FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
NEW HOPE CENTER, INCORPORATED- 11-040-9008
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) has completed its investigation into an allegation concerning New Hope Center, Inc. The complaint alleged that a client who requires 24-hour supervision was alone left in the Emergency Department. 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 (Standards for Day Training Centers) (59 Ill. Admin. Code Part 119 et seq.) and Mandated Reporting to the Office of the Inspector General (59 Ill. Admin. Code 50.20 [a-1] and [a-2]).

Located in Dolton, this agency manages two day training sites that serve about 190 people with developmental disabilities. It also provides residential and other supportive services to individuals.

METHODOLOGY

To pursue the investigation, New Hope Center Associate Director, the Coordinator of Day Training and a program staff person were interviewed. Two staff members employed by the client's residential agency were interviewed at a different time. The complaint was discussed with the resident and guardian. An "Injury Report" and sections of the client's record were reviewed with written consent. Relevant agency policies were also reviewed.

COMPLAINT STATEMENT

According to the complaint, the client was escorted to the Emergency Department after sustaining an injury at her 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. It was reported that the day training employee left the client at the hospital because her residential staff failed to pick her up in a timely manner.

FINDINGS

The HRA reviewed an "Injury Report" completed by New Hope Center stating 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 and 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 staff members including the person who wrote the injury report. The client's residential Qualified Support Professional (QSP) employed by another agency and the guardian were notified on that same day at 1:50 p.m. and 1:55 p.m., respectively. The same QSP was called five more times between 2:15 p.m. and 4:15 p.m. A copy of the report was faxed to the residential agency on that next day.

An "Incident Witness Form," dated October 19th, written by the day training staff person who had accompanied the client to the hospital was also reviewed. According to the form, they arrived at the hospital after 2:00 p.m., and the client was promptly seen by a physician. It was recorded that tests and an X-ray of her head were done. The day training staff person wrote that she never left the client's side. The program Coordinator kept calling her to determine whether someone from the client's residential agency had arrived at the hospital. She was sitting in a chair in the individual's room when her residential staff person arrived at 5:20 p.m. She reportedly apologized for being late and was informed about the client's need for sutures. The form was signed by the program Coordinator on October 20th.

When the complaint was discussed with the day training agency staff, they denied that the client was without staff supervision in the Emergency Department as alleged in the complaint. The assigned day training employee reportedly did not leave the hospital until the residential staff person had arrived. Two of the employees mentioned that the day training employee shared information with the residential staff person before she left the hospital.

New Hope Center's "Medical Emergencies" policy includes procedures when first aid or additional medical attention is needed for clients who attend the agency's developmental training site. The staff are instructed as follows: 1) to administer first aid if needed and to call 911 immediately in life threatening situations, 2) the staff person administering first aid should stay with the person if possible and someone else should call 911 and notify the Coordinator/Program Director. The staff person will notify the client's parent or guardian, the residential service provider if the individual does not reside at the agency, 3) the hospital's information will be obtained from the paramedics and a staff person will stay with the client at the hospital until relieved by the individuals' residential staff, released from the emergency department, admitted to the hospital or the parent/guardian arrives and, 4) the Coordinator/Program Director is responsible for ensuring completion of all required documentation regarding the incident. All documents must be completed before the end of the employee's and the Program Coordinator's shift.

CONCLUSION

According to Section 119.235 (a) of the Administrative Code, the individual's rights are protected in accordance with the Code, except that the use of seclusion shall not be permitted.

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.

No violations of Section 119.235 (a) of the Administrative Code, Sections 5/2-102 (a) and 5/2-112 of the Code, or the agency's policy were found. Based on documentation and the staff interviewed, the complaint that a client who requires 24-hour supervision was alone left in the Emergency Department is unsubstantiated. Additionally, the HRA notes that the agency is required to report only incidents when abuse and/or neglect are suspected under Sections 50.20 (a-1) and (a-2).