equipment or utensils are stored.

(31) Soaps, detergents, cleaning compounds or similar substances shall be stored in areas separate from food supplies and protected from small children and others for whom they pose a potential hazard.

(32) Supplies of staple foods for a minimum of one week and perishable foods for a minimum of two days shall be maintained on the premises.

(33) All kitchen areas shall be kept clean, free of litter and rubbish and protected from rodents, vermin and insects.

* * *

(38) Tableware and tables, dishes, and utensils shall be used which make the serving of food attractive and inviting.

Respondent has violated Section 80407 as follows:

1. On numerous occasions respondent has denied its residents three meals a day. These occasions include, but are not limited to the following:

A. On one day in June or July 1981 [redacted]. did not receive breakfast or lunch.

B. On one day in June or July 1981 [redacted]. did not receive dinner.

C. On June 9, 1981 [redacted]. received no dinner.

D. On June 9, 1981 [redacted] received no

breakfast.

E. On or about February 27, 1981 [redacted]. did not receive breakfast, lunch, or dinner. He received no food for 21 hours.

F. In or about February 1981 [redacted] was deprived of meals up to three times a week.

G. On or about November 5, 1980 [redacted] did not receive breakfast.

H. On occasion during the period from September through December, 1980, [redacted]. would receive only lettuce with mayonnaise three times a day and a glass of milk with protein powder. On other occasions during the same period the protein powder would be sprinkled on the lettuce.

2. During the months of December 1979 and January 1980 and on unknown occasions after those months, respondent denied [redacted] a night meal causing him to lose weight.

3. On numerous occasions during the period from September through December 1980 respondent fed [redacted] by placing his plate of food on the ground in the back yard. [redacted] would generally not be given eating utensils and would have to eat while his arms were restrained at his sides.

4. On occasion during the period from September through December 1980 and for an unknown period of time after those months, respondent attempted to and did make [redacted]'s meals unappetizing as a form of punishment.

5. On numerous occasions from 1979 to the present

respondent has used mini-meals as a form of behavior modification. When meals were broken into small bits to be earned by behavior, the food, particularly french toast, cold cereal, and fried eggs would become cold, rubbery, unappetizing, and unacceptable. When meals were broken into small bits to be earned by behavior, the residents frequently did not receive sufficient food. Many residents, including, but not limited to, [redacted], [redacted], [redacted], and [redacted] lost weight.

6. On occasion during the period September through December 1980 and on unknown occasions before and after that period, respondent did not have sufficient supplies of staple foods to last one week or of perishable foods for a minimum of two days.

7. In or about November 1980 there were numerous ants in the kitchen at BRI.

8. On or about June 5, 1981, respondent had soaps, detergents, and cleaning compounds stored in areas near food and accessible to the residents.

9. On or about June 5, 1981, respondent allowed a resident to transfer a cleaning liquid from one bottle to another directly over the food being prepared for breakfast.

XX

Health and Safety Code Section 1533 provides that:

"Any duly authorized officer, employee, or agent of the state department may, upon presentation of proper identification,

enter and inspect any place providing personal care, supervision, and services at any time, with or without advance notice, to secure compliance with, or to prevent a violation of, any provision of this chapter."

Health and Safety Code Section 1538 provides in relevant part that:

"(a) Any person may request an inspection of any community care facility in accordance with the provisions of this chapter by transmitting to the state department notice of an alleged violation of applicable requirements prescribed by statutes or regulations of this state....

"(b) The substance of the complaint shall be provided to the licensee no earlier than at the time of the inspection. Unless the complainant specifically requests otherwise, neither the substance of the complaint provided the licensee nor any copy of the complaint or any record published, released, or otherwise made available to the licensee shall disclose the name of any person mentioned in the complaint except the name of any duly authorized officer, employee, or agent of the state department conducting the investigation or inspection pursuant to this chapter."

Section 80351 provides that:

"Any duly authorized officer, employee or agent of the Department may, upon proper identification, enter and inspect any place providing services at any time, with or without advance notice. Provisions shall be made for private interviews with any person receiving services or any staff member and for examination of all records relating to the operation of the facility."

