FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
ELISABETH LUDEMAN DEVELOPMENTAL CENTER- 14-040-9011
HUMAN RIGHTS AUTHORITY- South Suburban Region

INTRODUCTION

The South Suburban Regional Human Rights Authority (HRA) has completed its investigation into allegations regarding Elisabeth Ludeman Developmental Center (ELDC), a state-operated facility located in Park Forest. The complaint stated that a resident was moved back to the same home after she was physically attacked by her housemate. The complaint alleged that the facility will not provide the guardian with incidents reports. Additionally, it was alleged that the resident's right to communication with persons of choice is being restricted. If substantiated, these allegations would be violations of the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/100 et seq.), the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/4) and the Illinois Probate Act (755 ILCS 5/11a-17 and 5/11a-23).

ELDC has forty four homes with a census population of 417 residents. This facility provides a wide range of services to persons with disabilities who have severe medical and/or behavioral health needs.

METHODOLOGY

To pursue the complaint, the Facility Director, the Medical Director and a Qualified Disability Professional were interviewed. The complaint was discussed with the resident and her guardian. Sections of the adult resident's record were reviewed with written consent. Relevant policies were also reviewed.

The HRA was provided with a copy of the plenary Guardianship Order, dated June 4th, 2002, that was not part of the record review. This order appoints the resident's mother as guardian over her personal care and finances.

COMPLAINT STATEMENT

The complaint stated that the resident was moved back to the same home after she was physically attacked by her housemate. It was reported that the facility's safety plan is not working because there has been more incidents involving physical violence since she was returned to the home. The complaint stated that the guardian had requested copies of incidents reports, but the facility's Medical Director told her that the documents belong to the facility. Additionally, the complaint stated that a staff person told the guardian that she could only call the resident once a day.

FINDINGS

<u>Information from the record, interviews and program policies</u>

The HRA determined that the resident was admitted to ELDC in 2013 and was diagnosed with an Intellectual Disability. She was placed in the facility's short-term program at intake and has a discharge goal of returning to the community. Her communication skills to adequately

meet her needs are reportedly very good. In response to the complaint, the resident's record contained incidents reports documenting verbal and physical aggression with housemate A. We found letters addressed to the Facility Director from her guardian documenting her concerns about the resident's safety in the home. We also reviewed documentation such as progress notes stating that the resident had provoked her housemates and especially housemate A prior to some of the incidents.

The first letter written by the guardian dated October 27th, 2013 indicated that she had talked to the Facility Director about a physical altercation between the resident and housemate A that had occurred on that previous month. Subsequently, she reportedly was informed that a meeting was held and that a safety plan was developed. The plan included keeping the resident and housemate A at arm's length from each other at all times. She wrote that the safety plan was not working because the resident was choked and punched on October 23rd. Also, she sustained a scratch on her finger and hair loss, and housemate A threw a remote control at her. According to the letter, the resident was afraid to go to sleep because her housemate was going to kill her. Per the letter, the guardian requested a written response regarding her concerns or she would seek other alternatives to keep her safe. Her letter further documented that she had never received copies of incidents reports previously requested. Again, she requested incidents reports and expanded her record request to include medical reports, safety plans, and written reports concerning her weekly and now bi-weekly phone conferences with the staff.

A second letter written by the guardian dated January 10th, 2014 indicated that the resident was moved to another home on the facility's campus but was placed back in the home with housemate A who had allegedly attacked her. Per the letter, she was moved back to the home because of a physical altercation that started when housemate B ran the mop over her feet twice on January 6th. The guardian wrote that she did not agree with the decision above because the resident was trying to defend herself during the incident. She also objected to the resident being returned to the home because two safety plans reportedly had failed to protect her from housemate A who was described as being extremely difficult to control and violent. According to a corresponding injury report, the resident told the staff that housemate B was mopping the floor and "hit" her with a mop. The resident responded by leaving the room and returning with a broom but was able to follow redirections to put the object down. She then started hitting her housemate and her housemate punched her back. She reportedly sustained bruises on her arms and her housemate had scratches on her face. The resident's guardian was notified on that same day.

According to a progress note, the resident was upset on the evening of January 15th, 2014, and she refused medication several times when offered. Her mother called the home but changed her mind about talking to the resident after she was informed about her inappropriate behaviors. She told the staff person that she would call the resident later. It was documented that the resident became very abusive toward the staff. She started "taunting" her housemates and threatened to inflict bodily harm on them. She was reminded about the home's rules; she then started slamming doors and was asked to go to her room.

