FOR IMMEDIATE RELEASE

East Central Regional Human Rights Authority
Report of Findings
Case 09-060-9004
Graywood Foundation

The East Central Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegations concerning behavioral health services at the Graywood Foundation located in Charleston, Illinois.

Complaints:

1. Behavioral programming is inadequate.
2. Resident safety measures are inadequate.
3. The agency does not respond appropriately to resident grievances.
4. The agency does not follow abuse/neglect reporting requirements.

If found substantiated, the allegations would be violations of the Mental Health and Developmental Disabilities Code (Code) (405 ILCS 5) and the Illinois Administrative Code for Community Integrated Living Arrangements (the CILA Rules) (59 Ill. Admin. Code 115).

COMPLAINT STATEMENT

A case has been opened due to the death of a Graywood CILA resident who was allegedly beaten by two of his peers which later led to the resident's death. The peers, also individuals with disabilities, were arrested and charged with criminal felonies. The Authority is examining the CILA's behavioral programming, safety measures and protections, grievances process and abuse reporting practices. Employees on duty during the time of the attack were subsequently charged with murder after it was reported that the employees did not intervene and may have played a role in the attack. One report to the Authority indicated that the employees may have rewarded residents for attacking peers who displayed behaviors that were unsatisfactory to staff, such as bedwetting. It is unclear how long this practice may have been used at the CILA. After the incident, the employees were fired by the CILA organization.

At this time two of the residents who were involved with the incident and three staff members had been arrested; the residents were held in custody and the staff members had been bailed out. Since the arrest of the residents, both have been sentenced to 30 months in Illinois Department of Human Services (DHS) custody. They must abide by the rules and regulations including any treatment, pay court costs, and cooperate with law enforcement/prosecution/ investigation regarding the death of the resident. The court cases for one of the three employee

defendants who was charged with obstruction of justice and destroying evidence has been resolved by making a plea agreement with the state and agreeing to testify against the other two employees who were charged with murder, involuntary manslaughter, criminal abuse and neglect, failure to perform duties and criminal life endangerment. This was based on court records available to the public that were published on the internet.

FINDINGS

Some evidence was not available to the HRA. Police reports of this incident and Graywood records were impounded for court evidence, and DHS' Office of the Inspector General (OIG) findings regarding this incident were unavailable. For obvious legalities, the HRA was not permitted to talk to the residents or the direct service personnel that were charged with the criminal felonies regarding the attack.

Interviews

On 04/23/09 at 1:00 pm. HRA members completed a site visit at the Graywood Foundation. They met with the Executive Director, the Assistant Director/Corporate Trainer, the Human Resource Director, the Program Development Director, the Director of Adult Programming and a Qualified Mental Retardation Professional (QMRP). About one week later we toured the facility where the deceased resident lived and was beaten.

The agency's process for screening employees was discussed. The agency staff explained that upon receiving a potential employee's application, they would check the Health Care Registry; they would check certification, abuse findings and would make sure the applicant at minimum had a GED or a high school diploma. The applicant would be interviewed. References would be checked both personal and work. The agency would conduct observations of interactions with staff and clients. The agency would also evaluate client, staff, and supervisor feedback. The agency has a "zero tolerance policy" on illegal drug use.

If hired, the new employee would attend orientation and a criminal background check would be done. It would take a process of almost four months to have the employee be certified as direct service personnel. There are 3-4 days of internal training, on the floor training, observation in the home and certifications. For direct service personnel there are 40 hours of classroom training on abuse, neglect, resident rights, Crisis Prevention Institute (CPI), and Cardiopulmonary Resuscitation (CPR). There is another 80 hours of on the job training. The agency uses DHS core curriculum but have Graywood policies and procedures as well. The agency also has a Direct Support Person, or DSP-certified supervisor. The agency also provides monthly in-service training, which can be standardized or house specific. There are also weekly house service meetings. Included in the house service training, are CPI and CPR and the medicine administration class as well. This also includes an 8 hour medication class taught by a registered nurse, and staff are tested for competency. If staff observe side effects, they are mandated to call nursing which is available twenty four hours per day.