Respondent has violated Sections 1533 and 1538 of the Health and Safety Code and Section 80351 as follows:

1. On or about June 5, 1981 department employees and consultants were denied the right to view the residents for one and one-half hours. Respondent then denied department employees and consultants the right to examine the residents for bruises. Department personnel were limited to a "hands off" viewing of residents while they were clothed.

2. On or about March 2, 1981 [redacted] was told by [redacted] that [redacted] had been pinched on the buttocks because licensing evaluators do not examine the children's buttocks.

3. On or about February 5, 1981 the respondent refused to allow CCL evaluators who visited BRI to investigate a complaint to view the residents for several hours. They were not allowed to view the buttocks of [redacted] or [redacted] for bruises.

4. On or about November 4, 1980 respondent refused to allow CCL evaluators at BRI to investigate a complaint to view the body of resident [redacted] for bruises. On this same date respondent refused to allow the evaluators to look at the facility files.

5. On or about August 12, 1980 respondent refused to allow the Community Care Licensing evaluators to review records relating to [redacted] and [redacted].

XXI

Section 1539 of the Health and Safety Code provides that:

"No licensee shall discriminate or retaliate

in any manner against any person receiving the services of such licensee's community care facility, or against any employee of such licensee's facility on the basis, or for the reason that, such person or employee has initiated or participated in an inspection pursuant to Section 1538."

Respondent has violated Section 1539 of the Health and Safety Code as follows:

1. During the period of licensure, respondent has threatened parents that if they complain about the program, their children will be terminated from BRI.

A. On or about March 10, 1981 Judy Weber threatened to have [redacted] removed from the program if Mrs. [redacted] continued to question [redacted]'s treatment at BRI.

B. On or about March 5, 1981 [redacted]. was taken off any form of treatment as a result of his mother's complaints.

C. During the period from May through October 1980, after his parents complained about the bruises on their son, respondent took [redacted] off any form of treatment and expressed the desire to get Noah G. out of BRI.

D. On or about May 16, 1980 in response to [redacted]' complaints regarding the spanks that [redacted] was receiving, [redacted] told Mrs. [redacted] to go to the school to pick up [redacted]. [redacted] also told Mrs. [redacted] that [redacted] should be picked up and that they would fight her like everyone else. [redacted] also

instructed Mrs. [redacted] not to talk to the [redacted]

E. In or about October or November 1979 [redacted] told [redacted] that if she continued her complaints, her son would be without a program.

XXII

Section 80409 provides in relevant part as follows:

"(a) The licensee shall arrange, or assist in arranging for medical and dental care appropriate to the condition and needs of persons served....

* * *

"(2) Transportation of persons to keep medical and dental appointments shall be arranged in accordance with a prearranged plan.

* * *

"(10) The licensee shall provide for assisting adults with self-administered medications as needed. Such assistance shall be limited to the following:

"(a) Medications usually prescribed for self-administration which have been authorized by the person's physician.

* * *

"(11) Facility personnel shall administer medications prescribed for children...."

Respondent has violated Section 80409 as follows:

1. During the period from September 1980 through February 1981 and on unknown occasions before and after that period, respondent cancelled medical appointments for a resident if that resident was too bruised.

2. In or about May 1980 respondent attempted to postpone a doctor's appointment previously scheduled for [redacted] because he was bruised. The appointment was finally cancelled because respondent's employees would not cooperate to provide necessary transportation for [redacted].

3. On occasion during the period September through December 1980 and on unknown occasions before and after that period, residents including [redacted] would not receive suppositories needed for bowel problems.

4. During the period from December 1980 through July 1981 [redacted] was given two (2) aspirin and Colace every night without a physician's direction.

XXIII

Section 80319(a) provides that:

> "(a) Personnel shall be sufficient in numbers and competent to provide the services for which the facility is licensed."

Respondent has violated Section 80319(a) as follows:

1. Respondent, on numerous occasions from 1979 through the present, failed to employ sufficient numbers of persons to adequately supervise and care for the residents and to conform with its own staffing plan.

