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HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case # 11-090-9015
Warren Achievement Center

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after learning of possible rights violations at Warren Achievement Center. The alleged violations are as follows:

1. Residents are unsafe with a change in supervision
2. Residents have been inadequately trained to live in unsupervised conditions
3. Residents have not been placed in a least restrictive environment when an intermittent CILA was staffed 24 hours
4. The agency did not use grant funding for properly designated purposes; grant money designated for consumer interaction was used instead for 3rd shift staff

If found substantiated, the allegations would violate the Illinois Administrative Code Rule 115 and the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102).

Warren Achievement Center services consumers throughout the Central Illinois area, including the immediate counties of Knox, Warren, Henderson, and Southern Mercer. The Center has residential programs, day training programs, and early intervention programs. 85 consumers participate in the day training program while 50 consumers participate in the residential program. The Center has 8 Community Integrated Living Arrangements (CILA) that include homes and apartments. The apartments are in 2 locations and have 8 units in one location and 9 units in the second location. The Center has 125 employees ranging from Direct Service Personnel and Nurses to Case Managers and Drivers. Consumers are adults with developmental disabilities.

To investigate the allegations, HRA team members met and interviewed Warren Achievement Center staff and reviewed pertinent policies and records.

COMPLAINT STATEMENT

The complaint stems from a newspaper article in which Warren Achievement Center staff explain that they had to terminate a supervisor position because of losing grant funding and now the consumers living in an apartment complex do not have 3rd shift staff. The complaint states

that the residents of a CILA apartment complex are unsafe due to staff being terminated from third shift supervision positions. Now the complex does not have third shift staff to supervise the consumers and they could be unsafe. The complaint also questions whether the residents of the complex have been adequately trained by Warren Achievement Center to live in the unsupervised conditions. The complaint also states that, because the staff worked with residents who are considered intermittent and did not need the 3rd shift staff, that the residents were not being placed in the least restrictive environment based on their living capacity. Also the complaint states that, because there were 3rd shift staff members with intermittent consumers that did not need a third shift, the agency did not use grant funding for properly designated purposes and that grant money was used to staff a third shift rather than for the consumers.

FINDINGS

Interview Staff (12/13/2011)

The Warren Achievement Center staff began the interview by explaining that there was one apartment supervisor terminated due to the funding loss, and that individual was more of an "Umbrella Supervisor." The consumers in the community were living alone and needed someone to call, and this individual filled that need, but that aspect has not changed with the loss of the position. The apartment still has a Warren Achievement Center staff member that is on-call that the consumers can contact 24 hours a day. The staff stated that the newspaper article was making a point about grant money and was misinterpreted. The Center staff explained that no consumer went without supervision; they just no longer have someone in the building. The staff proceeded to explain that overall services at Warren Achievement Center have been diminished because of the cuts.

The Warren Achievement Center staff explained that they have an extensive call system. All phone numbers that the consumers can call in an emergency are hung by a magnet on their individual refrigerators, including the 24 hour supervisor who is only one mile away. These lists are called "Go-To" cards. These "Go-To" cards are 5x7 laminated lists of phone numbers for the consumers to call in the event of an emergency. Most of the time, the consumers will be calling another CILA if something is needed, but sometimes, the consumer will call a family member when an issue arises. The staff explained that since they have implemented the "Go-To" cards, only one consumer has called the 3rd shift supervisor and it was because of carbon dioxide.

The staff also stated that the consumers have been trained for fire drills and tornado drills. The Department of Human Services (DHS), who were prompted by the aforementioned newspaper article, contacted the local Pre-Admission Screening (PAS) agent and asked the agent to speak with the guardians of the consumers who live in the apartment complex that lost the supervisor. The agent stated that the guardians had no concern regarding the 3rd shift supervisor no longer being on staff. The staff explained that some of the consumers that live in the complex did not have 3rd shift staff before they moved into the complex. The PAS agent also spoke with the consumers about the "Go-To" cards and they all knew who to call and what to do with situations. The staff also explained that the consumers are high functioning and only need intermediate supervision. The consumers staying in the apartment are also all ambulatory.