The agency has approximately 200 employees, 60-70 who work with adults and provide direct service. These staff may call the OIG directly. However, resident to resident aggression is not typically OIG reportable. They have a listening ear policy where staff and residents can call

an in-house number and leave a message which will be reviewed and responded to. A card with this number on it is given to each staff member and each resident. All staff are trained to call the OIG if suspected abuse or neglect occurs. Housekeeping and maintenance have this responsibility as well as direct care staff.

As far as handling grievances, the HRA was told that all homes have a cordless phone where any resident could take it to his or her room to make a private call. The authority was also told that most residents had cell phones. There is an in-house human rights committee that reviews all complaints. It consists of an outside representative who is a PAS (pre-admission screening) agent, a pharmacy technician, an administrator, a nurse, a youth supervisor, a QMRP, a resident and the executive director. They also keep meeting notes. There is also an on-call supervisor who is a QMRP. Currently there are four employees who serve as QMRPs and there are 9 homes. A house supervisor is in the home from 2:00 p.m. to 10:00 p.m., five days a week. There are also Commission on Accreditation of Rehabilitation Facilities, or CARF reviews and DHS technical assistance.

In regards to handling behaviors staff are certified using the state's DSP training program. Resident to resident rough housing and horseplay is strictly forbidden. If a resident exhibits a behavior, staff are instructed to try to calm the resident. If it continues they are to call for help and move towards using CPI techniques, then staff are to follow up with management. Staff are to document incident reports and complete documentation in the house log book as well as a behavior management form. Incident reports are reviewed by the QMRP, administration, nursing, and the Health and Safety committee. The Health and Safety committee meets about every three months and reviews incident reports and makes recommendations. It consists of staff, administration, nursing and a client. The agency has a process for handling emergencies, and there is policy that the police are called if anyone threatens or harms anyone else.

There is a consumer council which meets monthly and there are also monthly house meetings. After the incident of the resident being beaten which lead to his death, the staff asked at the monthly meeting what they could do to assist the residents with their grief. The response was that residents wanted female DSP staff to work there as well as males, and they wanted to plant a garden.

It was explained that since the incident there have been some environmental changes. There have been in-services conducted by the facility in regards to OIG reporting and the listening ear policy. The QMRP who is over the house has tried to be more proactive and available to staff and residents alike. The house has been named after the deceased resident and a scholarship has been created in his name.

The HRA team requested to tour the home of the decedent resident. The team members walked through and interacted with staff performing their duties. The home was clean and organized. Rights information was not displayed. OIG information was displayed in a way that residents would not know what the OIG was; it was posted simply as OIG with the toll free number. The team asked to see the cordless phone, the QMRP unlocked a room that was only available to staff and showed a cordless phone that residents could take anywhere in the house to use. However it was connected and charged in this locked room. An HRA team member asked

if this was the only phone available, the team was told they had another phone but it was not working at this time; however, it would be kept in this locked room when not in use.

Record and Policy Reviews

The HRA was provided a copy of the DHS Direct Support Person's Training Program Appendix # 3 (On-the Job Activities and Competency Based Training Assessments) (2004); it is one of the training tools used in the home. In the ***Adult Community Living Services and Employment Services Handbook Revised 11/30/2005*** it addresses that no horseplay is allowed in the homes. It also stated that physical assault may result in legal charges being brought against the offender. The HRA was provided updated policies and procedures on ***Behavior Modification (Reviewed 5-21-2003: Revised 7-7-2009, 7-15-09, 09-09-09) tracking # 7006 Subject Restraint of Individuals.*** This addresses that restraint may be necessary when:

- The individual displays aggression toward another individual. This may be another individual, staff member, visitor, or other community member.
- The individual displays self-injurious behavior. This includes the attempt to injure self by ingesting items. (glass, chemicals, rocks, etc.) or attempting to cut oneself.