XXIV

Section 80311 states:

> "(a) Each licensee shall furnish to the Department or the licensing agency such reports as the Department may require, including, but not limited to, the following:

"(1) Death, Injury and Unusual Incidents. A report within 48 hours by telephone or telegraph shall be made to the Department or to the licensing agency and to the person or persons responsible for the resident concerning the death of any resident from any cause; any serious injury as determined by the attending physician; and any unusual incident which threatens the welfare, safety or health of any resident, such as physical or psychological abuse of a resident by staff or other residents, or unexplained absence of any resident.... A written report shall be submitted to the Department or to the licensing agency within seven (7) days following any such event. This report shall include the name, age, sex and date of admission of the resident, date of event, nature of event, physician's findings and treatment, if any, name of attending physician, and disposition of the case."

Respondent failed to comply with Section 80311 as follows:

1. Respondent failed to report the incidents set forth in paragraphs XIV, XVI, XVII and XVIII of this accusation.

2. On or about December 9, 1980 [redacted]. received burns. Respondent failed to report this incident to the licensing agency until February 5, 1981.

3. On or about November 25, 1980 [redacted]. received a cut in a fall. The cut required suturing which was performed at Granada Hills Community Hospital. Respondent failed to notify the Department of this incident until March 20, 1981.

4. The respondent failed to submit an incident report to Community Care Licensing concerning a black eye suffered by [redacted] in or about March 1980.

XXV

Health and Safety Code Section 1522(a)(b)(2) provides that:

> "(a) Before issuing a license or special permit to any person or persons to operate or manage a community care facility, the state department shall secure from an appropriate law enforcement agency a criminal record to determine whether the applicant...or any other person specified in subdivision (b) has ever been convicted of a crime other than a minor traffic violation.... If it is found that the applicant...or any other person specified in subdivision (b) has been...convicted of a crime, other than a minor traffic violation, the application shall be denied, unless...the director grants an exemption....
>
> "(b) In addition to the applicant, the provisions of this section shall be applicable to criminal convictions of the following persons:
>
> "(2) Any person residing or regularly in the facility having routine contact with the residents."

Section 80319(b) provides that:

> "(2) All personnel shall have either training or related experience in the job assigned to them.
>
> * * *
>
> "(5) All specialized personnel shall be qualified by training or experience in accordance with recognized professional standards."

Section 80325(b) provides that:

//

"(b) For all persons working in the facility, including the licensee, the administrator and employees, there shall be a record of a health examination, including a chest X-ray or an intradermal test, performed by a physician not more than six (6) months prior to employment or within seven (7) days after employment."

Section 80315 provides:

"Only licensed drivers shall be permitted to operate motor vehicles used in transporting residents. The driving record of employees whose duties include transport of residents shall be secured from the Department of Motor Vehicles."

Section 80345 provides:

"Each licensee of a community care facility, other than a county, shall file or have on file with Department or licensing agency a bond issued by a surety company if the licensee is handling or will handle money in the amount of $50 or more per person or $500 or more for all persons in the facility in any month."

Section 80409(a)(8) provides:

"Staff providing care shall receive appropriate training in first aid from persons qualified by such agencies as the Red Cross."

Respondent has violated Health and Safety Code Section 1522 and Sections 80315, 80319, 80325, 80345(a) and 80409(a)(8) as follows:

1. On or about July 22, 1981 BRI had not submitted fingerprint cards for the facility nurse and for many staff members.

2. On or about July 22, 1981 BRI did not have a bond.

3. On or about July 22, 1981 BRI did not have proof

in the facility files that a driving record had been obtained from the Department of Motor Vehicles on each employee whose duties included the transporting of residents.

4. On or about July 22, 1981 facility files kept on treatment worker staff did not have verification of college degrees.

5. On or about July 22, 1981 respondent did not have either a physician's report or TB test results on the following persons: [redacted] and [redacted].

6. On or about July 22, 1981 there was no evidence on file that any staff person, other than the facility nurse, had first aid training.

XXVI

SPECIAL PERMIT:

GENERAL REQUIREMENTS VIOLATIONS

1. Respondent violated Section 1 of the general requirements contained on page 1 of the Special Permit to Provide Aversive Behavior Interventions (Exhibit C) (hereinafter "special permit") in that it has failed to maintain full compliance with the licensing regulations in Title 22, California Administrative Code, Division 6, as alleged in paragraphs I through XXV.

