IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

ILLINOIS LEAGUE OF ADVOCATES FOR THE DEVELOPMENTALLY DISABLED *et al.*	
Plaintiffs,	Case No. 13 C 01300
vs.	Hon. Marvin E. Aspen
ILLINOIS DEPARTMENT OF HUMAN SERVICES and **KEVIN CASEY**, *in his official capacity as Director of Developmental Disabilities*; and **COMMUNITY RESOURCE ALLIANCE,**	JURY DEMAND
Defendants.	

PLAINTIFFS' MEMORANDUM OF LAW IN SUPPORT OF THEIR EMERGENCY MOTION FOR TEMPORARY RESTRAINING ORDER

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Plaintiffs Illinois League of Advocates for the Developmentally Disabled *et al.* ("Plaintiffs), by their undersigned attorneys, respectfully submit this Memorandum of Law in Support of their Emergency Motion for Temporary Restraining Order and states as follows:

INTRODUCTION

Plaintiffs filed the instant cause on February 19, 2013 on behalf of a putative class of residents[1] of State Operated Developmental Centers ("SODCs"), which have been slated for closure and whop may have objection to a plan that Plaintiffs allege violates Section 504 of the Rehabilitation Act, the Americans with Disabilities Act, Federal and State Medicaid Law and regulations, as set forth in their Second Amended Complaint. (Docket Nos. 1, 55.)

Plaintiffs filed their Motion for Preliminary Injunction on February 27, 2013, to enjoin the State of Illinois' ("State") enactment of its plan with respect to the seven remaining SODCs and specifically, the Warren G. Murray Developmental Center located in Centralia, Illinois ("Murray"), which is the next SODC scheduled for closure. (Docket Nos. 8-9.) As Plaintiffs pointed out in their preliminary injunction reply brief, and as supported by affidavits and State's admissions, Defendants' plan to close Murray was part of the State's larger plan to eliminate all SODCs. (Docket No. 43.) At the time of filing of Plaintiffs' Motion for a Preliminary Injunction, Murray's closure was scheduled for November 30, 2013, and has been since moved up to October 31, 2013.

In recent days, Defendants accelerated the closure process drastically, and as more fully set forth herein, have undertaken actions that will place dozens of profoundly developmentally disabled adults who reside at Murray at extreme risk of injury and even death. At least 5-10 residents have already been transferred since the beginning of May. The Director of Murray,

[1] This class includes Individual name4d Plaintiffs, Associational Plainiffs, and their members, and OSG residents who may object to the State transfer plan but whose choice is unknown.

Jamie Veach, has also confirmed that by the end of May, Murray will discharge 40-50 residents from the facility.

Despite direct threats that they will be fired for interfering with the resident transition process, 14 Murray employees have bravely stepped forward to show exactly what is happening behind Murray's closed doors. The attached declarations of current and longtime Murray employees show that Defendants are: (1) rushing Murray residents through the discharge process; (2) excluding Murray staff from participating in the transition process for these residents; (3) disregarding the residents' needs and safety and even putting residents in harm's way; (4) failing to even inspect the homes before they transfer the residents (and all of their belongings) into the new homes; and (5) threatening Murray staff with termination if they voice any objection to Defendants' actions.

Defendants, who have an ongoing "transition plan" to close all SODCs and move all residents into 2-4 bed group homes, have dangerously accelerated the transfer of Murray residents into these homes in an attempt to obviate the Court's decision of whether the State's plan is lawful and render this case moot.[2] Defendants are accomplishing this acceleration by prohibiting Murray staff from taking any action to object to transfers which Murray staff believes are not in the best interest of the resident.

As further stated in the Statement of Fact, *infra*, Defendants are ignoring warnings about potentially dire consequences if certain residents are placed together. No safeguards are in place

[2] Defendants' strategy to move all the residents out of the facility before the Court can rule is transparent, however, it has proven successful in the past. In *ILADD et al. v. Illinois Health Facilities & Servs. Review Bd. d/b/a/ Jacksonville Developmental Center*, 2012 MR 103 ("*Jacksonville*"), Defendants argued that with the closure of the Jacksonville SODC, the action by the Jacksonville guardians to enjoin the closure was moot. Defendants prevailed on this argument. *See* Reply (Docket No. 43.)

to determine whether certain individuals with aggressive and dangerous behavior problems are kept apart from the most frail and helpless residents. Defendants are failing to inspect homes and are ignoring warnings relating to potential substandard housing conditions in other homes. Defendants are ignoring the procedures for Murray transfers, which have been in place for years and are freezing Murray professional staff out of the transfer process. Defendants are not following Murray's standard operating procedure, or indeed, any procedure at all, as they unsafely ship out residents that no one has properly assessed to homes that no one has properly inspected. Pre-transition visits are no longer done to ease the residents into the new group home environment—instead they are simply transferred and expected to sink or swim.