A third letter written by the guardian dated January 16th, 2014 indicated that housemate A had started calling the resident [inappropriate] names a few days after she was moved back to the home. The guardian wrote that housemates A and C had threatened to beat the resident until she was dead and that the staff had to intervene to keep housemate A from attacking her. The letter

documented that the guardian had requested a meeting with the Facility Director to discuss her concerns and that she wanted the staff to take immediate steps to protect the resident. However, the HRA found no clear indications during the record review that the Facility Director met with the guardian or steps taken to prevent further harm to the resident.

On January 17th, 2014, a staff person wrote that the resident's mother had called the home, and that she heard the resident telling her mother things about her housemates that were not true. When her phone time ran out, she said that she hated everyone in the home and started taunting her housemates and calling them names. She was informed about the home's rules and started slamming doors and went to her room as requested. On January 21st, another note stated that the resident's mother came to the home at 10:55 p.m., and she observed injuries on the individual from an incident that had occurred on the previous shift. She reportedly took the resident home with her after talking to the Residential Services Supervisor and a nurse about her injuries.

According to a corresponding injury report, the resident kept "picking" on housemate A and refused to go to her room as requested by the staff. She reportedly started screaming and throwing objects and the staff had to intervene to keep her from hitting her housemate. She then began scratching her arms and banging her head and refused to allow the nurse to examine her. A second injury report stated that the resident said that a staff person was physically abusive toward her during the incident above. It was documented that the allegation was reported to the Office of the Inspector General and that the facility had conducted an internal investigation.

A fourth letter written by the guardian dated February 23rd, 2014 indicated that housemate A choked, scratched, slapped, and pulled out some of the resident's hair on January 21st. Her housemate also pushed the resident on or around February 15th. According to the letter, the guardian had requested that 1:1 staff support should be added to her safety plan for as long as she remained in the home. She wrote that the resident was close to completing the program discharge requirements and that the intervention would also help her to stay focused on her goals. Again, the guardian requested a meeting with the Facility Director to discuss her concerns because she reportedly had never met with her as requested by letter dated January 16th. Also, the guardian referenced that she did not return her two phone calls after she wrote the letter. Three days later, an injury report indicated that housemate A had pulled out some of the resident's hair during a physical altercation. She reportedly was given Motrin for pain and her guardian was notified.

A fifth letter written by the guardian dated March 7th, 2014 indicated that housemate A had exhibited the hair pulling behavior again on the 5th. Per the letter, the guardian questioned why housemate A was so close to the resident and asserted that the staff were not following the safety plan. She mentioned that the resident had missed four days at her day training program because the assigned facility's Qualified Disability Professional told her that she could not attend the program if she was on restriction. The guardian's letter further documented that the resident's rights were being violated because she was not allowed to make or receive phone calls from March 2nd thru the 8th, 2014. According to the letter, a staff person told the guardian that the resident's right to communication phone was restricted for 48 hours. Then, she was informed that the restriction was for one week. The guardian referenced that privileges shall be suspended for 48 hours for maladaptive behaviors, according to the program rules, and shall resume pending no maladaptive behaviors. According to the letter, the guardian asked for clarification of the facility policy on restrictions. However there were no indications about a phone restriction or that the policy was clarified found in her record.

When the complaint about the resident's safety was discussed with the staff, the HRA was informed that the resident is still living in the same home. The facility has two homes for short-term admissions (one for males and one for females). The investigation team took a tour of the home, which had previously consisted of both males and females, and a door had been installed to keep them separated in the home. We note that the resident's bedroom is located in the back of the home and that housemate A's bedroom is in the front of the home. There is a bathroom with a shower on both sides of the home. According to the staff, the resident and her housemate are supposed to stay 3 ½ feet from each other, and they should only have contact during meals. We were told that neither resident were presently being provided with 1:1 staff support but have sporadically received this kind of intervention. It was reported that the residents have not engaged in any recent serious behavioral incidents with each other. The staff said that the guardian believed that the resident had been provoked during the behavioral incidents and that another state facility placement was offered. They also said that the resident has to be reminded about the safety plan because sometimes she wants to be friendly with her housemate.

The staff further reported that the resident is receiving services from the Crisis Intervention Program, which is a new program for higher functioning people with serious behaviors. This team consists of professionals and their main priority is to stabilize and to ensure a successful transition back into the community. According to the staff, the guardian's concerns are still being addressed weekly by telephone, and the Crisis Team provides her with a copy of every conference discussion. They reported that the resident was hospitalized on or around June 2014 and that she is doing better following the program rules. The facility will soon be sending out referral packets for a Community Integrated Living Arrangement program for the resident. We were told that the facility has recently discharged about seventeen residents to the community and that follow up services is provided when they leave. According to the Qualified Disability Professional, the guardian seemed happy about the services being provided when he talked to her on the site visit day.

