FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY - NORTHWEST REGION

REPORT 10-080-9016 and 10-080-9017
DD HOMES NETWORK - HAMMETT HOUSE

Case Summary: Public Health investigated and found violations on the abuse issues; the HRA did not find problems with stocked supplies in the home.

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving complaints of possible rights violations at Hammett House, a sixteen-bed intermediate care facility for persons with developmental disabilities in Sterling. The home is managed by Frances House, a northwestern Illinois affiliate of the DD Homes Network. Allegations in #9016 are that the facility has not protected residents from a housemate's physical abuse, has not adequately supplied hygiene products such as hand soap and fabric softener as well as fuel in the van, and does not allow residents to spend more than thirty dollars per month. Allegations in #9017 are that the facility has not protected a particular resident from a housemate's physical abuse and has not reported the incidents.

Substantiated findings would violate protections under the Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) Code (77 Ill. Admin. Code 350) and the Mental Health and Developmental Disabilities Code (405 ILCS 5).

The HRA visited Hammett House and discussed the issues with several program representatives. Relevant policies were reviewed as were various resident, employee and facility files.

FINDINGS

The complaints in #9016 and in #9017 regarding protection from a housemate's physical abuse and reporting abuse incidents were investigated by the Illinois Department of Public Health, the facility's licensing body. According to the Department's findings, Hammett House failed to implement abuse prevention policies and ensure the protection of a resident who was abused by a peer on at least three occasions. It was found that Hammett failed to investigate,

alert the Department and promptly inform the victim's guardian. The findings state that at the time of the review, the abuse had continued and affected two out of fifteen residents with the potential to affect thirteen others. The facility submitted correction plans to in-service staff and monitor for compliance.

We looked for evidence of staff training on reporting abuse during our visit at Hammett and were provided with in-service attendance sheets and a small sample of Competency Based Training Assessments from current employee files. Documentation showed that training on various policies and procedures regarding abuse and neglect occurred on a quarterly basis in 2010. The competency assessments, which are required for all direct care workers and their placement on the Healthcare Worker Registry, showed that two employees successfully completed three hours of classroom and five hours of on-the-job training on abuse and neglect prevention, recognition and intervention.

Regarding the complaint in #9016 that Hammett has not adequately supplied hygiene products and kept the van fueled, the staff we spoke with said they have no specific directives on keeping supplies or fuel. Their general practice is to maintain at least a two-week stock of items like soap, sanitizer, detergents, etc. The home's services director is responsible for assuring that supplies are in, but if for any reason they run out of something there are six other homes in the immediate area to share. Likewise, there is no policy or rule on keeping gas in the vans but in practice they prefer to keep them around half a tank. One administrator is responsible for the gas card, which is available to managers when needed.

The home's administrators said they had never heard of these complaints before, and we spoke with several residents who had no complaints either. We observed the home's bathroom, laundry and kitchen areas, all of which had ample supplies of soaps, detergents and fabric softeners to name a few items. We also reviewed personal care supply logs for a six month period and saw that various soaps, deodorants, shaving creams, shampoos, toothbrushes, mouthwashes, nail polish remover, lotions, facial tissues, and feminine pads were consistently stocked throughout. At the time of our visit, the facility's van had nearly half a tank of gas.

On the final complaint in #9016, not allowing residents to spend over thirty dollars per month, the staff said that residents are able to spend whatever they have available and that the complaint likely stems from guardians or families who may be misinformed or confused about personal funds versus the cost of care. Residents conduct their own banking on a weekly basis; they keep thirty dollars from monthly entitlements for personal use and the first twenty dollars plus half of the next sixty from any earnings they may have, say from day-training work and jobs. The home's services director is responsible for helping residents budget and shop. Residents are not prohibited from spending their money, and only if there was an overdraft or a resident needed help in making better decisions, like making healthier and safer choices, would purchases not be allowed.

We asked several residents in the home whether they had any trouble accessing or spending their money and were restricted to any amount. None of them had complaints. We followed up with a guardian and a couple family members who also voiced no complaints.

CONCLUSION

Hammett has policy establishing a process for protecting, identifying, investigating and reporting abuse and neglect (#5.24). In cases of alleged abuse between residents, appropriate actions will be taken to safeguard other individuals. Completion of staff training on the same is required as an employment condition and public listing for verification per the Healthcare Worker Background Check Act (225 ILCS 46) and specific standards for the training under the Long-Term Care Assistants and Aides Training Code (77 Ill. Admin. Code 395).

The issues of physical abuse, protection from physical abuse and incident reporting were investigated by the Public Health Department who substantiated violations. Our focus turned to staff training, and the facility provided evidence that training on the subject is being held regularly and that new hires satisfy training requirements. There are no apparent violations there based on the documentation provided.

Although ICF/DDs are to keep adequate housekeeping supplies on hand (77 Ill. Admin. Code 350.2020), there are no specific standards for stocking personal hygiene products. Obviously, making sure the residents have what they need personally is a given when providing an appropriate home environment. We saw no evidence that the residents of Hammett House are doing without. As for the van being fueled, again there is no specific standard, but thinking of emergency purposes the facility's practice of keeping the tank at least half full is a good one.

There is policy in place (#6.25) stating that the facility will provide individuals access to individual monies. Each will have a checking account, and spending is determined on needs and resources. Under law, a resident shall be permitted to manage his financial affairs and spend his money as he chooses unless prohibited by a court guardianship order (77 Ill. Admin. Code 350.3260 and 405 ILCS 5/2-105). We found no indication that residents at Hammett House were limited to spending thirty dollars. Based on interviews with staff, residents, a guardian and some family members, a violation is not substantiated.

COMMENT

Policy #6.25 on finances states that the facility "will be representative payee". The statement fails to reflect that an individual and/or guardian decides whether the facility will serve as rep. payee per the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-105). DD Homes Network should make this clear to individuals and their guardians and families.