As detailed in the Murray staff declarations, Defendants are planning to rush between forty (40) to fifty (50) residents out of Murray and into small group homes in the next two weeks. They have already transferred at least 5-10 OSG residents to homes that were not properly inspected. Defendants also attempted to transfer another two OSG residents (one aggressive in nature and the other wheelchair-bound) together, against the strong objections from Murray staff. Predictably, the aggressive resident tried to attack the wheelchair-bound resident in a van before Defendants even left the Murray parking lot. Despite this, Defendants' plan is still to transfer them together. Another two residents have been transferred to a home with evidence of water damage and weak floors. Still another two were attempted to be transferred to a home with construction materials scattered everywhere. Still another three are scheduled to being transferred together, despite one being violent in nature, and another having a sexual history. Still another resident with a history of running away ("elopement") was transferred to a group home without a fence and adjacent to a major road. Several have been transferred despite the fact that Murray employees who knew the residents and were traditionally part of the

transition process were excluded from key meetings or otherwise given insufficient time to prepare. Considering this and other events all happened in the move of 5-10 residents—it is astounding that Defendants plan to usher out forty to fifty residents *in the next two weeks*. The transition process to date has included both wards of the State as well as wards of private guardians.

For the OSG residents, the OSG has neither questioned nor objected to any part of Defendants' action in moving OSG residents of Murray. Defendants have removed these OSG residents because there is no question or objection raised. The OSG is merely another arm of the State, which also seeks to close the SODCs. The State is controlling the placement change of the OSC residents. In other words, one right arm offers the placement while the left arm accepts it. This is the essence of conflict of interest and is employed by the State as part of a program of intimidation to demoralize the private guardians into believing that the closure is inevitable and cannot be stopped by this Court in time.[3]

Plaintiffs (even the wards of the Office of the State Guardian who may not wish to be removed) will suffer irreparable injury if residents removed from Murray, which has been their safe and secure home for many years, are placed into uninspected homes with serious repair issues or through inappropriate evaluations. The long-standing operating procedures of Murray are being eviscerated by Defendants in an effort to (1) change the *status quo*; (2) remove as many residents as quickly as possible; and (3) render the judgment of this Court moot.

To preserve the *status quo* until this Court can render a decision on the preliminary injunction, this Court should enjoin Defendants' haphazard and reckless resident transition process to ensure the residents' safety.

[3] It should be noted that the OSG residents may object to their transition and as such are a part of the putative class. Their real position is unknown.

STATEMENT OF FACTS

Plaintiffs reference and incorporate herein the facts contained in their Motion for Preliminary Injunction (Docket No. 8); Memorandum of Law in Support of Their Motion for Preliminary Injunction (Docket No. 9); Reply in Support Thereof (Docket No. 43 ("Docket No.") and Second Amended Complaint for Declaratory, Injunctive and Other Relief (Docket No. 55).

A. Characteristics of Murray Residents.

The vast majority of Murray residents have profound, developmental disabilities. The Illinois Department of Human Services concedes that as of December 31, 2012 there were 261 residents of Murray, of which 84% had "Severe or Profound M.R. range," and 68% had a "behavior intervention program, often requiring higher levels of staff supervision." *See* Murray Developmental Center Profile, http://www.dhs.state.il.us/page.aspx?item=58719. Similarly, as of March 29, 2013, there is no dispute that 192 of the Murray guardians did not give consent to the State to community placement, and the State admitted that another 50 residents had "medical and/or behavioral needs preventing transition to the community at this time." *See* SODC Census and Tier Report, http://www.dhs.state.il.us/page.aspx?item=58786

B. Historical Safeguards During Transition and Standard Operating Procedures.

The Murray discharge process is governed by the Standard Operating Policies and Procedures ("SOPP"), attached as Ex. A. The SOPP governs the entire discharge process for Murray Residents pursuant to the Illinois Administrative Code, 59 Ill. Admin. Code 125 (providing for discharge procedures recipient rights).

