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HUMAN RIGHTS AUTHORITY- CHICAGO REGION

REPORT 14-030-9027
South Chicago Parents and Friends

Case summary: The HRA substantiated that the facility left a recipient outside the building in a van from 8:30 a.m. until 2:00 p.m. however the HRA finds that staff reported the event within the OIG mandated timeframe for notification. The HRA recommended that the facility revise the policy and procedure to clarify each step in the custody chain for recipients arriving and departing from the facility and to train the staff in this procedure. The facility agreed to this recommendation.

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving a complaint of possible rights violations at South Chicago Parents and Friends (SCPF). It was alleged that the facility left a recipient outside the building in a van from 8:30 a.m. until 2:00 p.m. and did not notify the recipient's guardian of the event until the following day. If substantiated, these allegations would be violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.) and the Illinois Probate Act (755 ILCS 5/11a-17 and 5/11a-23).

South Chicago Parents and Friends is a non-profit organization that provides services to adults with intellectual and developmental disabilities. Approximately 450 individuals are served at SCPF with 330 in home based programming and 180 at the facility day program.

To review this complaint, the HRA conducted a site visit and interviewed the Executive Director and the facility's Manager of Quality Enhancement and Training/OIG (Office of Inspector General) Liaison. Facility policies were reviewed, and the recipient's clinical records were reviewed with written guardian consent. The guardian's Court Order for Guardian of the Person has been entered into the record.

COMPLAINT

The complaint indicates that the recipient is a member of a group home in Chicago and she also attends the SCPF workshop during the day. The staff at SCPF transport the recipient from the group home to the workshop. On 4/29/14 the complaint alleges that the recipient was left in the van outside the workshop from 8:30 a.m. until approximately 2:00 p.m. when she was found by facility staff. No staff person at SCPF called the recipient's guardian until the day after the event, although the staff contacted the police immediately after the event and then contacted the staff at the workshop.

FINDINGS

The record contains the recipient's ICAP (Inventory for Client and Agency Planning) document which indicates that she requires "extensive personal care and/or constant supervision", with an overall age equivalent on adaptive behavior of three years and one month. The recipient lives in a CILA (Community Integrated Living Arrangement) and has attended the SCPF day program five days per week since 6/21/07.

The record contains an *Unusual Incident Form* completed by a DT (Developmental Trainer) staff immediately after the incident. It states, "As I was about to leave for the afternoon van run, I boarded the van and noticed that a consumer was already on the van. I asked another staff that was out there at the time did she put the consumer on the van or knew that she was on the van. I helped the consumer off with the assistance of the other staff member and told my supervisor of my findings." The date and time of the incident is recorded as 4/29/14 at 2:00 p.m. The report describes the action taken after the event by the Program Manager/QIDP (Qualified Intellectual Disabilities Professional): "Upon report DT Coordinator phoned [group home], 911, the executive director, and the OIG Liaison. DT staff escorted consumer back into building consumer was given water ate her lunch with staff supervision." The form is signed by the reporting staff member and the OIG Liason. The follow-up section of the report is written by the Program Manager and states, "Upon report DT staff brought consumer in building, consumer appeared fine, ate her lunch. DT Coordinator phoned [group home director], 911, executive director, [OIG Liaison], further investigation will be done. When paramedics were called stated do not come out unless it is an emergency and transport needs to be done. [Group home director] was notified she in turn notified medical coordinator, DT staff transported consumer to [hospital] estimated time 2:00 – 2:45 p.m." There is no space or cue to indicate the notification of parent/guardian on the *Unusual Incident Form*.

The record contains the written statements of all the staff involved in the incident. The investigation revealed that the driver of the van arrived at the facility and checked the van. When he did not see anyone remaining, he signed the log book and then locked the van and entered the building. A staff person entered the van at 2:00 p.m. and heard the recipient making a noise. Staff then recognized the recipient two seats behind the driver's seat. She was alert and responsive. Staff believed that the recipient had fallen asleep in her seat and was not noticed when everyone departed from the van. It is noted in the record that the recipient suffered no injuries. It is also noted that the recipient's guardian was not notified by the SCPF staff until the following day.

Facility Representatives' Response

SCPF staff were interviewed about the complaint. They reported that when the van arrives at the building to drop off the recipients, the driver or in this case, an Aide, is trained to enter the van and physically account for each recipient, noting the time in which they arrived. Another log inside the building is also completed for each person's arrival and departure times. At 10:00 a.m. the supervisor then checks the attendance log as a back-up of the van log. In this event, although a log was completed for the recipients, the staff person checking the van did not physically enter the van and ensure that everyone was off. It is assumed that the recipient had fallen asleep in her seat and was not visible when the cursory check was made. Additionally, the supervisor who then reviewed the arrivals and departures, did not check to determine whether the recipient was in attendance. At 2:00 p.m. another staff person entered the van to begin the afternoon departures and noticed the recipient. Staff indicated that the recipient did not appear to have been affected by the event.