2. Respondent violated Section 3 of the general requirements contained in the special permit in that the facility has made additions and modifications to the treatment program at the facility without the prior written approval of

the Department of Social Services, as follows:

A. Respondent subjected [redacted] and [redacted] to isolation, as alleged in paragraph XIV. Isolation is a form of time-out procedure. Respondent was specifically advised it could not use time-out procedures. (See Exhibit B)

B. On at least one occasion during the period of licensure, respondent subjected [redacted] to unapproved aversive treatment by requiring him to sort and re-sort flatware without interruption and without permission to speak for three hours.

C. Respondent's records indicate that restraints were used as a part of [redacted]'s program in a negative reinforcement paradigm. That is, [redacted] was able to earn removal of restraints by ceasing to engage in certain behaviors. This occurred during periods of 1980 and 1981 not precisely known to respondent. The use of restraints at BRI is not approved as part of BRI's behavior modification program or under any other circumstances.

3. Respondent violated Section 4 of the general requirements contained in the special permit in that the treatment program at BRI has been discontinued, suspended, and interrupted without prior notice to the Department of Social Services or to the relevant placement and referral agencies as follows:

A. On numerous occasions from 1979 to the

present, respondent ceased the use of aversives and other treatment prior to a resident's scheduled visit to a doctor or his parents.

B. During October 1980 and for an unknown period of time before and after that month, [redacted] was taken off all forms of treatment.

C. In or about September or October 1980 [redacted] was taken off treatment because he was excessively bruised.

D. On occasions during the period from September 3 through December 15, 1980 and on unknown occasions before and after that period, residents would be taken off treatment if they were badly bruised. If visitors came to the facility, the residents would be put in their bedrooms.

E. During the period from September through December 1980 and for an unknown period of time before and after that period, a resident would be taken off regular treatment, asked to do only tasks which placed little demand on him, and rewarded heavily, so a film could be made showing how much the resident had allegedly improved at BRI.

F. On or about March 5, 1981, as a result of complaints to BRI by [redacted], her son was taken off treatment.

G. On or about November 1980, [redacted] was taken off the aversive treatment program for several days

and after that period, respondent had [redacted], an unqualified person, acting as director for BRI. During that period, Mr. [redacted] was making treatment decisions for the residents at BRI.

E. During the period from February 1979 through December 1980 and for an unknown period of time after those dates, untrained employees were administering aversive behavior interventions to residents.

5. During the period of licensure, respondent violated Section 2(b)(1) of the A Standards in that persons acting as director of the facility lacked the requisite training and competency in the application of behavior modification techniques.

6. Respondent is in violation of Section 2(b)(2) of the A Standards in that during the licensure period, persons acting as director have failed to take responsibility for the health and safety of all residents receiving aversive behavior interventions, have failed to adequately monitor and control the use of aversive behavior interventions, and have failed to report instances of misuse and abuse of aversives to the licensing authorities as follows:

A. On one occasion during September through December 1980 a visitor came to BRI when [redacted]. was excessively bruised. The visitor was told that [redacted] was ill and off treatment for the day. [redacted] was kept in his bedroom during this period.

B. During the period from September through

prior to a doctor's appointment because he was excessively bruised.

4. Respondent violated Section 5 of the general requirements contained in the special permit in that it has failed to comply with the special permit licensing requirements (A Standards), as alleged in paragraph XXVII.

5. Respondent further violated Section 5 of the general requirements contained in the special permit in that it has failed to comply with the special permit program requirements (B Standards) contained in the Draft Guidelines, as alleged in paragraph XXVIII.

XXVII

SPECIAL PERMIT:

"A" STANDARDS VIOLATIONS

Respondent has failed to comply with the special permit licensing requirements (A Standards) contained on page 2 et seq. of the special permit (see Exhibit C) as follows:

1. BRI has violated Section 1(a)(1)(A) of the A Standards in that the facility has failed to maintain adequate written policies and procedures describing the use of aversives, the staff members empowered to authorize and/or implement their use, and the mechanisms for maintaining and controlling their use.

2. BRI has violated Section 1(a)(1)(C) of the A Standards in that the facility has failed to make adequate written policies and procedures available to staff, to residents' families, and to the Department.