Historically, in order to transition a resident out of Murray, several steps were taken to facilitate a smooth transition process and ensure the safety and well-being of the resident. First,

there would be a team meeting consisting of all the people on a "team" for the resident (*i.e*., the social worker, psychologist, nurse, QMR, cottage director, occupational therapist, physical therapist, etc.). (Hester, Aff., Ex. B, ¶ 4.) At the meeting, the team would identify whether the resident was appropriate for placement. (*Id.*) If the answer was yes, then the social worker would contact homes. (*Id.*) Once a home was selected, there would be, over the course of weeks, temporary pre-placement visits, first for a lunch or dinner, then for an overnight visit. (*Id.*) On average, each resident being transitioned out of Murray would receive three pre-placement visits to ensure a smooth transition process. (*Id.*) During these visits, the resident's belongings were not moved out of Murray, because the visit was temporary. (*Id.*) Following this would be a transition staff meeting to work closely with the staff at the home in terms of programs, needs and medical issues. (*Id.*) There would also be a series of tests done on the resident, as discussed in the SOPP. (*Id.*)

On the day before the transfer, there would be a conference with the home to identify any remaining issues and discuss the move and transfer of belongings. (*Id.*) Finally, the transfer would occur, and this would be followed with weekly visits for about 30 days from Murray staff, and then monthly visits. (*Id.*) For certain issues, Murray staff would work directly with people at the home and provide services to identify problems and make the transition process smooth. (*Id.*) The complete transition process out of Murray for each resident would take on average at least three weeks and possibly longer than a month. (*Id.*, ¶ 5); (Davis Aff., Ex. C, ¶ 6.)

C. Defendants' Plan to Transfer 40-50 Residents from Murray by End of May and Transfers in Progress.

Jaime Veach has informed Murray employees that between 40-50 residents will be transferred out by the end of May. (Koppen Aff., Ex. D, ¶ 3; Hester Aff., Ex. B, ¶3; Davis Aff., Ex. C, ¶ 4; Henson Aff., Ex. E, ¶ 15). All of the affidavits herein discuss incidents involving

residents that have been transferred in the last three weeks. Forty or more residents cannot be safety discharged out of Murray as fast as the end of May, 2013. (Davis Aff., Ex. C, ¶ 9.)

D. Inappropriate Placement into Group Homes

Murray nursing and therapeutic staff have, based on their experience and particular knowledge of specific Murray residents, concluded that residents' placements into group homes were inappropriate, given the needs of the resident. (Hester Aff., Ex. B, ¶ 7; Kiselewski Aff., Ex. F, ¶ 10; Gibson Aff., Ex. G, ¶5; Howell Aff., Ex. H, ¶¶ 4, 7-8; Creed Aff., Ex. I, ¶ 4.)

E. Dangerous Pairings

On May 6, 2013, Defendants informed Murray staff that two OSG residents were being transferred to a group home together. (Barton Aff., Ex. J, ¶3.) One of the residents is very passive, has profound MR, suffers from PICA Disorder and uses a wheelchair for distances, while the other resident has a history of violence and aggression. (Howell Aff., Ex. H, ¶ 3; Gibson Aff., Ex. G, ¶ 8; Rech Aff., Ex. K, ¶ 5, Henson Aff., Ex. E, ¶¶ 8-9; Kiselewski Aff., Ex. F, ¶ 7.) Murray staff objected to placing these two residents in a home together, as it was unsafe and would jeopardize their health and safety. (Howell Aff., Ex. H, ¶ 3; Kiselewski Aff., Ex. F, ¶¶ 9-10.) Defendants still went ahead with the transfer. The residents were placed in a van to go to visit the home but never even made it out of Murray's parking lot before the violent resident attacked the non-violent resident. (Howell Aff., Ex. H, ¶ 5; Henson Aff, Ex. E, ¶ 11.) Despite this incident, Defendants still plan to move these two residents into a 2-4 bed home together. (Howell Aff., Ex. H, ¶ 7; Henson Aff., Ex. E, ¶ 11.) Murray staff who have worked closely with these residents do not believe they are fit to be placed in a community home at all, let alone together. (Howell Aff., Ex. H, ¶ 3; Creed Aff., Ex. I, ¶ 4.)