The Warren Achievement Center staff said that the consumers' Annual Service Plans are updated and they have added safety questions but none of them actually need the questions. The staff explained that there are no checklists that the residents have to follow or anything of that nature while they are at their apartments. The staff roleplay with the consumers at monthly meetings, acting out scenarios such as what the consumer would do if someone comes to their door. The consumers do not have a curfew, but they do have a sign-in and sign-out system.

The Warren Achievement Center staff explained that total hours at the Center have been decreased, but they still have staff covering full-shifts. The staff member that was terminated because of funding was not at the apartment complex the entire night, but did door checks hourly (to see if the door was locked), picked up laundry, helped with morning breakfast, helped with morning medication, and did some charting (progress notes, nursing notes, etc.). The discharged staff member would double check the medication but not administer it. Now, the consumers take their own medications and 1st shift staff member double checks the medication rather than 3rd shift. If there is a discrepancy in medication, a note goes to the nurse. The staff explained that they never had medication problems when they had a third shift anyway. The staff stated that the consumers who live in the apartments live alone with no roommates and the consumers still have case managers who help them with planning.

The staff stated that the Fire Department and Police are aware that the 3rd shift supervision is no longer available at the complex and both departments have access to keys for each building. There is also a training scheduled with the Fire Department on working with people with disabilities. The training is not stemming from the loss in supervision but rather another situation that happened within the community. The staff explained that if there was a fire, the consumers are trained to get out of their apartments, and then call the 3rd shift staff member from the other apartment complex with a cell phone. The staff explained that the consumers at Warren Achievement Center have always been trained on how to act in an emergency anyway.

When the consumers were told about the staff member leaving, some of the consumers said that they would miss the staff member because they liked the interaction. The Center has a program with the local college students where they spend time with the consumers due to the reduced contact hours. The staff said that the students are supervised and trained through the school and it is an on-going volunteerism program.

The staff stated that the consumers are in the least restrictive environment and they think of 3rd shift as support that provides just enough to help the consumers. The staff considered the third shift supervisor that is gone to be an "invisible service" that was there only as a back-up in case something happened. The Center staff explained that the consumers can do whatever they are able to do, for example if a consumer wants to take a walk to the store, they can do it. Some other consumers may need staff to assist them with things that they want to do, but the staff does not want to restrict. They stated that the Center has been working on least restrictive environment forever and a lot of the consumers have progressed through the system.

The Warren Achievement Center staff explained that they have a Human Rights Committee that meets and discusses issues at the Center. The facility's Human Rights

Committee did not discuss the loss of the 3rd shift supervisor because they did not feel as though it was a problem. The Committee was informed but did not discuss the situation in the meeting. The Center stated that when they lost the funding, they terminated the individual with the least duties. The staff explained that when they read the 3rd shift logs, they saw that the supervisor was logging that there were no problems and that was part of the decision to terminate the position.

The Warren Achievement Center staff stated that maybe they were spending money on night watchmen with the 3rd shift supervisor position, and maybe they should not have been spending the money but there is no way to tell. The staff stated that they did not think it was a frivolous expense and the money was available so they used it. They stated that they have had this grant funding since 1978 (or maybe even later) through Program 160. The staff explained in 1974 they had 40 consumers in dorms that were the mental health center. They moved those consumers into a property rehabilitation project. The Center found 5 buildings, apartments, and homes. They borrowed money to create the apartment living for the consumers and the Department of Human Services (DHS) gave grant funding for supports and staff. The grant funds were more targeted for consumers in the apartments and the DHS knew how the funds were used. The staff stated that the DHS may be aware that they had supervision for the CILA but they may not have known for sure. They used the funding for recreational supports also. Every year they would create a plan on what to do with the funding, but the DHS stopped asking for agency plans. The staff stated that they believe that is part of the reason why the funding was dropped, because the DHS was not aware of what was being funded because they have no oversight. The staff stated that now the community and the college are volunteering to try and make up the difference in what was lost by the funding being cut.

