FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
HEART TO HEART SERVICES, INCORPORATED 16-040-9001
HUMAN RIGHTS AUTHORITY—South Suburban Region

[Case Summary— The Authority made four corrective recommendations regarding the allegation presented below that were not accepted by the service provider. The public record on this case is recorded below; the case was referred for enforcement.]

INTRODUCTION

The South Suburban Regional Human Rights Authority (HRA), the investigative division of the Illinois Guardianship & Advocacy Commission has completed its investigation into an allegation concerning Heart to Heart Services, Inc. The complaint stated that the agency impeded a resident's and her guardian's right to communication. If substantiated, this allegation would violate the Illinois Administrative Code (CILA Rules) (59 Ill. Admin. Code 115.100 et seq.), the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/100 et seq.) and the Illinois Probate Act (755 ILCS 5/11).

Located in Orland Park, this agency manages at least one Community Integrated Living Arrangement and provides various services such as day programming to elderly persons.

METHODOLOGY

To pursue the investigation, the complaint was discussed with Heart To Heart Services' Director. The complaint was discussed with the resident's guardian and sections of the resident's record were reviewed with written consent. Relevant agency policies were also reviewed.

The Direct Support Person involved in the incident was not fully cooperative with the investigation and refused to meet in-person with the HRA's investigation team.

COMPLAINT STATEMENT

The complaint stated that the guardian was denied access to the resident when she went to the home on August 7th, 2015. It was reported that a staff person told the guardian that she should have called prior to her visit.

FINDINGS

The resident's services plan dated April 20, 2015 indicated that she lives in a Community Integrated Living Arrangement (CILA) managed by the agency. She shares a four bedroom tri-level home with four housemates. Her diagnoses include a seizure disorder and her gait is sometimes unsteady. Her record contained a copy of the Illinois Department of Human Services— "Rights of Individuals" signed by her guardian. Her plan documented that supports and services provided were appropriate to meet her needs. It stated that the guardian would advocate for the resident when her services plans were reviewed.

The agency's Director first responded to the complaint by letter dated September 28th, 2015. She wrote that the resident's guardian was asked to leave the CILA shortly after she

arrived to see the resident on August 7th, 2015. This request came from a newly hired staff person who was not able to verify that the visitor was the resident's guardian. On that same day, the staff person was reportedly "thoroughly instructed and informed on her error" when the agency's Director returned her call. Later, three other managerial staff members also informed her of the same. According to the letter, the agency's Director apologized to the guardian on the incident day and "guaranteed her that this would not happen again". The administrative staff person reportedly believed that the complaint issue had been resolved after talking to the guardian. She wrote that the agency has 23 years of CILA experience with various kinds of guardians. And, they have never had an incident like this before and do not anticipate that this will occur again.

When the HRA called the agency's Director to schedule a meeting with the Direct Support Person (DSP) concerning the complaint, she repeated that she believed that this issue had been resolved. She said that she would ask the DSP if the staff person would be willing to meet with the HRA. Later, she provided the investigation team with the DSP's cell phone number, and the staff person said that the visitation issue had already been discussed with her when we called her. The DSP questioned why we wanted to meet with her face-to-face to discuss the complaint. She refused to meet with the investigation team and said that she needed to talk with the agency's Director. The agency's Director accused the investigation team of harassment when we called her for assistance again with scheduling a meeting with the staff person involved in the incident. The DSP did not return the HRA's second call regarding a meeting to discuss the complaint.

The guardian told the HRA that her visit to the CILA was routine on the incident day. She explained that the staff person opened the door and told her that she had not called prior to her visit. Reportedly, the staff person said that she needed to talk her supervisor before she could allow the guardian to see the resident. She asked the guardian to wait in the foyer and made several calls. However, she was not able to reach her supervisor and told the guardian that she needed to come back another time. According to the guardian, she had proper identification and showed it to the staff person. She had previously visited the home when the staff person in question was on duty. She said that the resident was home on the incident day because she can no longer attend her workshop according to her physician's order. She is looking for another home for the resident because her present bedroom is on the upper level and she has problems with balancing herself. The guardian told the HRA that the agency's Director did not apologize as stated in her letter above. She said that the administrative person did not take the incident seriously when they discussed the problem by phone. She told the investigation team that she has two other wards in the home. She reportedly has not had any more problems with visitation since the complaint incident.

According to Heart to Heart Services' "Visitors" policy, guardians or approved family members or advocates or the Department shall not be denied visits with their wards or loved ones or consumers who live in the agency's CILAs. The policy documents that the agency would prefer that all visits be scheduled to avoid confusion with planned agendas. However, visitation shall not be denied with proper identification. All visitors must sign the log book upon entering the home and sign out before they leave. Per the policy, visitation shall be denied for the safety of consumers if all means to validate the visitor's identity fails.

CONCLUSION

The Illinois Department of Human Services— "Rights of Individuals" include the right: to communication with persons of choice and to report any possible rights violation to the

agency's Human Rights Committee, the Department, the consumer's Service and Support Advocacy Agency, and other agencies such as the Illinois Guardianship and Advocacy Commission.

According to the 59 Illinois Administrative Code 115.250,

> (a) (1) The rights of individuals shall be protected in accordance with Chapter 2 of the Code, except that the use of seclusion will not be permitted.

According to Section 5/2-102 of the Mental Health Code,

> (a) All recipients of services shall be provided with adequate and humane care and services, pursuant to an individual services plan.

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 shall be promptly given notice of the restriction.

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.

The complaint that the agency impeded a resident's and her guardian's right to communication is substantiated. The agency's Director and the DSP said that the incident occurred and was corrected. We were told that the staff person was unable to verify that the visitor was indeed the guardian. However, the guardian said that she was told that she needed call before visiting the resident. The agency violates Section 5/2-103 (c) of the Code, and the program policy regarding communication with persons of choice. This also violates Section 5/2-201 of the Code because there was no restriction notice found in her record. No violations of the Code's Section 5/2-102 (a) were found.

RECOMMENDATIONS

1. Although Heart To Heart Services' Director reported that the isolated incident was discussed with the staff person identified in the complaint, the agency is reminded to follow Section 5/2-103 (c) of the Code, and the program policy regarding communication with persons of choice.
2. The program policy states that the agency's preference is that all visits should be scheduled. However, this language is not found in statutes that govern communication. Ensure that all applicable staff members understand that this is not a requirement for visitation.
3. Complete rights restriction notices as required by Section 5/2-201 of the Code.
4. Ensure that newly hired staff are adequately trained on CILA residents' rights before being left unsupervised.

SUGGESTION

1. Ensure that an agency manager is accessible when staff seek clarification.

COMMENT

Section 17 of the Guardianship and Advocacy Act (20 ILCS 3955) states,

> In the course of an investigation, a regional authority may enter and inspect the premises of a service provider or State agency and question privately any person therein within reasonable limits and

in a reasonable manner. Whenever possible, prior notice shall be given the parties regarding the nature, location, and person involved in a particular investigation.

The agency's Director should instruct the Direct Support Person in question to fully comply with all government or law enforcement agencies authorized to investigate complaints involving the agency.