The guardian's account of the allegations mirrored her letters previously mentioned in the report. She said that the Facility Director told her that the resident should have never been moved to another home as indicated in her letter dated January 10th, 2014. The guardian later agreed with the staffs' report that serious behavioral incidents between the resident and her housemate are no longer an issue. The resident told the investigation team that housemate A sometimes will try to start a fight or argument with her and will do the same thing with another housemate when she refuses to comply. She said that she is looking forward to moving into the community. She also said that the staff person who had allegedly abused her on January 21st, 2014 was removed from the home and that she does not want her to come back. The Qualified Disability Professional reported that he believes that the incident was unfounded by OIG and that the staff person is working in another home.

Regarding records, the Facility Director explained that guardians are notified by phone of incidents and injuries. She said that some guardians want to be notified of serious injuries and some of them about all injuries. This issue reportedly is discussed at the resident's annual staffing. We were informed that the guardian did not request copies of incidents reports as stated in the complaint. We note that the guardian had requested copies of all incidents reports and other documentation in the resident's chart, according to her letter dated October 27th, 2013 previously mentioned in the report. According to the Facility Director, guardians can get incidents reports through her upon their request, but she would prefer that they do not ask for

copies of all incidents reports. The guardian subsequently reported that the facility did provide some incidents reports. However, she did not know that she could request copies of all incidents reports until she was informed by the HRA. She said that she might expand her request for all incidents reports.

Regarding communication, the staff explained that there is a phone schedule for the nine residents in the home. Residents can make calls on the house phone on Tuesdays and they are allowed to make calls on other days if requested. They are allowed to receive calls at any time and calls are limited to fifteen minutes. Per the staff, the guardian was not informed that she could only call the resident once a day. However, a staff person told her that the resident could not talk on the phone when she had called one day. The staff person reportedly was verbally reprimanded by her supervisor. The staff denied that the resident was placed on a phone restriction as stated in the complaint. The HRA noticed that the guardian's letter dated March 7th, 2014 also mentioned a phone restriction. The resident told the investigation team that she can only make calls on Tuesdays and that calls are limited to fifteen minutes. She disagreed with the staffs' report that residents can make calls if requested on other days. There were no phone restriction notices found in her record.

ELDC "Rights of People Receiving Services" policy states that the facility is responsible for protecting and affirming the rights of its residents pursuant to the Mental Health and Developmental Disabilities Code.

The facility's "Injury Reports" policy states that clients will be provided with a safe environment in which the risk of injury is minimized. An injury report shall be completed for all injuries even if the injury does not occur on the facility's campus. The policy includes procedures for reporting injuries such as notifying the Residential Services Supervisor and the nurse within 10 to 15 minutes after observing them. It directs the staff to provide as much information as possible about the injury in the report's comment section. There was no mention of guardian notification.

According to ELDC "Clinical Records" policy, a resident's clinical record will be made available to the individual, parent, guardian or advocate upon their requests. It states that staff are available to answer questions during the record review.

The facility "Management of Maladaptive Behavior" policy states that residents have the right to receive visitors, mail, and to make and receive calls unless the Interdisciplinary Team (IDT) makes a determination that a restriction is necessary pursuant to the Mental Health Code. The policy does not mention how many calls, the duration, and days to make calls. According to the facility's rights statement, residents and guardians are informed whenever rights as identified in the Code are restricted. They are informed about how to appeal the facility's decisions.

CONCLUSION

According to Section 5/2-102 (a) of the Mental Health 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.

Section 5/2-103 (c) of the Code states that,

> Unimpeded, private and uncensored communication by mail, telephone and visitation may be reasonably restricted by the facility director only in order to protect the recipient or others from harm, harassment or intimidation, provided that notice of such restriction shall be given to all recipients upon admission.

Section 5/2-201 of the Code states, whenever any rights of a recipient of services are restricted, the recipient and guardian shall be promptly given notice of the restriction.

Section 5/3-211 of the Code states that,

> Whenever credible evidence indicates that another recipient is the perpetrator of the abuse, his or her condition shall be immediately evaluated to determine the most suitable therapy and placement, considering the safety of the recipient and others.

According to Section 110/2 of the Mental Health and Developmental Disabilities Confidentiality Act,

> Record means all records and communications, except for the therapist's personal notes, kept by an agency in the course of providing mental health or developmental disabilities service to a recipient and the services provided.

Section 110/4 states that,

> The parent or guardian shall be entitled, upon request, to inspect and copy a recipient's record. Whenever access or modification is requested, the request and any other action taken thereon shall be noted in the recipient's record.