Tour of East Broadway Apartments

The HRA toured the East Broadway Apartments. The apartments are laid out in a long row, with each individual apartment door opening to the outside. The HRA viewed several apartments, each consisting of a bedroom, living room, and a kitchen area that has a refrigerator and a stove. The office area is located in the complex but further down the row of apartments. There were "Go-To" lists in each apartment that the HRA viewed.

Discussion regarding private pay apartments

The HRA called Warren Achievement Center staff for clarification regarding the private pay individuals staying at the CILA. The staff member stated that the individuals lost funding when the facility lost grant 160 and did not qualify for Medicaid, so they are now private pay. The staff stated that the individuals get no services (such as ISPs, vocational services, medical services, etc.) other than the staff ensures they have food, that they have their medication and that they are safe. The staff stated that they have basically become renters at the CILA because they do not participate in any services. The private pay individuals get medical services from outside the facility through their guardians or family members. The staff also stated that they did point them in the direction of some community resources, such as volunteers, so that they do not sit alone in the apartment all day.

Department of Human Services Clarification

The HRA spoke with the Illinois Department of Human Services (DHS) regarding the information provided by Warren Achievement Center in this report. The DHS stated that grant 160 can be and is mostly used for staff to provide services for consumers. When asked if it is permissible to use the money for staff when the staff is actually providing extra services than the consumer requires, the DHS said that it is permissible. They explained that when they give the providers grants, the funds are in one lump sum and the DHS tells the facility to provide supports; the lump sum can be used for additional services above the allotted requirements for the consumer. They stated that it would be a problem if the money was given and the individuals got fewer services than required.

The DHS also stated that it is correct that they had not been requesting and reviewing agency plans from the Warren Achievement Center for some time. They also stated that the DHS does not regulate private pay services within CILAs. They stated that they would recommend that the consumers have ISPs because it is best practice but they cannot enforce that they have them.

Policy and Record Review

The HRA reviewed the article referenced earlier, in The Register Mail, a Galesburg, Illinois newspaper. Within the article it reads "In addition, other service providers have to be aware that some of those checks and balances are no longer there. The fire department must now have keys to the East Broadway and East Boston residential homes and recognize that, during third shift, no staff members are there to help the residents."

The HRA also reviewed 5 masked copies of CILA Support Rate sheets for the consumers at the apartments. Each sheet stated that the consumer receives intermittent supports and are to receive 15.0 hours per week of direct support staff. The HRA also reviewed a letter sent from Warren Achievement Center staff which explains that there are 8 individuals at the apartments, four of whom are private pay individuals and 4 of whom receive Intermittent CILA funding. The letter states that none of the 8 tenants require constant supervision.

In regard to the complaint that residents are unsafe with a change in supervision and that the residents have been inadequately trained to live in unsupervised conditions, the HRA began by reviewing the Warren Achievement Center's Residential Emergency Procedures. The General Emergency Procedure documents indicate that staff members are still involved in the process of the emergency procedures. For example, the emergency procedure for fire states "Any staff person who discovers smoke or fire should pull the nearest fire alarm or alert coworkers and consumers per site specific plans." The emergency for a bomb threat reads "Any staff receiving a threat that a bomb or explosive device has been placed within or near a residential site should notify the on-call staff immediately." In reviewing documents titled "Tornado/Storm Procedures for 1309 East Broadway" and "Fire and Disaster Plan for 1309 East Broadway" (both procedures specific to the apartment complex in question) also still have staff participation involved in the procedures. For example, step two of the tornado/storm procedures states "Staff will take the cordless phone to the designated location in the apartment of office they are at." The fire and

disaster plan has less participation by the staff, but the document does state "Residential staff will be trained in the use of a fire extinguisher and fire suppression techniques." The East Broadway fire and disaster plan also states, as the second step, that "The residential employee or two consumers will go to the house directly to the east to notify the fire department. If no one is home at that house, the consumers or staff will proceed to the next house to the east." This step differs from the staff interview which states consumers will use cell phones to call for assistance.

The HRA also reviewed site meeting notes conducted by a staff member with the consumers. Each meeting consisted of an emergency drill, and also during each meeting, answering the door in a safe way was covered. There was also a review of the consumer's "Go-To Cards" where the staff member noted that they "Answered questions regarding them [Go-To Cards] with each consumer."

