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REPORT OF FINDINGS
TRINITY SERVICES INCORPORATED—16-040-9003
HUMAN RIGHTS AUTHORITY—South Suburban Region

[Case Summary— The Authority made three corrective recommendations regarding the allegation, and the service provider accepted all of them. The public record on this case is recorded below; the provider did not request that its response be included as part of the public record.]

INTRODUCTION

The South Suburban Regional Human Rights Authority (HRA) has completed its investigation into an allegation concerning Trinity Services Incorporated. The complaint alleged that the agency failed to notify a guardian of the resident's injuries. 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 New Lenox, Trinity Services, Inc., provides services to children and adults with developmental disabilities and behavioral health needs in Peoria, the south and northwest suburban regions of Chicago, Illinois, South Central Illinois near Mascoutah, as well as northern Nevada. This agency provides employment, counseling and respite services. It also manages about 100 Community Integrated Living Arrangements with a total population of more than 600 residents.

METHODOLOGY

A site visit was conducted at which time the agency's Network Director, the Associate Network Director, and a Qualified Intellectual Disabilities Professional were interviewed. The complaint was discussed with the resident's guardian. Relevant policies were reviewed as were sections of the resident's record with consent of her guardian who also provided related email correspondence.

COMPLAINT STATEMENT

The complaint stated that the guardian learned about the resident's bruises on her face during a visit to her workshop on September 9th, 2015. It was reported that a workshop employee told the guardian that the resident's injuries had occurred at her home several days before her visit.

FINDINGS

According to the resident's services plan, dated July 10th, 2015, she has a seizure disorder and wears a protective helmet as ordered by her neurologist. It stated that she has deliberately fallen and usually becomes agitated around the time she is picked up at her workshop. She gets upset sometimes and she has difficulty talking and has tried to run away. She has mentioned many times that she would like to retire from her workshop because of her age. At the resident's

annual staffing, there was some discussion about her experiencing an increase in falls. Her services plan documented that her guardian was not able to attend the staffing but had discussed her concerns with the Qualified Intellectual Disabilities Professional, or QIDP, prior to the meeting. However, there were no clear indications of the guardian's concerns found in the resident's services plan.

Regarding the complaint, the resident's record contained a total of seven injury reports for July and September of 2015. According to the first two injury reports, the resident fell twice in her apartment on July 19th, and first-aid treatment was administered. In the first incident, the resident was found lying on the floor after her roommate told the staff that the individual had fallen. She had a scratch on her nose and forehead, which was described as the size of a "quarter." In the second incident, the resident told a staff person that she had fallen and a slight bruise above her right eyebrow was observed. In both instances, her injuries were defined as those described in Category I on the report form, which includes no injury or minimal injury observed. Her record does not indicate that her guardian was informed about the two incidents above.

An email addressed to the QIDP from the resident's guardian dated August 12th, 2015 indicated that injuries and incident reports were discussed. According to the email, the QIDP had informed the guardian during a phone call (date unknown) that the resident's gait was unsteady and that she had experienced some falls. The guardian told the QIDP that she was not aware of any falls nor had received any incident reports. She said that all injuries and falls must be reported to the Office of the State Guardian (OSG) in a timely manner. She said that notification included written incident reports. Also, she told the QIDP that she would make a decision about the resident moving to a retirement home after she had reviewed the documentation needed. On that next day, the QIDP sent the guardian an email stating that she had discussed her concerns about injuries and incidents with the staff and other team members. And, they said that the resident is reporting that she is falling. However, they have not witnessed her falling or observed any injuries after she has reported such incidents. According to the email, the resident will start falling if she feels like she is having a seizure. A copy of the injury report would be sent to the guardian concerning the July incident. She was seen by her physician and she is doing fine. She is now using the wall for support frequently at her workshop. She still would like to retire from her workshop and move to a different home.

