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HUMAN RIGHTS AUTHORITY - NORTHWEST REGION

REPORT 13-080-9004
WILLOWGLEN ACADEMY

Case Summary: the HRA found violations on both counts. The facility made immediate corrections and a response was not required.

INTRODUCTION

The Human Rights Authority opened an investigation after receiving complaints of possible rights violations in the care provided to residents at Willowglen Academy. It was alleged that a legal guardian was not timely informed of injury reports and physical abuse concerning her wards and that an accused employee was not removed from resident contact during any investigation.

Substantiated findings would violate requirements under Rule 50 (59 Ill. Admin. Code 50).

Located in Freeport, this program serves children, adolescents and adults with disabilities. At present Willowglen has a school, Community Integrated Living Arrangements, or CILAs, for children and adults and a day training center for those eighteen years of age and older.

We visited the main office where program leaders were interviewed. Relevant policies were reviewed as were resident records with written consent.

COMPLAINT SUMMA RY

A guardian of two adult residents was visiting another facility in the same community when she was told she should see one of them because he was "beaten up by staff" the day before. She was told he had a fat lip, a bloody mouth and a goose egg above one eyebrow. The guardian visited him immediately to find he indeed had these injuries and that he had reported it to administration and accused a specific employee. The guardian had not otherwise been notified and reportedly learned that the accused abuser was sent to work in another home instead of being removed from contact with all residents.

Another resident was said to have been taken to a hospital with a swollen eye. Although the guardian was notified, the facility reportedly failed to follow up with her on what happened.

We confirmed that the Office of the Inspector General (OIG) investigated abuse claims and did not substantiate them, although a recommendation was made to correct late reporting. This review centers on the guardian notification and accused employee issues.

FINDINGS

Records from the first resident's file included an incident report from September 13th, 2012; the reporter claimed that the resident appeared at the day training center's front lobby that morning with blood on his mouth. Her addendum stated in more detail that the resident came to the front window with a bleeding mouth. The nurse was called to check him out while another worker explained how busy they were at the home and that the injury was not noticed until they got to day training. The resident mentioned a staff member doing this to him and the worker was told to call the OIG.

That worker wrote her addendum as well as stated that she noticed the resident had a fat lip after another resident told her which staff member did it. She made sure her responsibilities with others were taken care of and then rejoined the resident at the front. There was no mention of contacting the OIG.

The first documented reference to reaching the guardian came on September 17th when a program leader wrote in a progress note that she was informed about the incident during a morning meeting on the 14th and added that the nurse was asked to follow up with the resident's guardian. There is no indication of whether that was carried out. Another note from the same writer stated that she also emailed the guardian on the 17th to give her an update. Email trails showed that the guardian made contact first on the 17th asking for information on what happened and the program leader's response apologizing for no prior notification and delay with details. She gave an update on his condition and said that various documentations were forthcoming.

According to an incident report completed by a program leader on September 19th, it was discovered that the incident was never reported and that a call was made immediately to the OIG. Final emails on the subject came from the guardian on September 27th saying she had received incident reports and medical follow ups by then but also mentioning her concern of talking with another program leader when she visited her ward back on the 14th who mentioned that the accused employee was still working in the home.

Records from the second resident's chart included an incident report which stated that a lump was noticed on the resident's face on the way home from day training on September 25th. A nurse wrote that he visited the resident right away, examined him and decided to clear him with a visit to the emergency room. There were no alleged abuses in this case, and the nurse

ended his entry by saying he left a voice message alerting the guardian. Initial hospital reports shortly after his arrival were that it looked like the resident had been hit; Willowglen immediately contacted the OIG. Discharge reports concluded differently however, that it was likely caused by cellulitis and that Keflex was prescribed. Another message was left for the guardian.

The staff we met with at Willowglen explained how they have comprehensive reporting procedures in place but that they collapsed in the first instance. House supervisors and day training staff or other direct care staff are to report alleged abuse to their program leader who then reports to administration. Case managers report to their program leader who reports to the executive director. In other words, there is a chain of command dividing the service and clinical sides and the two leaders collaborate on everything. In this case there was just no follow through after a care worker and a nurse were supposed to make the appropriate contacts. We were told that the care worker who first discovered the resident's injuries is an "as needed" employee who failed to make the appropriate hand-off and complete the CILA communication log, which would have provided a check and balance. The same breakdown occurred with the guardian. Nurses are supposed to assess injuries and determine whether or not to call guardians. In addition, initial incident reports were being revised or delayed which normally go to her. Regarding the accused staff not being removed from the residents, this staff member was moved to another home until the OIG notified them a couple days later after review that there was credible evidence of abuse at which time the staff was put on administrative leave. That was their impression of how to handle it from previous OIG trainings, although this will be handled differently in the future. The care worker is back to her original role since there were no substantiated findings.

Training and supports have been stepped up since the incident. There is increased communication every 24-hour period between supervisors and a report has been developed to record 8:00 a.m. nursing meetings for the administrator's review by 8:30 a.m. Generally staff are trained in abuse and neglect within their first week of hire and annually thereafter. New handouts on Rule 50 have been given out and covered with all staff four times since October. They shared the agenda for a March training that included discussions on Rule 50: what it regulates, what is required of reporters and for reporting, proper contacts within the program and documentation. Mental Health Code topics were included.

CONCLUSION

Willowglen policy on reporting abuse and neglect reflects definitions and requirements as outlined under Rule 50. Any employee must report to the OIG hotline and administrators immediately; four hours is the limit from discovery, and specific chains of command are identified. After the OIG notifies the agency that a report has been received, the guardian shall be notified within 24 hours. Although the policy sets up systems for securing safety, removing accused employees is not mentioned.

Rule 50 states that any allegation of physical, sexual or mental abuse by an employee must be reported to the OIG hotline within four hours of initial discovery. The authorized representative of the agency shall notify the victim or guardian and the accused that an allegation

has been received within twenty-four hours. The representative is responsible for removing alleged accused employees from having contact with individuals when there is credible evidence supporting the allegation of abuse pending the outcome of any further investigation (59 Ill. Admin. Code 50.20). An authorized representative is the agency head or is appointed by a governing body with overall responsibility of program management. Credible evidence is defined as any related to the allegation or incident that is considered believable and reliable (59 Ill. Admin. Code 50.10).

Here the facility admits that although they have appropriate abuse reporting procedures in place, they just were not followed through in the first case. A care worker was told to call the OIG but there was no verification of having done that. Likewise, a nurse who examined the resident's injuries was told to call the guardian, and again there was no verification of having done that. The staff told us that the accused employee should have been completely removed from any resident contact sooner and that will be there intent in the future. Willowglen identified and corrected the problems immediately, and has enhanced abuse/neglect training with all staff on a more frequent basis. There was nothing to say that appropriate reporting was not provided in the second case. Although there were substantiated violations in the first, we believe the facility has appropriately and thoroughly addressed the issues.

SUGGESTIONS:

A resident with visible injuries and two residents accusing the same employee is more than enough "credible evidence" to remove an accused employee from contact with all residents pending any investigation. This should be added to policy specifically.

Willowglen prefers not to designate an "authorized representative" allowing the OIG instead to direct all instances of reported abuse and investigations. We encourage the program to designate one nonetheless so there is a go-to person for ensuring all requirements are met and for when the OIG asks the facility to conduct any future investigations.

The policy on notifying guardians twenty-four hours after OIG notifies that it has received a report is confusing. The standard under Rule 50 is that the agency notifies within twenty-four hours of receiving a report.