Additionally, Defendants are planning to place another three residents together in a group

home. (Gibson Aff., Ex. G, ¶ 10.) One of these residents has a "history of sexual acts." (*Id.*) Another has "very violent aggression" that requires a high level of supervision. (*Id.*) In fact, this resident broke an individual's nose while out in the community. (*Id.*) The third resident is in a wheelchair, is passive and has no mobility. (*Id.*) Murray staff members believe (and have conveyed to others) that placement of these three residents together would jeopardize the health and safety of these residents. (*Id.*)

F. Failure to Inspect the Home/Unsafe Home Conditions

There is compelling evidence that Defendants are not inspecting group homes prior to transfer. On May 15, 2013, Murray staff members were directed to gather all of the personal belongings of a resident and take it to a new group home and that the resident would be following right behind them in a car. (Kelly Aff., Ex. L, ¶ 3; Hendricks Aff., Ex. M, ¶ 3.) When Murray staff members arrived at the home, it was "still under construction" and had construction materials scattered around. (Kelly Aff., Ex. L, ¶ 4; Hendricks Aff., Ex. M, ¶ 4.) The construction workers were still working on the plumbing and dry wall and said that the condition of the home was a "nightmare" and not ready to accept residents. (Kelly Aff., Ex. L, ¶ 5; Hendricks Aff., Ex. M, ¶ 5.) Immediately, the staff members informed their superior at Murray not to send the resident because the home was not ready. (Kelly Aff., Ex. L, ¶ 6; Hendricks Aff., Ex. M, ¶ 6.) Both staff members believe that nobody inspected this home. (Kelly Aff., Ex. L, ¶ 7; Hendricks Aff., Ex. M, ¶ 7.) When confronted about this by the staff, Murray Assistant Director Rick Starr said the problems with the transfer were "on the provider, not on me." (Kelly Aff., Ex. L, ¶ 7; Hendricks Aff., Ex. M, ¶ 8.)

During a pre-placement visit of another resident, the Murray social worker noticed weak floors in the laundry room to such an extent that he felt that if he applied pressure with his foot, it

would go through the floor. (Henson Affidavit, Ex. E, ¶ 5.) This social worker was informed that the home had a history of water problems due to an underground spring. (*Id.*) He informed CRA[4] and the home provider about this floor situation and the potential presence for mold. (*Id.*, ¶ 6.)

In another instance, a resident had a history of elopement (where the resident attempts to run away). (Rech Aff., Ex. K, ¶ 3.) Despite the objections of Murray employees, a resident was transferred on short notice to a group home that did not have a fence. (*Id.*) In yet another instance, Murray employees objected to the placement of a resident with elopement issues in a home next to a busy road. (Creed Aff., Ex. I, ¶ 5.)

G. Failure Of The OSG To Participate On Behalf Of Her Wards.

In order to be discharged to a group home, residents that are wards of the OSG require the consent of the OSG Representative, Freda Omer. Employees can testify that Ms. Omer has not participated in any way during transition meetings, and has never taken a position that a resident placement was improper. (Gibson Aff., Ex. G_, ¶ 12.) Ms. Omer has given consent to the discharge of various residents, despite being present at meetings where concerns were raised (a) as to the placement of a wheelchair resident with a violent resident (Henson Aff., Ex. E, ¶¶ 8-12; Rech Aff., Ex.K; ¶ 3; Creed Aff., Ex. I, ¶ 3; Kiselewski Aff., Ex. F, ¶ 7); (b) as to the placement of a resident with elopement issues in a home next to a busy road (Creed Aff., Ex. I, ¶ 5; Rech Aff., Ex. K; ¶ 3; and (c) as to placement of a resident in a home with evidence of suspected water damage (Henson Aff., Ex. E, ¶¶ 4-7.)

Ms. Omer has also admitted to employees that she did not visit certain group homes, going as far as to tell one employee that she did not visit the group home where the resident was

[4] CRA has been hired by the State to facilitate the discharge of SODC residents. Strangely, CRA is currently referring to itself as ACCT for reasons unknown.

being placed, and would not visit the home "since the State would not pay for her to visit the home because it was in another OSG Representative's district." (Stratemeyer Aff., Ex. N, ¶ 5; *see also* Kiselewski Aff., Ex. F, ¶ 5, Demijan Aff., Ex. O, ¶ 5.) (*See* 755 ILCS 5/13-5 (b)) placement of a ward outside of the ward's home many be made only after the public guardian or his representative has visited the facility in which placement is proposed.")

Furthermore, and in response to raised concerns about the short notice for meetings, Ms. Omer has admitted to at least one employee that she was just doing what she "had been told to do." (Demijan Aff., Ex. O, ¶ 4.) She also admitted at this time that she was "finding out about the meetings about the same time" that the employee was. (*Id.*)

H. Threats and Retaliation against Murray Staff.

Murray staff members have been threatened with termination if they object to any transfers or interfere with CRA's transfer process. (Koppen Aff., Ex. D, ¶ 4) ("At another meeting with Jamie [Veach] about a month ago, and again dealing with labor matters, he told me that if I interfered with the transition process, or 'try to slow it down in any way,' that I would be fired.") Also, they have been instructed not to tell the private guardians the truth regarding whether a group home is appropriate for their wards, or they will be fired. (*Id*.) In one case, Murray's social workers have even been barred from making any home visits, and as a direct result of the social worker's complaint about the safety of a home with potential water damage. (*See* Henson Aff., Ex. E, ¶¶ 13-16.)