The HRA was provided a copy of the ***Organizational Emergency Management Plan*** for handling assorted emergencies which included work place violence, utility failures, tornadoes, floods, fires, earthquakes, bomb threats, and biochemical mishaps. These plans seemed adequate for addressing each particular emergency except that the work place violence plan covered employee to employee violence only. We also looked at the Emergency procedures for unresponsive clients.

The HRA was provided with a copy of the monthly in-service schedule for a previous year which addressed the following: concepts of treatment, abuse and neglect, Rule 50 OIG, safety, fire, and disaster procedures, human rights, confidentiality, good neighbors, community/interdisciplinary team, behavior management programs, medication administration overview, infection control and food, visiting standards in the home, training which relates specifically to the type of treatment and intervention techniques being used specific to individuals living in the homes, first aid, cardiopulmonary resuscitation, and the Heimlich maneuver. A copy of the monthly calendar documented assorted upcoming training courses such as: a CPR Refresher, a CPI Refresher, human interaction, abuse and neglect, introduction to Developmental Disabilities, basic hygiene & sanitation 1 & 2, defensive driving, human rights, CPR and 1st aide.

The following policies, procedures and handbooks were also reviewed:

Policy/Medical & Health Needs of Clients (Graywood Foundation)

It states: "*The physical well being of an individual is the foundation for their emotional and spiritual well being. It is the responsibility of all staff and persons working with the clients we serve to ensure the medical needs of each client are being met. Failure to meet the medical needs a client is abuse and neglect*." **It further instructs staff, in a medical emergency to call 911 and to listen to the operator to stabilize the situation.** It continues to advise staff to contact supervisors and medical staff after medical attention has been secured. If staff are uncertain of the extent of injury, they are to contact nursing staff who are available 24 hours per

day. In non emergency situations staff are to communicate in the observation log and staff communication log. Staff need to notify the supervisor on duty so that follow up treatment with the client's regular physician may be followed. Emergency procedures were addressed for unresponsive clients. **It directs staff to call 911 and nursing.** It also advises staff on when to administer CPR and not to administer CPR if the individual has a do not resuscitate order.

Graywood Enterprises Policies and Procedures Theft and Criminal Conduct (03/29/00)

It states: "*This agency will not tolerate, under any circumstances, the theft of an individual's property or criminal conduct of any kind. The following is the policy and procedure for reporting and investigating allegations of theft and/or criminal conduct: If any staff member feels that they have witnessed any individual's personal property being stolen or any other form of criminal conduct occurring,* ***they should report the incident immediately to their supervisor****, a QMRP or the charge nurse. The supervisor must notify the Division Head immediately.*" (Emphasis added).

The Graywood Employee Handbook

It states that employees are to report any unsafe working areas or conditions. It also has a chapter on workplace violence. The handbook states that "*…the Organization has adopted a zero tolerance policy of violence and verbal or nonverbal threats. Violence, threats, or intimidation toward any other individual will not be tolerated and may be subject to disciplinary action up to and including separation of employment.*" It defines violence or threats of aggression including gestures or oral or written expressions, which "*…create fear or bodily harm; cause or are capable of causing death or bodily injury; threaten the safety of a co-worker, student or member of the general public; or, damage property.*" In its guideline implementation it states, "***Employees who are victims of or witness to violence or threats of violence must immediately report such conduct to their immediate supervisor and the Human Resources Officer.***" (Emphasis added). Under discipline it states that "*An employee who violates this guideline by engaging in any of the prohibited activities is subject to discipline up to and including immediate dismissal.*"

The employee handbook also covered incidents and accidents and states in this section, "***When an accident or incident to a consumer, employee, visitor, etc. occurs on the premises, any witnessing personnel shall render immediate assistance and immediately report the act to his or her supervisor for further action.*** *Only those personnel needed to assist in the situation should be on the scene. Other personnel should remain at their work area, unless instructed otherwise by their Supervisor.*" (Emphasis added).

Handbook for the Prevention of Accidents

There was also policy in this handbook for the prevention of accidents which instructed workers to not engage in horseplay. It advises that practical jokes and horseplay can lead to accidents and are not considered appropriate on-the-job behavior. This behavior is cause for immediate dismissal.

