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REPORT OF FINDINGS
UNITED CEREBRAL PALSY of Illinois Prairieland- 12-040-9011
HUMAN RIGHTS AUTHORITY-South Suburban Region

[Case Summary— The Authority made corrective recommendations regarding the allegations that were accepted by the service provider. The public record on this case is recorded below; the provider did not request that its response be included as part of the public record.]

INTRODUCTION

The South Suburban Regional Human Rights Authority (HRA), the investigative division of the Illinois Guardianship & Advocacy Commission, has completed its investigation into allegations concerning United Cerebral Palsy of Illinois Prairieland. The complaint alleged that the agency had failed to provide a safe and sanitary living environment. Additionally, the complaint stated that the guardian was not notified of the resident's hospitalization.

If substantiated, these allegations would be violations of the Mental Health and Developmental Disabilities Code, (the Code) (405 ILCS 5), the Illinois Administrative Code (CILA Rules, 59 Ill. Admin. Code 115), Mandated Reporting to the Office of the Inspector General (59 Ill. Admin. Code 50.20) and the Illinois Probate Act (755 ILCS 5/11).

Located in Joliet, United Cerebral Palsy of Illinois Prairieland manages five (5) Community Integrated Living Arrangements with a total population of 29 residents. This agency also provides day training, educational, respite and family support services to persons with developmental disabilities.

METHODOLOGY

To pursue the investigation, the allegations were discussed with the agency's Director of Adult Services, a Registered Nurse and a Qualified Support Professional. The complaint was discussed with a representative from the Illinois Department of Human Services Office of the Inspector General (OIG) and the guardian. Sections of the adult resident's record were reviewed with written consent. Relevant agency policies were reviewed. Additionally, the guardian provided the HRA with an email from the prescreening agency and a copy of the Office of State Guardian's guidelines regarding situations such as hospitalization that require notification that were not part of the record reviewed.

COMPLAINT STATEMENT

The complaint specifically stated as follows: 1) In February 2012, a bed that had been purchased by a family member on that previous month was stored in the resident's room, posing a hazardous situation. For example, a box spring mattress reportedly was propped up against the wall and was supported by his bed. A broken headboard and footboard were against the wall in an upright position about one foot from his bed. 2) It was reported that the resident had been in the hospital for about four days when an open urinal container with about 1 ½ inches of urine was observed next to the individual's night stand in his bedroom. This by-product reportedly was airborne, and it was later determined to be infected which also placed other consumers in the home at risk. 3) It was also alleged that the agency had failed to provide guardian notification concerning the resident's hospitalization.

FINDINGS

According to the record, the resident lives in a Community Integrated Living Arrangement (CILA) managed by United Cerebral Palsy of Illinois Prairieland. The home has four bedrooms; the resident has six housemates and requires 24-hour supervision. He reportedly has eight staff members who provide him with a safe environment. He was diagnosed with Mental Retardation, Psychosis, Organic Mood Disorder and various physical problems. On Monday, February 13th, 2012, a medical report stated that the resident was admitted to a community hospital's intensive care unit because of low blood pressure, fever and possibly urosepsis. The latter condition is a serious secondary infection which occurs when an infection in the urinary tract spreads to the bloodstream. He reportedly was given fluids and was started on antibiotics intravenously. His blood culture was positive for Proteus Mirabilis, which is bacterium that is usually found in a person's intestinal tract. However, his urinary culture did not show any growth. Later, a Computed Tomography scan revealed a calcified stone in his left ureter and his left kidney was swollen. He required emergency surgery and a stent was placed in his kidney. He was also seen by a general surgeon because of dense stool in his rectum with fecal impaction.

Documentation indicated that the CILA agency notified the guardian about the resident's hospitalization after the community prescreening worker visit to the home on February 16th. An email dated February 17th, 2012 addressed to the guardian from the community prescreening worker detailed her concerns about the visit. She wrote that she had learned about the resident's hospitalization and multiple medical problems during her visit. She noted that the guardian was not notified of the incident in accordance to the Office of State Guardian's policy because the agency assigned Qualified Support Professional (QSP) thought that the treating hospital had done this. She told the guardian that a box spring mattress, a headboard and a footboard were improperly stored in the resident's bedroom. Also, a male urinal with infected urine reportedly had been left in his room for at least four days. The community prescreening worker noted that her concerns also had been shared with the CILA agency.

A follow up email from an agency QSP to the guardian and dated February 24th, 2012 recorded the agency's efforts to correct the problems on the 17th. The QSP wrote that he had submitted a work order for the bed in question to be removed from the resident's room and that appropriate housekeeping and sanitation procedures were discussed with the direct care staff in the home. He also wrote that guardian notification was provided on the 17th, although the

hospital's nurse already had informed the guardian. A corresponding work order documented that the request should be completed within 14 days and that the furniture was placed in the garage on February 22nd. According to the record, the resident returned to the home from the hospital two days later. The HRA found no documentation that the Office of the Inspector General (OIG) was notified about possible neglect. This was confirmed by a representative from OIG, and we were told that the incident did not appear to present substantial risk of harm.