I. Failure to Follow the Standard Operating Procedures and Historical Safeguards.

Several Murray employees can attest to the current failure to follow the Murray mandated Standard Operating Procedures and historical safeguards discussed above. (Hester Aff., Ex. B, ¶ 6; Henson Aff., Ex. E, ¶ 18.) In addition to the above incidents (that implicate the SOPP),

Murray's social workers have been barred from making any home visits, as a direct result of the social worker's complaint about the safety of a home with potential water damage. (*See* Henson Aff., Ex. E, ¶¶ 13-16.) The SOPP mandates that social workers make home visits, and discuss in depth the role of the social worker in the transition process. (*Id.*, ¶ 18; SOPP, Ex. A.)

Murray employees can attest to instances where the opinions of the resident were directly ignored. In one instance, Defendants scheduled a transition meeting for a resident (and with the resident's attendance), despite the fact that they had been warned that the resident's electronic communication device was being repaired and the resident could not communicate without it. (Stratemeyer Aff., Ex. N, ¶ 4.) The meeting was eventually rescheduled, but not before the employee who raised the issue was told by Rick Starr that she "was trying to interfere with the CRA process." (*Id.*)

Additionally, several employees can attest to the fact that the pre-transition visit process (whereby a resident is slowly integrated into a group home) has been bypassed entirely. (Kelly Aff., Ex. L, ¶ ; Gibson Aff., Ex. G , ¶ 4; Stratemeyer Aff., Ex. N, ¶ 9.) In one instance, a resident was moved to a home that neither he nor the staff had ever visited and three hours away from Murray. (Stratemeyer Aff., Ex. N, ¶ 7.)

Furthermore, several employees can attest to meetings being given short notice (or no notice at all) and employees given inadequate time to prepare for addressing the resident's needs during transition. (*See* Rech Aff., Ex. _K, ¶ 4 ("This [transition] team was given less than 24 hours by CRA and Murray to get everything ready and prepare for a transition meeting…. This process was accelerated to a degree that potentially compromised the well-being of the residents"). In at least one instance, no employees from the resident's cottage (and who knew the resident best) attended the transition meeting. (Kiselewski Aff., Ex. F, ¶ 8.) The Murray

employee who raised this issue was chastised by her boss, Rick Starr, the Assistant Director of Murray, shortly after raising this issue. (*See id.*) ("I was then told by Rick Starr to come with him. We went to an empty room. I was told by Rick that this was the second time that I had called him out about not being notified about meetings…").

A CRA representative has even admitted to one Murray employee that if it was up to the representative, more time would be taken for resident needs, but that there was a tremendous amount of pressure being put on the representative "to get the residents all out of Murray now." (Rech Aff., Ex. K, ¶ 7.) In another instance, on May 6, 2013, the group provider admitted to a Murray employee that the home had not received the key documents that contain a resident's medical and behavioral information the Behavioral Intervention Plan or the Individual Service Plan, despite the fact that the resident was already scheduled to be transferred to this home on May 15, 2013. (Barton Aff., Ex. J, ¶ 3.)

J. Refusal to Disclose Public Information

On May 6, 2013, the Illinois Department of Public Health ("IDPH") followed up on an investigation of a complaint at Murray. **(***See*, IDPH Website printout Ex. P.) Dan Levad, the IDPH monitor charged with inspecting Murray, told Plaintiff Dr. Karen Kelly that he had been made aware that the Murray staff was being excluded from the transition process. (Dr. Kelly Aff., Ex. Q, ¶ 4.) On May 10, 2013, Dr. Kelly requested copies of all violations cited by IDPH against Murray for the past few months ("IDPH Reports") from Rick Starr, the Assistant Director of Murray. (*Id.*, ¶ 5.) Mr. Starr told Dr. Kelly he had been directed by Defendant Illinois Department of Human Resources ("DHS") that he was not to disclose the IDPH Reports and that she could make a Freedom of Information Act ("FOIA") request. (*Id.*) The same day, Dr. Kelly spoke to Jamie Veach, Director of Murray, requesting the IDPH Reports. Mr. Veach

told her if he gave them to her, he would lose his job. (*Id.*, ¶ 6.)

