FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
SOUTHWEST DISABILITIES SERVICES AND SUPPORTS— 12-040-9018
HUMAN RIGHTS AUTHORITY— South Suburban Region

[Case Summary— The service provider did not respond to the Authority's corrective recommendations listed in the report. The public record on this case is recorded below; the case was referred for enforcement.]

INTRODUCTION

The South Suburban Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission has completed its investigation into an allegation concerning Southwest Disabilities Services and Supports located in Chicago Heights. The complaint stated that the agency failed to notify the guardian about the resident's hospitalization. If substantiated, this allegation would violate the Mental Health and Developmental Disabilities Code, (the Code) (405 ILCS 5), the Illinois Administrative Code (CILA Rules, 59 Ill. Admin. Code 115) and the Illinois Probate Act (755 ILCS 5/11).

This agency manages nine Community Integrated Living Arrangements with a total population of about 40 residents as well as a day training center for persons with disabilities.

METHODOLOGY

To pursue the investigation, the HRA conducted two site visits, and the Director of Residential Services and the Program Director/Qualified Mental Retardation Professional were interviewed. The complaint was discussed with the resident's legal guardian and sections of the resident's record were reviewed with written consent. A relevant policy was also reviewed.

COMPLAINT STATEMENT

The complaint stated that the guardian learned that the resident had been admitted to a behavioral health unit when she received a call on June 6th, 2012 from a hospital's employee stating that he had been admitted without any contact information concerning his residential agency. It was reported that notification concerning hospitalization has been addressed with the agency many times.

FINDINGS

The HRA determined that the resident has been a client in the agency's Community Integrated Living Arrangement (CILA) program for about two years. According to a report written by a physician, the resident was admitted to a behavioral health unit on June 5th, 2012. He had been transferred to the receiving hospital for an evaluation. The report stated that the resident had gone "berserk at his group home." He was described as being aggressive, hostile and paranoid. He reportedly believed that his peers were teasing him. He was diagnosed with Schizoaffective Disorder and was discharged back to the agency on June 11th, 2012. There was no documentation that the guardian was notified about the resident's hospitalization found in the limited materials provided by the agency. We also noticed that the agency's assigned Qualified Mental Retardation Professional (QMRP) documented that the resident was seen by his psychiatrist as scheduled on June 7th, although he was hospitalized at the time. And, his hospitalization is not mentioned in her monthly progress note for June 2012.

When the complaint was discussed with the Residential Director, she explained that the staff do not transport clients to the hospital for a psychiatric evaluation or pick them up when they are discharged from the hospital. She said that an emergency packet, which includes a copy of the person's face sheet, medical card, and physician's orders, is sent with the client to the hospital. The staff are instructed to write the Residential Director's contact information on the face sheet again and to call an ambulance for transport. The Residential Director acknowledged that she was not familiar with the agency's policy concerning notification. She said that the staff's practice is to provide guardian notification within 2 to 4 hours after the client is transported to the hospital. The assigned QMRP is responsible for notifying the guardian. The HRA was informed that a certain representative with the Illinois Department of Human Services was notified about the specific incident. The agency does not keep records of phone calls, but individuals who are notified should be documented in the QMPH's note and the incident report.

The HRA requested a copy of the incident report leading up to the resident's hospitalization again, but the Residential Director could not find the book where the incidents reports are supposedly kept. She said that the agency's nurse should have a copy of the incident report. Then, we were informed that the QMRP would have to locate the incident report. The investigation team inquired about the data tracking sheets for June 2012, and we were told that the agency only keeps three months of raw data. The Residential Director further reported that the resident was discharged months ago from his day training program managed by another agency because of behavioral problems. She said that the resident was verbally aggressive and he did not get along with a certain peer. He is presently receiving supportive services from the Illinois Crisis Prevention Network (Support Service Team). This is a network of highly trained professionals, who have partnered with the Department, to work with individuals with severe behaviors and are struggling to maintain in their current home or placement. The resident reportedly is more compliant and attends the agency's day training center.

The agency provided the HRA with an incident report several months after the first site visit. It was completed by a staff person at the resident's day training program managed by another agency on June 4th, 2012. According to the incident report, the resident held a peer (1) against the wall and verbally reprimanded him for upsetting peer (2). The resident reportedly walked away and apologized when the program manager intervened. It stated that the assigned

residential QMRP was notified. We noticed that the incident report does not reflect any further behaviors or that he was transported to a hospital for a psychiatric evaluation.

The complaint was further discussed with the Program Manager, who reportedly has worked at Southwest Disabilities Services and Supports (SWDSS) for 17 years. She also serves as the QMRP for the resident, and she has been the assigned worker since he was placed at the agency. On questioning, she could not recall the reason for the resident's hospitalization, and she did not bring the resident's file with her to the scheduled meeting. We discussed the incident report written by the resident's outside day training program staff. The QMRP suggested that the incident report was relevant to his admission to an inpatient unit on June 5th, but the investigation team disagrees with this. According to the QMRP, she is not familiar with the agency's policy concerning incident reports, hospitalization, and guardian notification. She explained that the residential staff are instructed to call the House Manager, the QMRP and 911 when a resident is aggressive and cannot be redirected. She said that documents such as the resident's emergency contact information accompany the person to the hospital. She said that an incident report is completed. The QMRP is supposed to call the resident's guardian on that same day if the incident happens before 11:00 p.m. otherwise notification will be provided on that next morning. She reported that the agency stated practice is to notify the hospital when a resident is under guardianship because the hospital "cannot do anything" without consent.