The agency's Director of Adult Services told the HRA that the resident's family member had purchased the bed for the individual a few days before he was hospitalized. However, the complaint stated that the bed had been purchased about a month before the prescreening community worker's visit to the home. The staff person and the guardian confirmed that the bedding pieces had been removed from the resident's room as documented on the work order. The HRA was informed that the resident has a roommate and that urinals are kept in the bathroom. The nurse interviewed disagreed that the urine observed in the urinal was infected as stated in the complaint. She said that the resident was diagnosed with a kidney stone and that he did not have a urinary tract infection according to the hospital's report. Again, we were informed that the QSP had notified the guardian about the resident's medical condition on February 17th, five days after he was hospitalized.

According to the guardian, the ward has been a client of United Cerebral Palsy since 1997, and he was placed in the agency's CILA program in 2005. She said that, when a ward is placed with an agency or facility, the service provider is given a copy of the Office of State Guardian's guidelines concerning injuries and hospitalization that might occur during regular and after business hours. According to the guidelines, when a ward is hospitalized for general or psychiatric treatment, the provider is required to notify the regional office by telephone, fax, email or voice mail, no later than on the following work day.

The agency's "Residential Trainer Duties and Responsibilities" policy outlines tasks such as housekeeping, assisting clients with hygiene and dressing, preparing meals, etc. The agency reportedly does not have a policy concerning cleaning urinals, but they are cleaned with bleach and water daily.

CONCLUSION

Section 5/1-117.1 of the Code defines neglect as the failure to provide adequate medical or personal care or maintenance to a recipient, which failure results in physical or mental injury to a recipient or in deterioration of a recipient's physical or mental condition.

According to the Illinois Administrative CILA Rules Section 115.250 (a) (5), Section 5/2-112 of the Code and the agency's "Human Rights" policy, every recipient of services has the right to be free from abuse and neglect.

According to Section 50.20 of the Illinois Administrative Mandated Reporting Rules and the agency's "Unusual Incidents Procedures" policy,

> (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.
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> (a-4) Screening, delaying or withholding reports of incidents or allegations of abuse or neglect from OIG is strictly prohibited.

The agency's "Unusual Incidents Procedures" policy further states that the employee shall fill out an agency's incident report form immediately after reporting the allegation to his or her supervisor or program director designee. And, the program director will inform the client's parent, guardian or designated representative of serious injury or illness.

According to Section 5/2-102 of the Code and the agency's "Human Rights" policy, 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.

The Illinois Probate Act Section 5/11a-17 states that the personal guardian shall make provisions for the ward's support, care, comfort, health, education and maintenance.

> Section 5/11a-23 of the Act states that every health care provider and other person (reliant) has the right to rely on any decision or direction made by the guardian … to the same extent and with the same effect as though the decision or direction had been made or given by the ward.

The Authority is unable to substantiate the complaint stating that the agency had failed to provide a safe living environment as follows: 1) the resident's box spring mattress was propped up against the wall and was supported by his bed, 2) a broken headboard and footboard were against the wall in an upright position about one foot from his bed, and, 3) the resident had been in the hospital for about four days when an open urinal container with infected urine was observed in his bedroom. This by-product reportedly was airborne and also placed other consumers in the home at risk. Although the Authority does not discount that the complaint issues might have posed a hazardous situation for the resident and his housemates, we have no clear evidence of this. They were reportedly corrected by the agency before the allegations were reported to the HRA. Also, a medical report in the record documented that the resident had a bacteria infection that is usually found in a person's intestinal tract and stools, but he did not have a urinary tract infection. No clear violations of Sections 115.250 (a) (5) of the Illinois CILA Rules, 5/2-112 of the Code or the agency's residents' rights statement were found. However, we

found no evidence in the resident's record that the agency reported the allegations to the OIG as required by law. This violates the Illinois Administrative Code Sections 50.20 (a-1), (a-2) and (a-4).

The Authority substantiates the complaint stating that the guardian was not notified of the resident's hospitalization. The resident's record documented that he was hospitalized on February 13th, and his guardian was informed on the 17th, five days later. The Illinois Probate Act directs that the recipient's guardian should be involved in any decisions which affect the person's well-being. This is also reflected in the agency's unusual incidents policy, which states that the program director will inform the recipient's guardian of serious injuries or illnesses. Although the resident's record indicated that the hospital might have notified the guardian about the resident's hospitalization, the CILA agency has a responsibility to maintain communication with his guardian regarding the individual's medical condition. We conclude that the agency violates Sections 5/11a-17 and 5/11a-23 of the Act and its policy because the guardian was not informed about the resident's hospitalization in a timely manner.

RECOMMENDATIONS

1. Follow the Illinois Administrative Code requirements and the agency's "Unusual Incidents Procedures" policy concerning reporting possible abuse and neglect.

2. Follow the Illinois Probate Act Sections 5/11a-17 and 5/11a-23 and the agency's policy and maintain communication with residents' significant others regarding decisions about the individual's care and well-being.