All IDPH inspection reports and violations are required to be made public in the facility by posting alongside of the facility license. 77 Ill. Admin. Code 350.230 requires that facilities post or make available all documents pertaining to IDPN inspections, including violations and the most recent survey.

When, however, a Murray Registered Nurse attempted to make a complaint to the Illinois Department of Public Health, she was told that she could not make a complaint against Defendant CRA (a/k/a ACCT) but that complaints against CRA must be directed to the Governor's office. (Creed Aff., Ex. I, ¶ 6).

K. The Dangerous Effects of Mass Transfers (Jacksonville)

Defendants are following the same accelerated process as used in the closure of Jacksonville Developmental Center ("Jacksonville") in November 2012, when Defendants abruptly moved (without evaluation or thought to proper placement) approximately 30 residents to other facilities in a matter of days prior to the December 3, 2012 closure.[5]

Since Jacksonville's accelerated closure in 2012, there have been **204 incidents** involving former Jacksonville residents. These incidents include, among other things, police involvement, elopements, behavior management (which includes injury to self or others), hospital or emergency room visits, psychiatric hospitalizations, temporary re-admission to an SODC, and even death. (*See* JDC Monitoring Tracker, Transitions effective April 1, 2012—March 31, 2013, attached as Exhibit R).[6]

[5] In September 2012, DHS called in the Bureau of Transitional Services, which then abruptly moved over 160 residents in less than three months—30 residents were moved in September, 42 in October, and an astounding 96 were moved in November, with approximately 35 residents being moved on November 29, 2012 to other SODCs.

[6] The 204 incidents involve 94 separate individuals of the 180 who were removed..

ARGUMENT

Under Federal Rule of Civil Procedure 65, a temporary restraining order may be issued to maintain the status quo until a preliminary injunction hearing can be held. *Granny Goose Foods, Inc. v. Brotherhood of Teamsters & Auto Truck Drivers Local No. 70*, 415 U.S. 423, 439 (1974). The status quo is the "last peaceable, uncontested status of the parties which preceded the actions giving rise to the issue in controversy." *St. Charles Mfg. v. St. Charles Furniture Corp.*, 482 F. Supp. 397, 405 (N.D. Ill. 1979).

In ascertaining whether to grant a temporary restraining order, courts look to the same elements required by a preliminary injunction: (1) likelihood of success on the merits; (2) that no adequate remedy at law exists; and (3) the plaintiff will suffer irreparable harm if the injunction is not granted. *Domanus v. Lewicki*, 857 F. Supp. 2d 719, 723 (N.D. Ill. 2012) (holding that plaintiffs were entitled to a TRO and preliminary injunction); *see Ty. Inc. v. Jones Group, Inc.*, 237 F.3d. 891, 895 (7th Cir. 2001) (stating elements for preliminary injunction). The court may issue a temporary restraining order on the strength of the specific facts contained in the affidavits, declarations or other verified papers submitted. *See* F.R.C.P. 65(b) (stating that a temporary restraining order may be issued based on "specific facts in an affidavit or a verified complaint clearly show that immediate and irreparable injury, loss, or damage will result to the movant before the adverse party can be heard in opposition"). If the moving party meets these threshold requirements, the court "must consider the irreparable harm that the nonmoving party will suffer if preliminary relief is granted, balancing such harm against the irreparable harm the moving party will suffer if relief is denied." *Stuller, Inc. v. Steak N Shake Enterprises, Inc.*, 695 F.3d 676, 678 (7th Cir. 2012). The district court must also consider the public interest in granting or denying an injunction. *Id.*

I. PLAINTIFFS HAVE A BETTER THAN NEGLIGIBLE CHANCE OF SUCCEEDING ON THE MERITS.

The Seventh Circuit has held that in order to establish a likelihood of success on the merits, Plaintiffs need only demonstrate a "better than negligible chance of succeeding." *Cooper v. Salazar,* 196 F.3d 809, 813 (7th Cir. 1999). The "threshold for this showing is low." *Id.*, citing *Roland Machinery Co. v. Dresser Inc.,* 749 F.2d 380, 387 (7th Cir. 1984).

In its Motion for a Preliminary Injunction and Reply brief, (Docket Nos. 8-9, 43), Plaintiffs set out the legal reasons for why it has a better than negligible chance of succeeding on the likelihood of the merits on its American with Disabilities Act ("ADA"), Rehabilitation Act, 42 U.S.C. 1983, Title XIX of the Social Security Act and *Olmstead* claims. For the sake of judicial economy, Plaintiffs incorporate those arguments but will not repeat them again here. (*See id*.)