Staff members indicated that generally the Program Manager will contact the parent/guardian immediately after an incident. They stated that if this isn't clear in the policy and procedure they will review and revise the policy so that they are trained to contact parents/guardians as soon as they are aware of an incident. In this case the Program Manager contacted the CILA staff, the executive director, the OIG Liaison, and then called for emergency 911 services. Paramedics reported to staff that they would not respond unless there was an emergency and the recipient was taken to a hospital emergency room for assessment. The CILA staff met the recipient at the hospital after SCPF staff transported her there. The OIG Liaison then called the guardian the following morning at approximately 10:00 a.m. and reported the event.

STATUTES

The Mental Health and Developmental Disabilities Code defines neglect as "the failure to provide adequate medical or personal care or maintenance to a recipient of services, which failure results in physical or mental injury to a recipient or in the deterioration of a recipient's physical or mental condition" (405 ILCS 5/1-117.1). The Code also states, "A recipient of services shall be provided with adequate and humane care in the least restrictive environment, pursuant to an individual services plan. The plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian." (405 ILCS 5/2-102).

OIG regulations (59 Ill. Admin. Code 50.20 (c) (2) (B)) describe the timeline for reporting allegations of abuse or neglect to the guardian of a recipient. It states: "Within 24 hours after notification of an allegation, the authorized representative of the community agency or facility shall notify the victim or guardian (if applicable) and the accused employee that an allegation has been received. If the authorized representative or designee is unable to reach the guardian by phone, a letter of notification shall be sent within 24 hours."

The Illinois Probate Act of 1975 defines the duties of the guardian:

"To the extent ordered by the court and under the direction of the court, the guardian of the person shall have custody of the ward and the ward's minor and adult dependent children; shall procure for them and shall make provision for their support, care, comfort, health, education and maintenance, and professional services as are appropriate….The guardian shall assist the ward in the development of maximum self-reliance and independence." (755 ILCS 5/11a-17a).

Also, the Probate Act gives direction to providers to rely on guardian decision making:

"Every health care provider…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." (755 ILCS 5/11a-23).

PROGRAM POLICY

SCPF provided the facility policy and procedure for Transportation Check In and Out Logs. It states, "Upon van arrivals via south entrance, DT will log arrival time for each consumer on the check in/out log and initial each consumer's time. A time must be logged for each consumer- lines drawn down are not sufficient. At 10:00 a.m., QIDP/Coordinator – Transportation will then verify that the individuals marked absent on the building check in were not on the morning transportation system. After ensuring all consumers have arrived and are in the building and accounted for, the QIDP/Coordinator- Transportation will then initial each van route under the corresponding date…."

SCPF provided the facility policy for reporting abuse/neglect allegations. It states, "It is the policy and responsibility of South Chicago Parents and Friends, Inc. to report all allegations of abuse/neglect and deaths to the Office of Inspector General in the Illinois Department of Human Services within the required time frames in an appropriate and thorough manner. All employees, which includes owners, operators, contractors, subcontractors, and volunteers of South Chicago Parents and Friends, Inc., shall adhere to the standards set forth in this policy directive. Nothing in this policy directive precludes the agency's responsibilities as outlined in Illinois Administrative Code, Chapter 1, Title 59, Part 50, herein referred to as 'Rule 50'." The policy defines "neglect" as "An employee's, agency's, or facility's failure to provide adequate medical care, personal care, or maintenance, and that, as a consequence, causes an individual pain, injury, or emotional distress, results in either an individual's maladaptive behavior or the deterioration of an individual's physical condition or mental condition, or places an individual's health or safety at substantial risk of possible injury, harm, or death."

SCPF provided policy for the reporting of incidents involving abuse, neglect and financial exploitation. It states, "If an employee witnesses, is told of, or suspects an incident of physical abuse, sexual abuse, mental abuse, financial exploitation, neglect or a death has occurred, the employee or agency shall verbally report allegations to the OIG Hotline. The employee or agency shall report the allegation immediately, but no later than the timeframe specified herein [within four hours after the initial discovery of an incident]. Employees will follow up with an unusual incident form within ½ hour of reporting the allegation to the Program Manager. The agency shall then ensure that allegations of abuse, neglect, and deaths are

reported to the OIG Liaison in a timely manner so as not to unduly delay or compromise the investigation. The OIG Liaison will notify the Director of Program Services and Supports, who will notify the Executive Director, if necessary. The OIG Liaison will contact the parent/guardian and, if necessary, the residential provider of the alleged allegation." Policy dictates that Liaison must notify the guardian of the allegation within 24 hours. If staff is unable to reach the parent/guardian, a letter of notification shall be sent within 24 hours.

CONCLUSION

The facility documentation confirms that the recipient was indeed left in a van from 8:30 a.m. until 2:00 p.m. on 4/29/14 while in the care of SCPF. It is also confirmed that the staff at SCPF contacted the recipient's mother/guardian the morning after the event at approximately 10:00 a.m. This complies with OIG regulations for guardian notification of allegations of abuse and neglect. The HRA does substantiate that the facility left a recipient outside the building in a van from 8:30 a.m. until 2:00 p.m. however the HRA finds that staff reported the event within the OIG mandated timeframe for notification.

RECOMMENDATIONS

1. Revise the policy and procedure to clarify each step in the custody chain for recipients arriving and departing from the facility. Train staff in this procedure.

SUGGESTION

1. Revise policy and procedure and train staff to notify parents/guardians immediately after any unusual event and include a space on the *Unusual Incident Form* for notification of parent/guardian.