The HRA also reviewed a document titled the "Warren Achievement Center Record of Emergency Drill." The records reviewed occurred between 10/1/10 and 10/9/10 at both the East Broadway and East Boston locations. The drills were done on 2nd shift (with the exception of one 3rd shift drill at the East Boston location) and the drills were done for fire, tornado, and bomb (the HRA saw no evidence of a disaster drill completed, which is also on the emergency drill documentation). Each drill document tracks which individuals were involved in the drill, a summary of the drill results, length of time it took to evacuate, and recommendations regarding the procedure. The drills were done by a staff member knocking on each apartment door stating that there was a fire drill or bomb threat. The documents indicated that the staff would go from door to door announcing the drill. During one emergency drill, the summary states that "One consumer asked what to do; another got dressed before coming out." Another drill on 10/1/10 stated that "One consumer had to be rerouted from the community bathrooms, confusing tornado drill with fire drill." The documents indicated that during 4 of the 10 drills reviewed, there was one consumer that was not present for the drill. There was no evidence that there were variations on these drills or that the drills were done without staff being present.

The HRA reviewed the "Adult Residential Consumer Services Manual" which has a revision date of 9/08. In the manual, under the description of the East Broadway location, it states "There is someone there all the time to help you, unless you have team approval to stay home unsupervised for a specified amount of time." The manual also states that there will be site meetings, fire drills, tornado drills, and bomb threat drills. In the section regarding fire drills, it states "Staff will assist you according to your abilities" and "You will be expected to respond according to training and any time the site fire warning system is activated." The other two drills state that when the consumers move into their apartment or home, they will teach the consumer what to do in the emergency.

The HRA also reviewed the incident reports for the East Broadway apartments for the last two years and there were only 4 incidents in that span (8/2/09 - 9/24/09). Each incident written up was minor, such as falling or a consumer accidently cutting themselves while shaving.

The HRA also reviewed masked Individual Service Plans (ISPs) of consumers living in the apartments on East Broadway. The ISPs reviewed were of consumers who were funded and not private-pay consumers. In the goal section of one consumer's plan, dated 3/16/2010, it states

“[Consumer] has some knowledge regarding her ability to respond appropriately to severe weather/natural disasters [Consumer] cannot identify community warning system and describes/demonstrate what to do, cannot describe what to do in the event of a flood, and cannot describe what to do if utilities are out.” The ISP also proceeds to state that "[Consumer] has knowledge regarding household safety. [Consumer] does not know to call for repairs or problems in the household and cannot identify poisonous household products.” The ISP also states that "[Consumer] has limited knowledge regarding her medication [Consumer] cannot report when dosage is not effective - too much or too little, cannot state/demonstrate what to do if dosage is missed, cannot explain the risks of not taking medication and does not know how to take medication properly." Another goal states "Still requires staff assistance with her medication [Consumer] cannot purchase over the counter medication." This ISP does not corroborate the statement made by the staff that the 3rd shift staff only checks the medication and does not administer it. The ISP also states the consumer cannot contain a stove-top fire, use a fire extinguisher, or identify flammable liquids.

In that same ISP, there is a residential safety plan dated 4/19/07, that states that in the event of an actual fire, the consumer “may become stressed and lack good decision making skills. [Consumer] requires staff assistance and direction to remain safe.” The same document states, in the section regarding tornadoes, that the consumer “requires staff assistance and direction to remain safe.” In the most recent ISP, it does state that the individual “[Consumer] has knowledge regarding her ability to respond appropriately in a fire [Consumer] does not know that she cannot use an elevator in the event of a fire.” The consumer has improved in that area according to her ISP.

In another East Broadway consumer’s ISP, dated 3/4/2010, it states that a consumer has knowledge in how to respond appropriately to a fire but does not know how to use an elevator in the event of a fire, cannot call 911 from outside of the home or give correct information. The same consumer also cannot demonstrate how to contain a stove top fire, cannot identify flammable liquid, or cannot demonstrate how or when to use a fire extinguisher. The ISP also states that the consumer cannot use cooking utensils or household appliances safely.