This Court should, however, take notice of Defendants' recent actions to transfer, swiftly, Murray residents with profound developmental disabilities to small group home settings, regardless of whether such setting can handle the individual's special needs. This strategy is part of a larger plan to close all of Illinois' SODC facilities. (*See* Affidavit Exhibits attached to Preliminary Injunction Reply Brief, Docket No. 43.) As evidenced by the *fourteen* Murray employees who have risked their jobs to testify as to the current inadequate transition process, as well as the previous guardian affidavits cited in Plaintiffs' Reply to its Motion for a Preliminary Injunction (Docket No. 43), the State's current transition process for Murray residents and planned closure of all of Illinois' SODCs without adequate and appropriate replacement services jeopardizes the health and safety of SODC residents. As such, it violates the ADA, Rehabilitation Act, Section 1983, the Social Security Act and *Olmstead*.

These statutes allow for choice, and protect residents from being force-fit against their will into small group homes that cannot provide necessary care, without any adequate safeguards whatsoever. *See Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 603-604 (1999) ("We emphasize that nothing in the ADA or its implementing regulations condones termination of institutional settings for persons unable to handle or benefit from community settings"); *see also id.* at 604-05 ("[T]he ADA is not reasonably read to impel States to phase out institutions, placing patients in need of close care at risk…. Nor is it the ADA's mission to drive States to move institutionalized patients into an inappropriate setting, such as a homeless shelter, a placement the State proposed, then retracted, for [Respondent].").

II. PLAINTIFFS HAVE NO ADEQUATE REMEDY AT LAW AND WILL SUFFER IRREPARABLE HARM IF PRELIMINARY RELIEF IS DENIED.

Plaintiffs have no adequate remedy at law and will suffer irreparable harm if preliminary relief is denied. This is because the forced transfer of Murray residents is happening *right now.* Murray employees have been told by top decision-makers that between 40-50 residents will be sent out of Murray by the end of May. (*See Supra* Statement of Facts). Based on the affidavit testimony, at least 5-10 residents have been transferred out of Murray in May. This process is happening, despite the fact that several Murray employees have attested to residents being transferred to group homes that were not appropriate placements for the resident, and jeopardized the resident's health and safety. *See supra.*

When Plaintiffs filed their motion for a preliminary injunction on March 1, 2013, Murray residents had not yet been transitioned out under the CRA process. Both Plaintiffs and Defendants came to an informal understanding that transitions would not occur in March and April. In May, however, Defendants accelerated their closure plans for Murray and transitioned out between 5-10 Murray residents to small group home settings. These transitions occurred

under an expedited process that deprived the resident of many safeguards and protocols established under Murray's own Standard Operating Procedures and Policies ("SOPP") and previously followed by Murray. (*See supra*). Among the shocking revelations of the CRA process for transitioning residents is the following:

1. A pairing of a wheelchair bound, passive resident with a very aggressive and violent resident, despite the protestations of several Murray employees. This pairing did not even make it out of the driveway before the aggressive resident tried to attack the wheelchair bound resident.
2. Residents not being provided temporary pre-placement visits, as required by the SOPP, but instead being completely moved into a new home with all of their belongings, regardless of the transition shock to the resident.
3. Residents being transferred to a group home with a history of water damage, as well as a weak floor likely attributed to such damage.
4. Residents being transferred despite the Murray employee inter-disciplinary team not being given notice of transfers until within 24 hours of the transfer happening, and such notice not giving Murray employees enough time to prepare for all information related to assessing whether the transfer is proper.
5. A transition meeting being scheduled despite the fact that the resident was still waiting for his electronic communication device to be repaired and returned to him, and could not communicate without it.
6. A resident's belongings taken (as well as a plan to take the resident that same day) to a group home that was still under construction and with construction materials spread throughout the inside and outside of the home.

7. A resident being planned to move to a home despite the OSG Representative, Freda Omer, admitting that she had never visited the home.

8. Aggressive residents -- who have a history of running -- being placed in group homes next to busy roads over Murray employee objections and without any planning as to how to protect the resident's health and safety.

9. Aggressive residents being placed in group homes that did not have 1 on 1 care, despite such care being necessary for the resident.

10. A resident being moved to a home three hours away from Murray, even though he (as well as the Murray staff who worked with him) had not previously visited the home or met the staff.

11. Homes that are not being inspected, in violation of the law. *See* 755 ILCS 5/13-5.

12. Murray employees who dare raise concerns to this expedited process, such employees have been threatened with punishment and even discharge, or otherwise stripped of their duties.