Policy of Prohibition of Corporal Punishment and Abuse

Under this policy, corporal punishment and abuse of residents whether intentional or by negligence is prohibited. It went on to explain that unacceptable employee behavior includes

unnecessary physical force, excessive withdrawals of service or supplies, or prolonged isolation. Abuse may also include unacceptable behavior and actions between residents, in which case the victimized resident must be protected and preventive measures against abuse taken.

Adult Community Living Services and Employment Services Handbook revised 8/08/2008

Under General Rules for Conduct and Behavior at Work, above all, staff are to avoid any altercation or physical violence on duty. Fighting or physical assault may result in legal charges being brought against the offender.

Under General Rules for Conduct in the Home, it states that no horseplay is allowed in the homes. It also state states that physical assaults may result in legal charges brought against the offender.

It also lists the rights of the individual receiving services.

Process for Hiring Staff

The HRA looked at the hiring process for staff; an application and the policies, procedures, and protocols were provided from Graywood. Questions on the application were appropriate to recruit staff who would work with individuals with disabilities. By reviewing the selective hiring policies and procedures it was stated that the goal was to hire employees who have high standards of personal hygiene and personal appearance, show enthusiasm for work, readily accept responsibility and willingly work with and help others. It details a process for protecting applicants from being asked discriminatory questions, but would utilize specific questioning techniques to find out if this person has a good work ethic, if the prospective employee is attentive to detail, employment history, education background, and would provide authorization to release information to complete a background check. There were questions about the prospective employee's work performance to previous employers, type of work, and beginning and ending salary. There were also a question about why the employee left. There are directives about the interview process in regards to dependability, a pleasant personality, teamwork, performance and personal appearance. This was for the interviewer to consider before actually hiring the staff.

Employee Confidentiality Agreement

It states that staff have to agree to not release personal health information and protect the clients' privacy. Staff also have to agree to protect the "organization's business information." Failure to do so would be cause for termination from employment.

The HRA reviewed the policies and procedures for filing grievances and making complaints to outside advocating agencies. The following were reviewed:

New Policies, Procedures, and Protocols, Area: of Human Rights Committee, Subject: Problem Resolution Process, Procedure

Page 8**.** States: "All individuals, guardians and families served have the right to contact the HRC, the Guardianship and Advocacy Commission, Prairieland Service Coordination, Equip for Equality, the Office of Public Aid, and/or the Illinois Department of Human Services.

Employees shall provide assistance to individuals in contacting these groups and shall provide the appropriate address and telephone number upon request.

Resources for Consumers and Guardians page 19

It lists phone numbers and address but the numbers for Guardianship and Advocacy is for a different region, instead of listing the region that the resident lives in.

OIG Reports

The HRA reviewed OIG reports on other incidents with Graywood, two of which showed findings of abuse and neglect against two staff members at two different times and of physical abuse towards one of the residents who was convicted as a defendant for aggravated battery and great bodily harm.

There were 14 cases of OIG investigations that covered a 9-month period, 6 had substantiated findings of abuse committed by staff at other CILA's that are owned by Graywood Foundation. Another OIG investigation did not have substantiated abuse, but had recommendations regarding adequate staffing due to another death of a CILA resident five weeks prior to the death of the resident which initiated this report. There was another case involving senior management at Graywood Foundation who were cited for not following abuse/neglect reporting requirements. Other recommendations were staff training and preparation to support individuals' needs who are served by the agency, including CPR as necessary.

Coroner's inquest notes

Per the Coroner's inquest notes, the resident that died was kicked, punched, stomped, and severely beaten. The victim was targeted because he had urinated in the bed, was difficult to deal with, and had stolen money. Staff did follow up with management when one of the residents was unconscious and then later called 911.

Unannounced visits to Graywood CILAs by the HRA

The HRA did unannounced follow-up visits to five homes and releases were obtained from the guardian for 5 residents before the visit. The HRA was looking for the OIG number to be posted, residents' rights to be posted, to observe staffing levels and how staff interact with residents, to see evidence of programs being followed, if the phone was accessible and if residents could make unimpeded phone calls. The HRA also asked staff what they would do if they saw another staff person interacting inappropriately with another resident. The results differed greatly among each house.