3. BRI is in violation of Section 1(b) of the A Standards in that the facility has failed to maintain complete records on each resident. This violation includes but is not limited to failure to retain daily records kept by direct service staff as required by section (1)(b).

4. During the period of licensure, respondent violated Section 2(a)(1)(A) of the A Standards in that the facility has failed to assure that a qualified clinical supervisor/director (hereinafter "director") is responsible for the delivery and termination of aversives at all times, as follows:

A. During the period from September 1978 through the present, [redacted] has on numerous occasions acted in the capacity of director. Mrs. [redacted] has no education or experience to qualify her for such a position.

B. On or about the evening of March 8, 1981, [redacted] was acting as director at BRI. She was not qualified for that position. She did not have authority to make treatment decisions and referred all such decisions to [redacted].

C. On or about July 22, 1981 [redacted], who is herself not qualified for the position of clinical director, was conducting the training of the new clinical director.

D. During the period from September 3 to December 15, 1980 and for an unknown period of time before

December 1980 and on unknown occasions before and after that period, respondent instructed its employees to administer pinches to residents' inner thighs, inner arms, buttocks, and bottoms of the feet to keep the resulting bruises and abrasions from being visible to licensing authorities, parents, and physicians.

C. During the period from September 3 through December 15, 1980 and for an unknown period of time before and after those dates, respondent instructed its employees to put away all restraints and water squirt bottles and not to use any aversive stronger than a "no" if outsiders were at BRI. During visits by outsiders all treatment for the residents was terminated.

D. In or about September or October 1980, [redacted]. was taken off treatment for 10 days because he was excessively bruised. Respondent failed to report [redacted]'s injuries to the licensing authority.

E. In or about May 1980, respondent attempted to postpone a doctor's appointment previously scheduled for [redacted]. because he was badly bruised. Respondent finally caused the appointment to be cancelled.

F. During the period from September through December 1980 and for an unknown period of time before and after that date, respondent cancelled medical appointments for a resident if that resident was too bruised.

G. On occasion during the period from September through December 1980, and on unknown occasions

before and after that period, respondent failed to give [redacted]. suppositories he required for a bowel problem because it was inconvenient for the staff.

H. In or about October 1980 respondent would record only one water squirt when in fact several were given in succession.

XXVIII

SPECIAL PERMIT:

"B" STANDARDS VIOLATIONS

The special permit program requirements (B Standards) referred to in Section 5 of the special permit are contained in the February 14, 1979 draft of the "California Guidelines for the Use of Behavior Interventions to Restore Personal Autonomy" (hereinafter the "Draft Guidelines"). (See Exhibit D.) Respondent has violated the Draft Guidelines as set forth below. All section or standard numbers in this paragraph XXVIII correspond to standard numbers found in the Draft Guidelines.

1. Respondent is in violation of Standard I A 2(a) of the Draft Guidelines (p. 17) in that the facility on June 5, 1981 was unable to produce and at the time of service of this Accusation is still unable to produce written policies and procedures on 1) the use of aversive behavior interventions (hereinafter called "aversives"); 2) the staff members authorized to use them; and 3) the monitoring and control of their use.

2. Respondent is in violation of Standard I A 2(b)

of the Draft Guidelines (p. 17) in that on June 5, 1981 the facility was unable to produce, and at the time of service of this Accusation is still unable to produce, written documentation describing the coordination and continuity of the total program at BRI for each individual resident.

3. Respondent further violated Standard I A 2(b) of the Draft Guidelines in that during the period of licensure respondent failed to adhere to a coordinated and consistent program plan for individual residents as follows:

A. On one occasion in 1979, [redacted] told the staff at BRI to "consequate" [redacted] with a spank for urinating and/or defecating in his pants although spanks for such conduct were not part of [redacted]'s program plan.

B. In or about March 1980 and for an unknown period of time before and after that month, respondent's employees administered spanks to [redacted]. for crying after he was spanked for neck snapping. Being spanked for crying was not part of [redacted]'s program plan.

C. During April 1980 spanks were administered to [redacted] because he stopped running, even though spanks for this conduct were not part of [redacted]'s program plan and were not recorded.