(*See supra* Statement of Facts.)

Defendants claim in their Response to Plaintiffs' Motion for Preliminary Injunction that:

> The transition process takes time—it includes collaboration with the guardian or family, searching for willing and able providers, placement and pre-transitional visit (with the guardian's consent) to ensure the placement is a good fit for the individual.

(Docket No. 40, p. 5). Clearly, this is not happening at Murray. In reality, Defendants are rushing residents through the process, ignoring the professional opinions of Murray staff familiar with the residents, excluding Murray staff from participating in the transition process,

disregarding the residents' needs and completely failing to even inspect the homes, let alone allow the pre-transitional visit process to unfold.

The stakes could not be any higher. In their Memorandum in Support of their Motion for a Preliminary Injunction, Plaintiffs warned of what could happen with an improper placement of a resident with profound developmental disabilities. Those concerns are now a reality. Residents have been placed in harm's way under the State's expedited transition process. No reasonable attempt has been made to ascertain whether these homes are a good fit or whether the resident gives consent to the transition. In fact, for many of the OSG Residents, the State has simply consented for them under a process that is pre-ordained and in breach of its guardian duties.

The services offered by SODCs are necessary and critical to the residents' physical well-being. The current accelerated process of closing all SODCs without adequate replacement services, such as twenty-four hour care, places individuals with profound developmental disabilities at unnecessary risk of hospitalization, injury or death. *Id.* An interruption in care, even if temporary, can have serious consequences on the health and well-being or the profoundly disabled.[7] Plaintiffs have established that they have no adequate legal remedy against Defendants and will suffer irreparable harm by the closure of SODCs. Accordingly, Plaintiffs have met the threshold requirements needed to establish their right to a preliminary injunction.

III. A BALANCING OF THE HARMS TO THE PARTIES MILITATES IN FAVOR OF INJUNCTIVE RELIEF IMPOSED AGAINST DEFENDANTS.

Having established the threshold requirements of (1) likelihood of success on the merits and (2) inadequate legal remedy, this Court must balance the harms caused by the Defendants'

[7] The closure of JDC is illustrative to what will become of the residents of Murray and the other SODCs if Defendants are not enjoined—hasty, ill-advised removal and placement of residents into either inappropriate or dangerous settings, or other SODCs, either far away from family or SODCs which will themselves be closed in a short period of time.

intended closures of SODCs. The harm caused by Defendants' closure of SODCs, causing displacement of the state's most severely disabled citizens and the elimination of an entire class of services for the disabled, not to mention the safety concerns for the SODC residents as well as the public at large, far outweighs the potential harm suffered by Defendants if they are enjoined from implementing Defendants' Plan.

IV. THE PUBLIC INTEREST IS SERVED BY GRANTING INJUNCTIVE RELIEF.

The public interest is served by granting the injunction because the continuation of SODCs provides the best protection against harm for both the SODC residents, as well as the general public. SODCs provide more security than the typical small group home to which the SODC residents would be (and in the case of Jacksonville, have been) transferred under Defendants' Plan. Placing some of the SODC residents with a history of physical violence group homes, which are less equipped to handle such residents, poses a risk to themselves and the public. (*See Supra* Statement of Facts).

Additionally, the injunction supports Illinois' public policy of protecting the physical health and safety of its citizens. *See Chicago Steel Rule & Die Fabricators Co. v. ADT Security Systems, Inc.*, 327 Ill. App. 3d 642, 647-48, 762 N.E.2d 839 (1st Dist. 2002). Illinois' public policy of promoting and protecting the health, safety and welfare of Illinois citizens has been expressly recited by Illinois legislature. *See* 70 ILCS 705/1 (West 1998). The injunction will support this public policy of providing a full range of services for the developmentally disabled.

By entering a Temporary Restraining Order against the Defendants, this Court can preserve the status quo until a preliminary injunction hearing can be held. The Declarations herein set out the serious harm that is being done and will continue to be done if Defendants are not enjoined.

For the foregoing reasons, Plaintiffs request that this Court enter a Temporary Restraining Order against the Defendants, enjoining them from proceeding with the improper transfer process in which they are now engaged, until the Court makes a determination on Plaintiffs' Emergency Motions for Temporary Restraining Order.

Dated: May 21, 2013

Respectfully submitted,

ILLINOIS LEAGUE OF ADVOCATES FOR THE DEVELOPMENTALLY DISABLED, *et al.*, Plaintiffs

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