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

Section 5/11a-23 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 complaint stated that a resident was moved back to the same home after she was physically attacked by her housemate. The resident's record contained letters written by her guardian, injury reports and progress notes documenting verbal and physical aggression between the individual and her housemate. Although a safety plan reportedly was developed to protect the resident, the staff said that the resident did not always follow the safety plan because sometimes she wanted to be friendly with her housemate. She was moved to another home but was placed back in the same home after having a physical altercation with another housemate. According to the staff and progress notes, the resident was sometimes the aggressor during the behavioral incidents with her housemates. However, the guardian does not agree with this. The Authority cannot substantiate that the resident's rights were violated as presented in the complaint above. We found no clear evidence that the staff did not follow the safety plan. No

violations of Sections 5/2-102 (a) of the Mental Health Code and 5/3-211 or program policy on injuries were found.

The guardian's letters further documented that she had requested a meeting twice with the Facility Director. Although phone conferences were reportedly held with guardian, there were no indications of a meeting found in the record. The guardian subsequently told the investigation team that the Facility Director did meet with her after she had called the Department. No clear violations of the Illinois Probate Act were found.

The complaint alleged that the facility will not provide the guardian with incidents reports. The first letter written by the guardian dated October 27th, 2013 indicated that she had previously requested copies of incidents reports. Again, she requested incidents reports and included other documents in her request. The Facility Director told the HRA that guardians can receive copies of incidents reports upon their requests, but she would prefer that they do not request all of them. The guardian reported that she did receive copies of incidents reports after the HRA had met with the staff. The Authority substantiates that the guardian was not provided with incidents reports upon her request. This violates Section 110/4 of the Confidentiality Act and program policy on records. According to the Facility Director, the Director of Medical Records places a form in the resident's chart when a request for records is received. She said that the records are provided if a signed release is included with the request.

The complaint alleged that the resident's right to communication with persons of choice is being restricted. The HRA does not discount that a staff person told the guardian that she could only call the resident once a day. However, we found no evidence of this during the investigation or any restriction of rights notices concerning communication. The Authority cannot substantiate the complaint as presented above. However, the staff reported that the guardian was told that the resident could not talk on the phone when she had called one day. This violates Sections 5/2-103 (c) and 5/2-201 of the Code, and program rights and maladaptive behavior policies, but the matter was immediately corrected when discovered by management.

RECOMMENDATIONS

1. Follow the Mental Health and Developmental Disabilities Confidentiality Act Section 110/4 and the facility's Clinical Records policy.
2. Document all requests for access to records in residents' charts.
3. The facility shall follow its Rights of People Receiving Services and its Management of Maladaptive Behavior policy whenever any rights are restricted.

SUGGESTIONS

1. The Code states in Section 2-103 that reasonable times for telephone use may be established. Fifteen minutes in a person's own home is anything but reasonable regardless of the number of housemates. While juggling multiple callers at once is certainly difficult, the Code under Section 2-202 states that policies and procedures may amplify or expand but shall not restrict or limit the guaranteed rights within. The program can be more creative in accommodating everyone. We also noticed that the staff reported that residents are allowed to make calls on Tuesdays and possibly other days. Be sure to follow Section 2-103 that permits residents to make calls on any day.
2. Best practice dictates that the Facility Director should meet promptly with a resident's guardian concerning all treatment issues if requested.

3. The Facility Director is reminded that the Mental Health and Developmental Disabilities Confidentiality Act overrule her preference that guardians do not ask for copies of all incidents reports.

4. Consider revising the facility's Injury Reports policy to include guardian notification.

COMMENT
The Authority was informed that resident A was physically aggressive toward the resident and a staff member in separate incidents after the HRA's site visit. The facility is reminded to follow Section 5/3-211 of the Code.

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, some provider responses appear verbatim in retyped format.

RE: Response to recommendations and suggestions provided by the Guardian & Advocacy Commission on case HRA No. 14-040-9011.

Recommendations:

1. The Ludeman Center is obligated to do so accordingly to DHS/ELC Policy & Procedure.
2. The Records Administrator has created a recording system to track all record review requests.
3. The Facility has and will continue to follow its policies and procedures as it pertains to the rights of the persons served and any maladaptive behaviors.

Suggestions:

1. There are no longer specific time limits (this does not override specific behavior intervention plans) Note: ALL residents must be mindful/courteous of his or her peers as all are aware the home is shared with others and their rights must be respected as well. This is no different than sharing space with others in the community. I.E. Dorm Rooms, Shared Apartment Space, CILA Homes etc.
2. The Facility Director can at his/her discretion designate others to act on her behalf. As the policy states The Center Director or his/her designee.
3. The Facility Director objects to this assumption. The Facility Director does not have a preference and has not expressed a preference as it pertains to what a guardian can or can't ask for. Policy & Procedure dictates actions taken by the Facility Director.
4. The policy was reviewed and no revisions are warranted at this time. Guardian notification is listed at the top left hand corner of the required Injury Report document. On this document whom notified is documented, whom completed the notification is listed, the time of notification is listed and how notification occurred either by phone, mail or other. This has always been Ludeman's procedure as it pertains to guardian notification.