D. In or about October 1980, when [redacted]. was "off treatment," a treatment worker snapped a rubber band at [redacted] to make him move to another area. (This was an aversive for [redacted] who feared rubber bands.)

E. During the period from September 3 through

December 15, 1980 and for an unknown period of time before and after that period, [redacted] frequently and inconsistently changed the programs for the residents, making it difficult for treatment workers to determine what the current program was for an individual or to understand the program.

F. On occasion during the period from September through December 1980, and on unknown occasions before and after that period, [redacted] would deprive [redacted]. of the privilege of watching T.V. for inappropriate behavior although such punishment was not part of [redacted]s program plan.

G. In or about October 1980, respondent's employee administered a water squirt to [redacted] as a "joke" while [redacted] was "off treatment." The water squirt was not in response to any particular behavior, and was not recorded.

H. In or about October 1980 respondent's employee moved up the hierarchy of aversives to a water squirt without following any procedure for approval of the increase and without documenting the change for other treatment workers to follow.

I. On occasion during the period from September through December 1980 and on unknown occasions before and after that period, respondent would prompt residents to become aggressive for the purpose of showing how bad the child allegedly was before treatment.

J. In or about December 1980 [redacted] was prompted to grab the secretary's hair so it could be filmed. When [redacted] was eating, [redacted] filmed a close-up of food spilling out of his mouth. [redacted] would be prompted to misbehave, allowed to rehearse, then filmed. Food was scattered around the room by respondent's employees and filmed to make it appear that Danny had thrown the food.

4. Respondent is in violation of Standard I A 2(c) of the Draft Guidelines (p. 17) in that on June 5, 1981, the facility was unable to produce, and at the time of service of this Accusation is still unable to produce, written policies and procedures which emphasize positive approaches to the growth and development of individual residents.

5. Respondent further violated Standard I A 2(c) of the Draft Guidelines in that in or about the period from September through December 1980, and for unknown periods of time before and after that period, respondent stressed the administration of aversives rather than the use of rewards.

6. Respondent further violated Standard I A 2(c) of the Draft Guidelines in that respondent has not had, during the period of licensure, a system to wean residents from aversives or a system to de-escalate aversives.

7. Respondent violated Standard I A 2(d) of the Draft Guidelines in that on June 5, 1981, all personnel were not fully aware of the facility policies on the use of aversives.

8. Respondent is in violation of Health and Safety Code Section 1550(c), Title 22 Cal. Admin. Code, Section 80403(f), and Standard I A 4 of the Draft Guidelines (p. 19) in that physical restraints are used and have been used continually on residents throughout the licensing period, as alleged in paragraph XIV, despite numerous orders and warnings from the complainant to cease use of such restraints. This excessively restrictive approach has been used for the convenience of staff, in response to understaffing, and in lieu of more productive and appropriate treatment methods.

9. Respondent violated Standard I A 6 of the Draft Guidelines (p. 19) in that on June 5, 1981 the facility was unable to produce a complete record on each individual which was easily accessible by direct service staff, parents and licensing officials.

10. Respondent is in violation of Standard I A 7 of the Draft Guidelines (p. 19) in that up to the time of service of this Accusation data were not taken on behaviors which were being positively reinforced in a fashion which would enable staff to see interrelationships, in that such data were not taken often enough or in a form compatible with the data on the use of aversives. (see technical notes, p. 19).

11. Respondent is in violation of Standard I B 1b, c, d, and e, of the Draft Guidelines (pp. 24-25) in that the facility was unable to document on June 5, 1981, and at the time of service of this Accusation is still unable to document, that prior to the use of any aversive on any individual, the

following factors are considered:

(A) The relative effectiveness of the available procedures for dealing with a given behavior.

(B) The undesirable long and short-term side effects that may be associated with a procedure for a particular individual.

(C) The conditions under which a specific procedure may be clinically contraindicated for a particular individual.

(D) The relative efficiency of a specific procedure chosen in terms of its duration, frequency, and staff requirements.

12. Respondent is in violation of Standard I B 2 of the Draft Guidelines (p. 26) in that the facility was unable to document on June 5, 1981, and at the time of service of this Accusation is still unable to document, that prior to the use of aversive behavior interventions, a thorough multi-disciplinary assessment of the individual takes place, covering the areas listed in the Draft Guidelines.