In two homes, the HRA team observed that there was only one direct service person in the afternoon when the residents arrived home. One of the individual workers, who was working alone, was responsible for providing direct service for individuals who appeared to have profound mental retardation. We asked if that worker would be the only staff available during the time that residents were home and awake and we were told there was only one staff scheduled until10:00 p.m. Interaction between the residents and this staff member was good. At the other home the DSP (direct service personnel) advised us that more staff were coming. This staff person appeared to be nervous and agitated that the HRA was there. Residents had not

arrived home yet. This staff person ran about the house and would only respond when an HRA member directly engaged him. At this time both of these homes were 8 bed homes, with six residents.

Three of the homes seemed to be adequately staffed with staff interacting with the residents in a very positive way. DSPs were preparing what appeared to be a very healthy meal from scratch for the residents. In another, staff were making arrangements to take several residents fishing which seemed to be a regular outing. The residents stated they looked forward to the outing, and they interacted with staff positively. When the HRA looked at some of the working files they appeared to be in good shape. One showed a plan for medication reduction. One of the medication administration records was reviewed by an HRA member who is a registered nurse. Upon review, records were up to date and current. A resident's behavior support plan was reviewed as well. The plan was developed by a psychologist who, based on formal assessments, targeted elopement, self-injury, verbal and physical aggression and property destruction as problem behaviors. A detailed and extensive procedure for keeping the resident safe and for helping her and the staff cope with the identified behaviors was included. Most instructions called for staff to be calm, supportive and positive with the resident and to help avoid or diffuse situations by recognizing triggers, verbally empathizing, removing others from the area, blocking against physical strikes and using CPI as trained. Supervisors and appropriate medical personnel are to be notified immediately whenever behaviors are injurious. The plan was signed by the psychologist and the resident's guardian; there is no indication as to whether it was approved by the program's behavior management committee.

When asked what they would do if they saw another staff person interacting inappropriately with another resident, the responses varied:

1. Call my supervisor.
2. Contact higher level staff.
3. Call OIG.
4. Contact the QMRP.
5. Suspend staff and refer to OIG, wait for investigation.

The HRA looked for rights to be posted in the homes. In all five homes it appears that rights were not exactly posted but put in a working format of a flip file system where it appears that workers would flip through a page which listed each right for training purposes. Most of these only had a few of the rights listed. One only had six rights listed each one was on a separate page. This was different from house to house. In the ***Adult Community Living Services and Employment Services Handbook revised 8/08/2008*** on pages 9 and 10, there are 18 rights listed which the individual must sign off on that they have received this list of rights. This appears to be an annual activity from the format of the book. It does not list consumer advocacy group phone numbers on the page of the rights. There are some on the last page and the Guardianship and Advocacy information is for a different region then the one that Graywood residents live in.

OIG information was not posted appropriately in most homes. It was simply listed as OIG not explaining what the acronym stood for. But, the agency has made an effort to fix the

problem and has sent the HRA a copy of emergency numbers to be posted in the homes where they are visible to staff and residents alike.

Three of the five homes have the phones cradled in a locked room where only staff may obtain them. However, we were told by all staff that residents could use the phone to make private phone calls when requested and that the phone was made available during the hours when residents were home and awake.

CONCLUSIONS

Complaint 1. Behavioral programming is inadequate.

Mental Health and Developmental Disabilities Administrative Act (20 ILCS 1705/15f) Individualized behavioral support plan:

"(a) As used in this Section: "Behavioral challenges" means episodes of significant property destruction, self-injurious behavior, assaultive behavior, or any other behavior that prevents a person from successful participation in a Home and Community Based Services Program for Persons with Developmental Disabilities, as determined by the community support team. ….