In the profile section of another consumer’s ISP, dated 10/7/2010, it is stated that the consumer “requires assistance and support in order to ensure safety and to develop new skills. Her placement in an Intermittent CILA program is somewhat unstable at this time based upon [consumer] non-compleance [sic] to complete tasks in a timely manner. Efforts are being made to address these issues and [consumer] has made a verbal commitment to become more independent with her schedule. [consumer] and her family have indicated they hare satisfied with her current living arrangement and she will continue to be offered services in the Intermittent CILA program at the present time.” In the comments/discussion section of the ISP, it reads “The IDT discussed concerns with [consumer's] ability to continue residing in an intermittent CILA arrangement based upon increasing non-compliance with completing tasks, coupled with a decrease in the number of hours that staff are present in the facility. During the ISP meeting [consumer] was able to correctly state what she would contact staff at another facility in an emergency but she was not able to state what facility she would contact. [Consumer] had previously been provided with a laminated card containing instructions and telephone numbers for emergencies, but the card cannot be located at this time … The option of moving to a 24-hour

CILA was discussed, to which [consumer] replied, 'No, I wasn't to live where I'm at.' Staff discussed further with [consumer] the expectations of individuals residing in an intermittent CILA and [consumer] agreed to complete required tasks in a timely manner in order to continue living in her apartment." The individual case management report, dated 10/7/2010, states that the consumer "is legally blind and needs assistance when accessing the community for her safety and also for assistance with many independent living skills (This addressed through staff services and allows [consumer] to live in a semi-independent apartment. Through the assistance of … residential staff have implemented recommendations to accommodate [Consumer's] needs. Staff have assisted [Consumer] in making environmental changes to her apartment in order to make life easier for [Consumer] because of her vision. Staff continue to ensure items are places in specific areas where [Consumer] is able to find them easily)."

The final consumer ISP reviewed, has a residential safety plan, dated 4/19/07 that states "In the event of an actual emergency, she may become stressed and lack good decision making skills. [Consumer] requires staff assistance and direction to remain safe." This comment was made in regards to a bomb threat, tornado, and fire. The consumer's newest ISP, dated 3/1/2010, three years after the safety plan, indicates that the individual has increased her understanding on what to do in an emergency situation. The newest ISP states that the consumer can state her name and address, describe the appropriate use of 911, demonstrate what to do if her clothes are on fire, respond appropriately to a smoke alarm, and evacuate when there is a fire among other things. The ISP also states that the consumer cannot describe what to do in the event of a flood or earthquake. This same consumer is not able to contain a stove-top fire, identify flammable liquids, or use a fire extinguisher.

None of the ISPs reviewed indicate that the consumers have no understanding of procedures for dealing with emergencies, only goals to achieve progress in some areas of emergency preparedness.

In reviewing a letter sent to the HRA by Warren Achievement Center staff, it states that the latest an individual moved into the Intermittent CILA was September 2005. The other move in dates for the individuals were 2004, 2001, and 2000. This indicates that, according to the 4/19/07 residential safety plans reviewed above, consumers were living in an intermittent CILA that required "staff assistance and direction to remain safe" in the event of an emergency.

The HRA also reviewed the Inventory for Client and Agency Planning (ICAP) for each masked record. The ICAP is an adaptive behavior tool used to assess children and adults with disabilities. The HRA reviewed ICAP documents for 4 of the individuals residing at the East Broadway apartments. All documents state that the residents live in an Intermittent CILA, but in the "Current Resident" section, two of the documents state "other-Intermittent CILA" in the current residence section, while two of the documents state "semi-independent with staff in building." With clarification from the staff, the HRA discovered this was a carry through from 10 years ago that was never changed for the new reports. In reviewing the ICAP service score on the 4 individuals, one individual received a level 7, which means "limited personal care and/or regular supervision," two individuals received a level 6, which means "regular personal care and/or close supervision," and another individual received a level 5, which means "regular personal care and/or close supervision." Also, based on the ICAP, the age equivalents of the

individuals are 5.25 years, 7.58 years, 8.25 years, and 6.08 years. The HRA recognizes that the ICAP is not the only tool used to determine level of living by the facility and that other input is also involved.