13. Respondent is in violation of Standard I C 1 of the Draft Guidelines (p. 30) in that the facility was unable to produce on June 5, 1981, and at the time of service of this Accusation is still unable to produce, the documentation of a multidisciplinary team's rationale for not using less restrictive alternatives for each individual upon whom aversives are used.

14. Respondent violated Standard I C 2 of the Draft

Guidelines (p. 47) in that the facility was unable to document on June 5, 1981, and at the time of service of this Accusation is still unable to document, that the facility's interpretation of an individual's behavior as acceptable or unacceptable takes into account the individual's, the family's, and the community's social, religious, and ethnic values.

15. Respondent further violated Standard I C 2 of the Draft Guidelines in that the facility interpreted behaviors as unacceptable without any rational basis, as follows:

A. During the period from September 3 through December 15, 1980 and for an unknown period of time before and after those dates, residents at BRI would be spanked or water squirted for moving their feet or putting their hands to their faces.

B. During his residence at BRI, [redacted] was deaf and unable to speak. He indicated hunger, anger, and tiredness by crying. Spanks were administered to [redacted] for crying.

C. During the period November 20, 1978 through July 18, 1980 respondent administered aversives to [redacted] for "toe-walking" although it was caused by a medical problem and his parents had asked the facility to ignore this behavior.

D. On one occasion in October 1980, respondent was giving [redacted] a "no" for touching his face. The consequence was raised at that time, without proper procedure, to a water squirt. Thereafter, whenever [redacted] would wipe the water

off his face, he would get squirted again.

16. Respondent violated Standard I C 4 of the Draft Guidelines (p. 55) in that individual residents on June 5, 1981, lacked written program plans with provisions to teach the individuals the circumstances under which problem behaviors can be exhibited appropriately or to replace the maladaptive behaviors with adaptive or appropriate behaviors.

17. Respondent is in violation of Standard I C 5a, b, d, f, and g of the Draft Guidelines (pp. 55-56) in that the facility was unable to produce on June 5, 1981, and at the time of service of this Accusation is still unable to produce, for each individual resident, a behavior modification plan or program which specifies in writing:

(a) The targeted behavior stated in objective and quantifiable terms;

(b). The behavioral objective or goal of the program, including the time frame;

(c) The schedule for use of the behavioral method;

(d) The control or probe techniques to determine the necessity for continuing intervention;

(e) The conditions under which an individual's specific plan or program is changed or modified.

18. Respondent is in violation of Standard I C 7 of the Draft Guidelines (p. 57) in that the facility was unable to produce on June 5, 1981, and is still unable to produce at the time of service of this Accusation evidence that appropriate

medical or other health professionals participate on the multidisciplinary team and in the regular review process; rather, the extent of tissue damage done by aversive procedures was regularly kept from residents' physicians.

19. Respondent violated Standard I C 8 of the Draft Guidelines (p. 57) in that individual residents were placed in isolation, while restrained, without the direct observation of persons conducting the program, as set forth in paragraph XIV, allegations 2F and 3D, and in paragraph XVII, allegation 1L.

20. Assuming arguendo that the use of restraints was approved at BRI, respondent is in violation of Standard I C 10 (p. 58) in that restraints are used as a form of aversive intervention as alleged in paragraph XIV, and are not restricted to a temporary emergency measure used while more effective intervention is planned.

21. Assuming arguendo that the use of restraints was approved at BRI, respondent is in further violation of Standard I C 10 in that the facility was unable to produce on June 5, 1981, and at the time of service of this Accusation is still unable to produce, documentation of the systematic trial of less restrictive alternatives, and, where appropriate, of the reasons for failure to try alternatives.

22. Assuming arguendo that the use of restraints was approved at BRI, the facility is in violation of Standard I C 10 in that staff members continually fail to check restraints every 30 minutes.

23. Assuming arguendo that the use of restraints was

approved at BRI, respondent is in further violation of Standard I C 10 of the Draft Guidelines in that restraints have been used in a manner which has caused injuries to residents as alleged in paragraph XIV.