(b) Each individual participating in a Home and Community Based Services Program for Persons with Developmental Disabilities…who exhibits behavioral challenges, shall have an individualized behavioral support plan. Each individualized support plan shall: (i) be designed to meet individual needs; (ii) be in the immediate and long-term best interests of the individual; (iii) be non-aversive; (iv) teach the individual new skills; (v) provide alternatives to behavioral challenges; (vi) offer opportunities for choice and social integration; and (vii) allow for environmental modifications. The plan must be based on a functional behavioral assessment conducted by a professional trained in its use. The plan shall be implemented by staff who have been trained in and are qualified to effectively apply positive non-aversive intervention. All behavioral supports required by the plan shall be applied in a humane and caring manner that respects the dignity of the individual and shall be implemented in a positive and socially supportive environment, including the home.

Illinois Administrative Code (59 Ill. Admin. Code 115.320 (3)):

"3) Behavior management and human rights review

Each agency is required to establish or ensure a process for the periodic review of behavior intervention and human rights issues involved in the individual's treatment and/or habilitation. Agencies required to have behavior intervention and human rights review policies and procedures under licensure or certification standards shall continue to comply with those standards."

SUMMARY

Graywood is required to provide any resident who has behavioral challenges with an

individualized support plan based on a professional, functional assessment. A policy and systems review indicates that appropriate practices are in place for behavioral programming, including oversight by a behavior management committee. Without access to the deceased or the aggressors' records however, it is unclear whether they were supported by individual plans that were followed. More clearly, for the individual who was beaten, any behavioral interventions used at all were not conducted in a humane and caring manner that respected the dignity of the resident. The environment at that time was not safe or therapeutic; it brought physical and psychological pain, as well as producing humiliation to all residents involved. And, the other residents were engaged in abusive behaviors. Given the evidence available to the HRA regarding current practices, **Complaint 1. Behavioral programming is inadequate is not substantiated.**

Complaints 2 and 3. Resident safety measures are inadequate and the agency does not respond appropriately to resident grievances.

STATUTES

Illinois Administrative Code (59 Ill. Admin. Code 115.250):

"(a) 5) Every individual receiving CILA services has the right to be free from abuse and neglect."

Illinois Administrative Code (59 Ill. Admin. Code 115.320 d, 1) Administrative requirements:

".... All direct service employees and any other compensated persons…shall receive training and demonstrate competence…in the following training areas: [CPR…first aid; concepts of treatment, habilitation…behavior management, safety…abuse, neglect and unusual incident prevention, handling and reporting]…."

Illinois Administrative Code (59 Ill. Admin. Code 115.320 g.1) Unusual incidents:

"1) The agency shall have written policies and procedures for handling, investigating, reporting, tracking and analyzing unusual incidents through the agency's management structure, up to and including the authorized agency representative. **The agency shall ensure that employees demonstrate their knowledge of, and follow, such policies and procedures** [emphasis added]**.** Unusual incidents shall include, but are not limited to, the following:

A) Sexual assault;

B) Abuse or neglect;

C) Death;

D) Physical injury;

E) Assault;

F) Missing persons;

G) Theft; and

H) Criminal conduct."

Mental Health and Developmental Disabilities Code (405 ILCS 5/ 2-103) Communication:

"Except as provided in this Section, a recipient who resides in a mental health or developmental disabilities facility shall be permitted unimpeded, private, and uncensored communication with persons of his choice by mail, telephone and visitation.

(a) The facility director shall ensure that correspondence can be conveniently received and mailed, that telephones are reasonably accessible….

Mental Health and Developmental Disabilities Code (405 ILCS 5/2-200) Notice of Rights:

"…. Every facility shall…post conspicuously in public areas a summary or rights which are relevant to the services delivered by that facility."

The Code adds that residents must be advised of their rights to contact advocacy groups, the Guardianship and Advocacy Commission and Equip for Equality (405 ILCS 5/2-103, 5/2-200 and 5/3-206).

Illinois Administrative Code (59 Ill. Admin. Code 115.250 a) Individual rights:

Residents are to be informed of their rights on admission, including, "…their right to contact the Guardianship and Advocacy Commission, Equip for Equality, the Department's Office of Inspector General, the agency's human rights committee and the Department. …. Individuals or guardians shall be permitted to present grievances and to appeal adverse decisions.