In regard to the complaint that the residents have not been placed in the least restrictive environment when an intermittent CILA was being staffed 24 hours, the HRA reviewed the logs from the East Broadway staff. The logs ranged from 7/31/10 through 10/31/10 and the last entry for 3rd shift was on 8/31/10. In reviewing the 3 shift logs, the majority of the tasks consist of door checks and monitor checks with little, if any, interaction with the consumers. In the morning there is a wake up call and medication is started, which started at 6 am and ended at 8am. The individual working was also going to the Boston apartments several times during the shift and going to the Boston apartments in the morning to assist with medication.

The HRA also reviewed a basic job description for direct care staff (there was no description provided that was site specific) which states that part of the staff's primary function is to "provide care, support, supervision, and training to assigned individuals …"

In regard to the complaint that the agency did not use grant funding for the properly designated purposes, the HRA first reviewed the State of Illinois Department of Human Services community services agreement for the fiscal year of 2009. The agreement has an itemized payment section which has the programs named. The program that was funding the staff member that was let go is titled "Client/Family Support." In the "Scope of Services" section of that document, it is stated that "The Provider will provide the services as described herein and in accordance with all conditions and terms set forth herein and all applicable administrative rules. All programmatic reporting required under this Agreement is described in the Attachment(s) and Program Manual(s)." The document proceeds to list requirements of the provider receiving the grant, but does not state specifically if the grant can be spent on staffing.

The HRA also reviewed another document titled "Developmental Disabilities CSA Attachment A" which states in the introduction that "This document serves as an attachment to the Department of Human Services (DHS) standard Community Services Agreement and sets forth supplemental contractual obligations between the provider and DHS. The attachment provides contractual requirements beyond and in addition to those in the Community Services Agreement and is intended to deal with the programmatic areas of the Division of Developmental Disabilities (Division of DD)." Also, in the "Program Services" area of the document, it states "The Provider agrees that the intended purpose of funding for services for individuals with developmental disabilities is to promote quality of life, functional independence and the health, safety and welfare for those individuals identified as eligible and appropriate for services." The document also states that "The Provider of grant funded services agrees to execute Agency Plan forms provided by the Department and to submit completed forms to the Department when requested and within time frames specified by the Department. The Provider must have an approved Agency Plan on file with the Division of Developmental Disabilities and is required to comply with all conditions and provisions therein."

The HRA also reviewed a description of the grant program from the Department of Human Service's website. The narrative description states that "This program is designed to give

children and adults with developmental disabilities the supports needed to remain living at home in the community with their families or on their own at a semi-independent level. The program is tailored to the individual and the family's needs and provides such services as individual or family counseling, community orientation, transportation, medication review, life skills training, behavioral training and crisis intervention. Most services are carried out in the home."

The HRA also reviewed the CILA Licensure Survey conducted by the DHS for the dates of 10/18/2010 - 10/10/2010. The survey shows the CILA sites to be in 99% compliance with the notes reading "Agency has a very positive reputation. Housing facilities are clean, well maintained and well integrated into the Community … Staff are knowledgeable about the CILA program. Documentation of services is excellent."

MANDATES

The HRA reviewed regulations and requirements regarding the complaints stated in this report. The CILA regulations define "Intermittent Supervision" as "'Intermittent supervision or support.' Supervision or support provided to an individual under the auspices of a licensed agency less than 24-hours per day. When employees are not on-site, supervision or support shall be provided by means of 24-hour on-call availability and by a variety of alternatives or supports, such as non-disabled roommates, paid neighbors, non-paid family members and other formal or informal arrangements" (59 Il. Adm. Code 115.120).

The CILA regulations state that CILAs must provide consumers with a list of their rights upon entering a program, and one of the rights state that "Every individual receiving CILA services has the right to be free from abuse and neglect" (59 Il. Adm. Code 115.250).