24. Assuming arguendo that the use of restraints was approved at BRI, respondent is in violation of Standard I C 11 (p. 59) in that restraints have been and continue to be used as punishment, for the convenience of the staff, and as a substitute for an adequate program.

25. Respondent is in violation of Standard II A 1 j of the Draft Guidelines (p. 63) in that the facility has failed to have competent and qualified personnel implement and monitor individual residents' plans as alleged in paragraph XVI.

26. Respondent is in violation of Standard II A 1 k of the Draft Guidelines (p. 63) in that the facility was unable to produce evidence on June 5, 1981, and at the time of service of this Accusation is still unable to produce evidence, that individual residents and parents are fully informed, as specified in the Draft Guidelines, of the purposes, actions, and outcomes of aversive behavior interventions.

27. Respondent is in violation of Standard II A 1 m of the Draft Guidelines (p. 63) in that the facility was unable to produce evidence on June 5, 1981, and at the time of service of this Accusation is still unable to produce evidence that the staff at BRI periodically conducts meaningful reviews of the residents' progress toward goals and objectives in individual plans.

28. Respondent is in violation of Standard II A 1 n of the Draft Guidelines (pp. 63-66) in that the facility has regularly deceived parents as to the nature and extent of the aversives used on residents, thus making effective informed consent impossible (see Note 1, p. 64); has provided parents with no description of treatment alternatives (see Note 3, p. 65); has given parents no time sequence of expected results (see Note 9, p. 65); and has regularly informed parents that refusal to consent to the use of aversives desired by facility staff would result in explusion of the resident from the facility, rather than being without penalty, as required (see Note 11, p. 66).

29. Respondent is in violation of Standard II A 1 p of the Draft Guidelines (p. 66) in that the facility has denied parents the right to challenge without penalty the decisions and actions within an individual's program which relate to the individual's rights and protections as alleged in paragraph XXI.

30. Respondent is in violation of the Standards in Section III of the Draft Guidelines (pp. 73-80) in that the facility at the time of service of this Accusation is unable to produce evidence of compliance with any level of the required procedures to review and evaluate the application and the effects of aversive behavior interventions.

31. Respondent was in violation of Standard IV A of the Draft Guidelines (pp. 82-85) in that until shortly before service of this Accusation it had no qualified program

(clinical) supervisor or director.

32. Respondent is in violation of Standard IV B 2 (Qualifications) of the Draft Guidelines (p. 86) in that the facility was unable to produce on June 5, 1981, and at the time of service of this Accusation is still unable to produce evidence that direct service staff members are pursuing continuing education at the college level in the area of behavior modification.

33. Respondent is in violation of Standard IV B 3 (Qualifications) (p. 86) in that on regular occasions during 1980 and 1981, the application of aversive and restrictive interventions by staff members demonstrated a lack of knowledge of and competency in use of aversive behavior interventions, and lack of knowledge of ethical considerations.

XXIX

Assuming arguendo that the letter of October 25, 1977, authorizing BRI to conduct behavior modification and to utilize negative reinforcers (aversives), was not superseded by the special permit, respondent has violated or permitted the violation of the requirement, set forth in the letter, that negative reinforcers not include the "cold shower" or "time out," as follows:

1. On occasion during the period from September 3 through December 15, 1980, and on unknown occasions before and after that period, [redacted]. was hosed down with a garden hose to "consequate" an inappropriate behavior in lieu of receiving a regular shower.

2. On occasion during the period from January through July, 1980, and on unknown occasions before that period, [redacted]. was given cool showers for wetting his bed, as alleged in paragraph XVII 1 O.

3. During the period of licensure, residents [redacted]. and [redacted] were subjected to "time out" periods, as alleged in paragraphs XIV 3 D, XVII 1 J, and XVII 1 L.

XXX

The conditions and the acts of respondent set forth above, and each of them, constitute grounds for revocation of respondent's license and respondent's special permit and for denial of renewal of respondent's license and special permit.

WHEREFORE, complainant prays that respondent's license to operate a community care facility and its special permit to use aversive behavior interventions be revoked, and their renewal denied.

DATED: January 29, 1982

ANNE BERSINGER
Deputy Director
Community Care Licensing Division
Department of Social Services
State of California