Illinois Administrative Code (59 Ill. Admin. Code 50.20 b) Abuse:

"The OIG hotline…number shall be posted in plain sight at each…facility location where individuals receive services."

SUMMARY

Graywood has numerous behavioral, incident and training-related policies in place as required by regulations, but they were failed during the incident, at least by employees who did not demonstrate their knowledge and competence in preventing or handling violence. Resident to resident rough housing and horseplay were not forbidden by the staff in the Higgins house the night of the incident. Residents exhibited numerous "behaviors", and it seems that staff did not try to calm the residents or call for help and move towards using CPI or any other safety measure until it was too late.

Per the OIG reports and the HRA's observations in at least one home, it appears that staffing levels are very limited and may not be adequate to effectively provide support for the individuals. This jeopardizes everyone's safety including residents and staff off that CILA.

The phone in the CILA home where the resident was beaten was cradled in a locked room. This room is only available to staff with a key; it was likely impossible for residents to call for help during the incident if they wanted, and, if it remains out of reach to residents,

unlikely they will be able to in the future. The HRA received a letter from the Graywood Foundation explaining that phones would be kept in a common area but bases will be kept in the locked offices only available to staff. The phone will only be in the locked office to charge while residents are sleeping. The problem with this is that residents without personal cell phones still have to rely on staff to bring out the phone if there is an emergency during overnight hours. In addition, the limited rights and OIG materials that were posted, in some homes not posted at all, do not provide enough information for a resident, family, legal representative or any visitor to determine whether their full gamut of rights are potentially violated, if they feel unsafe and wish to make appropriate contacts, or pursue a grievance at will. Correct telephone numbers and address need to be made available to consumers without going through Graywood staff or management. **Complaints 2 and 3. Resident safety measures are inadequate and the agency does not respond appropriately to resident grievances are substantiated.**

Complaint 4. The agency does not follow abuse/neglect reporting requirements.

STATUTES

Illinois Administrative Code (59 Ill. Admin. Code 50.20) Reporting an allegation of abuse or neglect and death reports:

"1) If an employee witnesses, is told of, or has reason to believe an incident of abuse or neglect or a death has occurred, the employee, community agency or facility shall report the allegation to the OIG hotline according to the community agency's or facility's procedures. The employee, community agency or facility shall report the allegation immediately, but no later than the time frames specified….

2) Within four hours after the initial discovery of an incident of alleged abuse or neglect, the required reporter shall report the following allegations by phone to the OIG hotline:

A) Any allegation of abuse by an employee;

B) Any allegation of neglect by an employee, community agency or facility; and

C) Any injury or death of an individual that occurs within a facility or community agency program when abuse or neglect is suspected.

D) At a minimum, required reporters to the OIG hotline shall provide details concerning:

i) Information about the victim, including name, date of birth, sex, disability, identification number and/or social security number (if known);

ii) Information about the incident, including what happened, when it happened, where it happened, how it happened and the identification of all witnesses;

iii) Information about the accused (if known), including name, contact information and if the accused is presently working with or will be working with the alleged victim within the next 72 hours; and

iv) Information about the complainant, including name, contact information, relationship to the victim and the need for anonymity (if applicable).

3) Written documentation of deaths from the required reporter Within 24 hours after initial discovery, the required reporter shall call the OIG Hotline and report (as described in Section 50.30):

A) Any death occurring within 14 calendar days after discharge or transfer from a residential program or facility;

B) Any death occurring within 24 hours after deflection from a residential program or facility;

C) Any other death of an individual occurring within a residential program or facility or at any Department-funded site even though not alleged to be a result of abuse or neglect....screening, delaying or withholding reports of incidents or allegations of abuse or neglect from OIG is not allowed. ….

b) OIG hotline

The OIG hotline (#1-800-368-1463) shall be communicated to individuals and guardians at the time of admission and the number shall be posted in plain sight at each community agency and facility location where individuals receive services.