The CILA regulations also state that "Evacuation drills are conducted at a frequency determined by the agency to be appropriate based on the needs and abilities of individuals served by the particular living arrangement but no less than on each shift annually" (59 Il. Adm. Code 115.300).

The Mental Health and Developmental Disabilities Code states "(a) A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan" (405 ILCS 5/2-102).

The CILA regulations also state that "The objective of a community-integrated living arrangement is to promote optimal independence in daily living and economic self-sufficiency of individuals with a mental disability" (59 Il. Admn. Code 115.100). The regulations also state "c) Services shall be oriented to the individual and shall be designed to meet the needs of the individual with input and participation of his or her family as appropriate d) 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" (59 Il. Admin. Code 115.200).

CONCLUSION

Complaint #1 - Residents are unsafe with a change in supervision & Complaint #2 - Residents have been inadequately trained to live in unsupervised conditions

The complaint states that residents at the East Broadway Apartment complex are unsafe due to a staff member being terminated from a third shift supervision positions. The Warren Achievement center staff stated that the individual who was terminated was more of an "Umbrella Supervisor" and did not directly participate in the individuals' lives. Basically the individual was just someone for the individuals to call and had duties in the background that were unseen by the individuals. The staff also stated that the individuals had been trained with fire drills, tornado drills, and also have "Go-To" cards attached to their refrigerators. They stated that they still have staff covering all shifts, just not staff in the exact building at all times. Also, that on top of the training, the Fire Department and Police are aware of the situation and both departments have access to keys to get into the building. The HRA reviewed general emergency procedures and saw that the procedures had not been updated since staff was terminated and still included references to a staff member. Also, during the training sessions, there were situations where individuals had difficulties with the drills, such as a consumer asking what to do and another getting dressed before leaving the apartment. Also, in a review of the consumer's masked ISPs, there were some areas of the ISPs where the consumers needed improvement in their skills, such as an area which states the consumer cannot identify the community warning system. The HRA also reviewed the incident reports, which there are only 4 minor incidents in the last 2 years. In accordance with the CILA rate determination sheet reviewed, 5 of the individuals at the complex are considered intermittent and only require 15 hours of direct support staff per week. Although the ISPs indicate that some of the individuals may have issues with the training that was given, the facility is giving the required amount of supervision for intermittent consumers in accordance with the Department of Human Services and the facility is also giving the consumers regular disaster training. Due to these facts, the HRA finds the complaints **unsubstantiated** but offers the following **suggestions**:

- Some of the consumers seemed to have difficulties in certain areas of the disaster preparedness. There are also areas in the ISP that indicate the consumers have difficulties in other potentially dangerous areas, such as a consumer not being able to contain a stovetop fire. The HRA suggests giving these consumers extra education in the areas that they are lacking to assure that they make the correct decisions if an incident were to occur.

- Policy and procedure that was viewed by the HRA was not updated to show that 3rd shift is no longer covered by staff (including the handbook). The HRA suggests updating the policy and documentation to show procedure without the staff.

- Consider varying the drills in a way that does not require the physical presence of staff to better determine how consumers would respond when staff are not present, the need for any additional emergency protocol and consumer training needs.

- The emergency training indicated that staff went to the individual consumers' doors and stated that there was a fire drill but there was no evidence of fire drill training with a fire

alarm. The HRA suggests that the Warren Achievement Center conduct training with the consumers using fire alarms.

- There was no evidence that any educational materials were being used for the safety training other than the "Go-To" cards. The HRA suggests that the Warren Achievement Center create educational materials to give to the consumers describing safety procedures. Also, ensure that educational materials are in a format that is easily understood by the consumers (e.g. pictures or social stories).

- In the staff interview, it is stated that during a fire drill the consumers are to go to a specific area and use a cell phone to call for assistance. In the documented fire and disaster plan, it is stated that consumers go to a specific area and then the staff or two consumers go to a house to call for assistance. There seems to be a disconnect between what policy states is the procedure and what staff considers to be the procedure. The HRA suggests that Warren Achievement Center reviews and possibly updates procedure to assure that the facility is all in agreement on fire and disaster plans.

