FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
HEART TO HEART SERVICES, INCORPORATED— 11-040-9007
HUMAN RIGHTS AUTHORITY- South Suburban Region

[Case Summary—— The Authority did not substantiate the complaint as presented; the public record on this case is recorded below. The agency did not provide a response to the report.]

INTRODUCTION

The South Suburban Regional Human Rights Authority (HRA), the investigative division of the Illinois Guardianship & Advocacy Commission has completed its investigation into an allegation concerning Heart to Heart Services, Inc. The complaint alleged that the agency failed to pick up a resident from the Emergency Department in a timely manner. If substantiated, this allegation would violate the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/2-102 [a] and 5/2-112), the Illinois Administrative Code (CILA Rules) (59 Ill. Admin. Code 115.200 [d]) and Mandated Reporting to the Office of the Inspector General (59 Ill. Admin. Code 50.20 [a-1] and [a-2]).

Located in Orland Park, this agency manages one Community Integrated Living Arrangement (CILA) and provides various services such as day programming to elderly persons.

METHODOLOGY

To pursue the investigation, the allegation was discussed with Heart To Heart Services' Director and a Qualified Support Professional. Three staff members employed by the resident's community day training agency were interviewed separately. The complaint was discussed with the resident and guardian. Sections of the adult resident's record were reviewed with written consent. Relevant agency policies were also reviewed.

COMPLAINT STATEMENT

According to the complaint, the resident was transported to a local hospital's Emergency Department after sustaining an injury at her community day training program. She reportedly requires 24-hour supervision, but she was left alone (without staff supervision) for several hours while waiting on medical care. The complaint stated that the day training employee left the resident at the hospital because her residential staff failed to pick her up in a timely manner.

FINDINGS

An HRA review of the resident's record indicated that she was diagnosed with Severe Mental Retardation. A copy of "Rights of Individuals" was signed by the resident's guardian on April 18th, 2008, which includes the right to be free from abuse and neglect. An "Injury Report" completed by the resident's community day training agency stated that the client fell over the door plate while leaving the building for her bus on October 19th, 2010 at 1:45 p.m. She reportedly made contact with a wheelchair and sustained lacerations on her head or face. Her lacerations were cleaned, and she was transported by ambulance to a local hospital's Emergency Department. The cause of the injury was determined to be accidental and was observed by three program employees including the person who wrote the incident report. According to the report, the client's residential Qualified Support Professional (QSP) and her guardian were notified on that same day at 1:50 p.m. and 1:55 p.m., respectively. Documentation indicated that the same residential staff person was called five more times between 2:15 p.m. and 4:15 p.m. A copy of the injury report was faxed to the residential agency on that next day.

According to the residential progress notes, the QSP was informed by phone about the incident on that same day. She told the Community Day Training Coordinator that she could not leave the office to relieve the day training employee at the hospital until closing time. She said that she would call other staff members for possible assistance and would inform the Coordinator as soon as possible. She wrote that she was unsuccessful in securing help after making calls for about one hour. The Community Day Training Coordinator reportedly called back regarding the status of relieving the employee at the hospital. She said that the day training agency would be closing soon, and that the client could be transported home, if a replacement was not found. She also told the QSP that she was not sure if the client was ready to be discharged from the Emergency Department. The Community Day Training Coordinator was later informed that the QSP was going to the hospital as soon as possible. She reportedly arrived at 5:20 p.m., and the day training employee was relieved of duty.

The QSP further wrote that treatment had not begun when she arrived at the hospital. The resident's wound was later cleaned, and pain medication and sutures were needed. Information was shared with the agency's Director upon her arrival to the hospital. According to the hospital's discharge instructions, the resident's sutures should be removed in seven days, and she was released at 6:12 p.m. By documentation, the home staff were informed about the incident upon the resident's arrival to the home. For October 20th, 21st and the 22nd, the agency's Director and the home staff wrote that the resident was monitored and was "okay." On the 23rd, her sutures were removed, and she was given a medical release to return to her community day training program on that next Monday.

When the complaint was discussed with the residential staff, the HRA was informed that the resident is cognitively low functioning and requires 24-hour supervision. The agency's Director and the QSP denied the allegation. They said that the community day training employee was still at the hospital when the QSP arrived around 5:30 p.m. The resident was still waiting to be treated for her injuries. There was no indication that the day training employee was going to leave the hospital before she was relieved of duty. She was discharged from the Emergency Department around 6:30 p.m.

The guardian told the HRA that the residential agency's Director said that the day training employee had left the resident at the hospital. The resident was unable to assist with this investigation because of her limited cognitive ability. However, she indicated that she remembered being taken to the hospital. In separate interviews, the allegation was denied by three community day training employees including the person who had accompanied the resident to the Emergency Department. According to the Community Day Training Coordinator, she told the assigned employee that she would relieve her at the hospital, if necessary. The investigation team was also informed that information was shared with the residential staff person before the day training employee left the hospital.

Heart To Heart Services provided the HRA with one section of the agency's policy regarding clients who require a visit to the hospital's Emergency Department while attending their workshop. According to the policy, a client will be transported to the emergency room in the event of a high fever, head trauma, sprains, broken bones, and fluid or blood flow. The workshop staff are directed as follows: (a) to notify the guardian about the incident and provide contact information concerning the hospital, (b) to stay at Emergency Department with the individual until relieved by a staff person from Heart To Heart. Once there, the agency's staff person will remain with the individual for the duration of the visit. The policy states that the incident will be documented and progress notes will be written for a period of 72 hours. The client will be allowed to return to his or her workshop when medically cleared by the physician. The supervisor and/or Director will investigate any injuries or illnesses that require hospitalization or physician's care. Although these procedures were reportedly in place when the incident occurred, there was no date or agency name found on the policy page.

According to the agency's rights statement, a client has the right to be free from abuse or neglect.

CONCLUSION

The Illinois Administrative CILA Rules Section 115.200 (d) states,

> Based on their needs, individuals shall receive supervision and supportive services which may range from continuous to intermittent. CILAs shall be designed to promote optimal independence in daily living, economic self-sufficiency and integration into the community through the interdisciplinary process.

Section 5/1-101.1 of the Code defines abuse as any physical, sexual abuse, or mental injury inflicted on a recipient of services other than by accidental means.

Sections 5/2-102 (a) and 5/2-112 of the Code state that services shall be provided with adequate and humane care and that every recipient of services in a developmental disabilities facility shall be free from neglect.

According to Section 50.20 of the Illinois Administrative Mandated Reporting Rules,

> (a-1) If an employee witnesses, is told of, or suspects an incident of physical, sexual or mental abuse, financial exploitation, neglect or a death has occurred, the employee, community agency or facility shall report the allegation to the Office of the Inspector General hotline according to the community agency's or facility's procedures.
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> (a-2) Within four hours after the initial discovery of an incident of alleged physical, sexual or mental abuse, financial exploitation or neglect, the required reporter shall report the allegation by phone to the OIG hotline.

Based on documentation and the staff interviewed, the complaint that the agency failed to pickup a resident from the Emergency Department in a timely manner is unsubstantiated. No violations of the CILA Rule 115.200 (d), Sections 5/2-102 (a) and 5/2-112 of the Code, the agency's policy or client rights statement were found. Further, the agency is required to report only incidents when abuse and/or neglect are suspected under Sections 50.20 (a-1) and (a-2).

COMMENT

The Authority would like to thank Heart To Heart Services for its cooperation concerning this investigation although the agency initially was not willing to provide the HRA with copies of the agency's policies. The HRA suggests that policies be dated and identified with the agency's name.