The QMRP told the HRA that phone calls are documented in her monthly progress notes and that they are sometimes recorded on her calendar. However, there was no indication that the guardian had been informed about the resident's hospitlization recorded in her monthly note for June. She said that scheduled medical appointments are always recorded in her notes. Upon reviewing the monthly note, she acknowledged that she had erroneously recorded that the resident was seen by his psychiatrist as scheduled on June 7th, although he was hospitalized at the time. She said that the physician's note would have reflected otherwise. On questioning, we were informed that the daily progress notes are integrated into a monthly note written by the QMRP and that the original tracking data sheets for each month are archived for a short period of time and shredded after three or four years.

According to the guardian, the resident said that the police were called to the home after he had refused to get out of the bed because he was not feeling well. He reported that he was taken to a nearby hospital and was later transferred to another hospital. Per the guardian, she learned that the ward had been hospitalized when she received a voice message from the hospital on June 6th, 2012. She said that notification concerning illness and hospitalization has been addressed with the agency many times, but this continues to be a problem with the agency. 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 "Hospital Returning" policy states that clients who need to go to the hospital will be transported by ambulance. They are also returned to the facility using the same mode of transportation upon their discharge from the hospital. The HRA reviewed SWDSS'

policy concerning injuries to program participants. According to the policy, the supervisor on duty or on call will immediately inform the parent/guardian of serious injuries requiring emergency treatment by phone. An injury report will be promptly completed. The policy does not include provisions concerning illnesses or hospitalizations. And, the agency did not provide policies on the above and unusual incidents.

CONCLUSION

According to the CILA Rules Section 115.220 (e) (13) of the Illinois Administrative Code,

> The community support team shall be directly responsible for working with the individual and parent(s) and/or guardian to convene special meetings of the team when there are issues that need to be addressed as brought to the attention of the team by the individual, parent(s) and /or guardian.

Section 115.250 (c) of the Illinois Administrative Code states that,

> Individuals or guardians shall be permitted to present grievances and to appeal adverse decisions of the agency and other service providers up to and including the authorized agency representative.

According to Section 5/2-102 (a) of the Mental Health and Developmental Disabilities Code,

> 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 plan shall be formulated and periodically reviewed with the participation of the resident to the extent feasible and the resident's guardian, if appropriate.

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 substantiates the complaint stating that the guardian was not notified of the resident's hospitalization. We found no written evidence during the investigation that the agency notified the guardian that the resident had been hospitalized on June 5th, 2012. His record also lacked an incident report concerning the circumstances leading up to his admission to

a behavioral health unit. The resident told his guardian that the incident took place at the home. The agency's QMRP suggested that the incident happened at his day training program, although the incident report does not support this or reflect that he was transported to a hospital for a psychiatric evaluation. Although the complaint indicated that the hospital 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. The Illinois Probate Act directs that the recipient's guardian should be involved in any decisions which affect the person's well-being. The agency violates the Code's Section 5/2-102 (a), and Sections 5/11a-17 and 5/11a-23 of the Act.

Based on the complaint, the HRA concludes that there has been some discussion between the guardian and the agency concerning notification pursuant to the Illinois Administrative Section 115.220 (e) (13). We hope that this investigation brings resolution to this issue.

RECOMMENDATIONS

1. The agency must ensure that all resident guardians or representatives are timely notified about incidents that impact the individual's health and well-being pursuant to Section 5/2-102 (a) of the Code, and Sections 5/11a-17 and 5/11a-23 of the Act.

2. Educate staff on guardian notification requirements and provide the HRA with proof of the staff education.

SUGGESTIONS

1. Document in the chart when a resident's guardian or legal representative is notified about significant events such as hospitalization.

2. The Residential Director reported that a named representative with the Illinois Department of Human Services was notified about the specific incident. However, this was not found in the resident's chart reviewed. The HRA suggests that the agency should document in residents' records all communications with outside agencies and others.

3. Ensure that incidents reports are completed.

COMMENT

The Authority notes that this investigation took a long time to complete because Southwest Disabilities Services and Supports was not cooperative. We requested documents many times before a few were provided. At the site visits, we learned that most of the materials such as progress notes, which were never received, are reportedly archived after three months. We noticed that the 10 of 11 policies provided by the agency were not relevant to the complaint issue. However, we mentioned the agency's injury policy in the report to give some reference concerning medical emergencies. The HRA notes that archived materials are still subject to HRA requests and subpoenas.

Because the HRA's investigation process was delayed due to the provider's lack of cooperation in providing records and because the records were only obtained after intervention by the Illinois Department of Human Services and the threat of a subpoena, the HRA finds an additional rights violation related to the HRA investigation process as a whole. The Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/8) states the following:

"In the course of an investigation, or in the course of monitoring issues concerning the rights of recipients or the services provided to recipients as authorized by subsection (l) of Section 5 of the Guardianship and Advocacy Act, regional human rights authority of the Guardianship and Advocacy Commission created by the Guardianship and Advocacy Act may inspect and copy any recipient's records in the possession of a therapist, agency, Department or facility which provides services to a recipient, including reports of suspected abuse or neglect of a recipient and information regarding the disposition of such reports."

The HRA recommends the following:

1. Follow the Confidentiality Act with regard to the provision of records during HRA investigations.