- The HRA suggests that the consumers are trained on cell phone usage and that proper emergency numbers are pre-programmed into each consumer's cell phone.

Although the HRA did not find the complaint substantiated due to the fact that the Warren Achievement Center seems to be adhering to the regulations set forth by the Department of Human Services, there were some discrepancies that caused concern regarding the level of care needed by the consumers living in the apartment. In reviewing the masked ISPs, some consumers reviewed seemed to have difficulties with disaster preparedness drills as well as problems taking care of themselves with daily living situations. Additionally, the ICAP scoring indicated that 3 of the 4 individuals needed regular personal care and/or close supervision. Lastly, documentation indicates that consumers were living in an intermittent CILA when they could not evacuate from emergency situations without staff assistance, which indicates that perhaps they needed 24-hour supervision. The Human Rights Authority recognizes that our organization is not able to make clinical determinations regarding the judgment and skill levels of consumers and that many elements are involved in determining individual care, but the HRA still feels uneasy about the ability of the individuals living in the East Broadway apartments to live safely with intermittent supervision. The HRA strongly suggests that, given the change in 3rd shift oversight, that documented reviews be conducted of each resident's needs as part of the treatment planning process that includes a clear statement about the appropriateness of the resident's placement and the needed level of supervision.

Complaint #3 - Residents have not been placed in a least restrictive environment when an intermittent CILA was staffed 24 hours.

The complaint states that residents have not been placed in the least restrictive environment when an intermittent CILA, that required 15 hours of supervision per week in accordance with the DHS CILA rate determination model, was staffed for a full 24 hours. The Warren Achievement Center staff stated that the individual who was supervising was an

"Umbrella Supervisor" that performed more invisible services such as checking the doorknobs and helping with medication. The staff stated that the supervisor really did not interact with the residents to the point where it would be considered that the residents are not in the least restrictive environment. In reviewing the logs for the 3rd shift staff, the supervision had very little interaction with residents and the main duties were checking doorknobs, checking monitors, checking medication, and performing wake-up calls. The Mental Health and Developmental Disabilities Code states "(a) A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan" (405 ILCS 5/2-102). In speaking with the DHS, they stated that extra time is permissible. Therefore, the HRA does **not substantiate** the complaint.

Compliant #4 - The agency did not use grant funding for properly designated purposes; grant money designated for consumer interaction was used instead for 3rd shift staff

The complaint states that Warren Achievement Center did not use grant funding for properly designated purposes and that grant money that was designated for consumer interaction was used for 3rd shift staffing. The Warren Achievement Center staff stated that maybe they were spending money on a night watchman with the position, but they did not think that it was a frivolous expense. They also stated that the money was there, so they used it. The staff stated that the DHS gave them grant funding for supports and staff, that the money was more targeted for consumers in the apartments, and that the DHS knew how the funding was being used. The staff stated that they may be aware that they had 3rd shift supervision for the CILA but they may not have known for sure. The staff also stated that every year they would create an agency plan but DHS stopped asking for the plans. The HRA reviewed the grant agreement between DHS and Warren Achievement Center as well as supplemental documentation given by DHS. None of the documentation provided indicates whether the money can be spent on staffing. The description of program 160 does state that "This program is designed to give children and adults with developmental disabilities the supports needed to remain living at home in the community with their families or on their own at a semi-independent level. The program is tailored to the individual and the family's needs and provides such services as individual or family counseling, community orientation, transportation, medication review, life skills training, behavioral training and crisis intervention. Most services are carried out in the home." Also, in speaking with the DHS, they stated that program 160 can be used for staff that provide supports for the clients and reaffirmed that the facility had not had agency plans requested. Due to the fact that the grant money can be used for staffing, the HRA finds this complaint **unsubstantiated.**

The HRA would also like to suggest that, in accordance with the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) that the individuals staying in the facility as private pay have ISPs created for services that they are receiving from the facility. The HRA acknowledges that these are private pay individuals and that the Warren Achievement Center states that they are treating them as though they are renters, but the Center is also providing some minimal services for the individuals such as providing safety and assuring that the individuals have food and medication.