c) Other reports of allegations of abuse and neglect

1) Any other person, individual, family member, guardian, advocate, or staff from another community agency or facility who witnesses, is told of or has reason to believe an incident of alleged abuse or neglect or a death of an individual may have occurred, may report the incident to OIG by telephoning the OIG hotline, or in writing by fax or other electronic reporting system offered by OIG to the OIG Intake or mail at:

Office of Inspector General, 901 Southwind Road, Springfield, Illinois 62703

SUMMARY

Graywood representatives reported that its staff may call the OIG directly and are trained in reporting requirements. In addition, they have updated in-servicing on OIG reporting. But there was evidence of an OIG investigation in July of 2008 where the Inspector General's office made recommendations regarding Graywood's senior management for not following abuse/neglect reporting requirements. From our interviews with staff, only 2 out of 5 mentioned that they would call OIG if they saw a coworker potentially abusing a resident, the rest deferred to higher level management to follow up. Although agencies are permitted to have set procedures and a OIG liaison for reporting, representatives suggested to us that any staff person can call the OIG directly, which is not understood by all of the staff we interviewed. The agency has made improvements in policy since the incident such as training staff within 5 days of hire on the OIG Rule 50 Module. However, based on staff responses, OIG reports, and how the fatal incident was handled, or not handled for that matter, policy and Rule 50 at the time were not followed. **Complaint 4. The agency does not follow abuse/neglect reporting requirements is substantiated.**

Of note, since this initial complaint the agency has created a new phone list which is easier to understand and explains whom to call and why in case an individual needs help. It lists the 911, the corporate office, residential administrator, how to make an anonymous complaint, how to call your PAS agent, how to report a rights violation, and how to call OIG. The HRA was updated that Graywood has made several improvements to its policies and sent copies which included a revised policy on restraint. Per the letter from the agency it stated that staff are being retrained on this policy. They are implementing a video series "Creating an Abuse Free Environment."

Improved policies are:

OIG Rule 50 Module and test staff receive with 5 days of hire
Copy of a new Individual Program Plan and Protocol
Copy of a new Behavior Support Plan
Proof of Positive Behavioral Support Training (11/10/09)
Behavior Management /Human Right Policies and Committees
Examples of Rights Restrictions that were removed
Higgins House Staffing Patterns (Staff : Individual ratio)
Revised Restraint Policy and Test

The HRA appreciates the steps that the Graywood Foundation has made to improve the environment and services to individuals and submits the following recommendations:

Recommendations:

1. Ensure adequate staffing in each home, particularly those where individuals with significant behavioral challenges reside.

2. Post conspicuously at each home a list of all rights under Chapter II of the Code as related to the services being provided.

3. Ensure that staff understand and perform their duties as mandated abuse reports. Examine any perceived punitive measures related to reporting.

4. Make phones available to residents at all times for emergencies.

5. Update advocacy resource information such as ***The Adult Community Living Services and Employment services Handbook*** for residents with current information for advocacy agencies address and phone numbers.

Suggestions:

Graywood's new policy for abuse neglect reporting (7/15/09, Tracking #7005) states in 1. d) "*When the Executive Director/designee determines that a medical emergency exists, immediately contact 911 for assistance;*" The policy should specify who designees are and include exceptions for all staff to call 911 first so that precious minutes are not lost in an emergency.

One of the residents at the house meeting immediately after the incident requested to go to church. The HRA could not determine whether this happened or not. Considering the trauma and post traumatic stress the CILA residents experienced and associated needs; accommodate those needs as much as possible.

Document on all behavior support plans whether they have been committee-approved.

Given the gravity of the violent incident, Graywood's behavioral/human rights committee should spend some time monitoring and periodically inspecting each site to ensure resident safety and that approved behavior interventions are carried out.

Ensure that the program's confidentiality policies that "protect the organization's business information" in no way conflicts with Rule 50 reporting requirements.

COMMENT

Graywood CILA residents have a right to live free of abuse and neglect in their home and have their needs met. The incident in question led to the death of one resident, seriously impacted two other residents and may have impacted other residents as well. What happened to all of the residents residing in this house should never happen again to any resident residing in a Graywood CILA.