A third injury report documented that the resident had bruises as mentioned in the complaint. According to the injury report, the resident told the staff that she had fallen on September 7th and scratches on the right side of her nose and above her right eyebrow were observed. First-aid treatment was administered. Her injuries were defined as those described in Category II on the report form, which includes injuries that might not be severe but require a higher level of evaluation or assessment. The injury report was completed by the Team Leader two days after the incident. Her record lacked indication that the guardian had been informed about the incident timely. On September 9th, an email addressed to the resident's guardian from the QIDP stated that she had discussed the incident with the Team Leader. She wrote that, according to the Team Leader, the resident said that she had tripped over her feet in her bedroom. On that same day, the guardian replied by email and said that "OSG should have been notified." According to the record, the resident was seen by her physician on September 10th because of injury to her face.

A fourth injury report stated that the resident had tripped over a chair at her workshop and had a cut on her face on September 17th. Her injury was described as those defined in

Category II above. A nurse applied a "butterfly bandage'" on the resident's injury. Ice was also applied. According to the fifth, the sixth, and the seventh injury reports, the resident fell twice on September 28th, and she fell again on the 30th. In the fifth incident, she reportedly fell in the parking lot when she was getting out of the van to go inside of her workshop building. She sustained scratches on her back area and ice was applied. Her injuries were defined as those previously described in Category I and the Team Leader was notified. In the sixth and the seventh incidents, she reportedly fell inside and then outside of her workshop building. There were no injuries noted on the report forms. In all four instances above, there was no indication of guardian notification.

When the complaint was discussed with the guardian, she said that she had requested to be notified about all injuries and incidents according to the OSG's guidelines. Also, she had sent a reminder about notification via email to the agency's assigned QIDP in August of 2015 because she was not receiving incident reports as requested. She explained that she saw several bruises on the resident's face during a visit to her workshop on September 9th, 2015. A workshop employee told her that she had the bruises when she came to her day training program a couple of days before her visit. On that same day, she called the agency about the resident's injuries and the QIDP told her that she was not aware of them. Later, she reported that the home staff said that the resident had fallen, but they did not witness the incident.

According to the staff interviewed, the resident has been a client of the agency for about 15 years, and she has lived in the same home for more than three years. The staff reported that the resident walks fast and that her gait is unsteady. She wears a helmet on her head because of a seizure disorder. Her risk for falling increases as her anxiety, verbal aggression, and other behaviors increase. According to the QIDP, the guardian did not want to be notified about incidents reported by the resident if there were no visible injuries. She said that the guardian had requested notification about all injuries and incidents after the September 7th incident in question. However, the guardian disagrees with this as noted above. She said that she notifies the guardian about "everything now." The investigation team was informed that private guardians are asked what they expect regarding notification. An injury report is completed when a staff person witnesses an incident even if injuries are not observed. An injury report is not completed when a resident reports that she has fallen and injuries are not visible. The Team Leader usually calls the Program's Associate Director when injuries are observed. According to the agency's Network Director, the Team Leader should have notified the guardian about the September 7th, incident, but the guardian called the QIDP before she could call her.

Trinity Services "Support Team Process" policy states that the team is responsible for developing a single integrated plan for each client who receives supports or services from the agency. The support process begins with the identification of a team of which client receiving supports or services is the most important member. The Program Director will designate one member of the team to coordinate the ongoing activities of the team. One of the team's goals is to empower the individual. The client may coordinate his or her plan if legally competent or designee as appropriate. The client, guardian, or designee's input will be recognized in the decision making process. The coordinator of the plan may schedule a meeting to clarify or to provide additional information when needed.

Trinity's "Reporting and Investigating Unusual Incidents" policy states that all employees must immediately report any unusual incident involving a recipient of services that they observe or become aware of to their supervisors. The staff person who witnesses the incident is required to complete an incident report. The Program Director shall ensure that

unusual incidents are promptly reported and investigated and that corrective action is provided in a timely manner if appropriate. These incidents include, but are not limited to the following, abuse/neglect and physical injuries that require immediate medical treatment by a physician. A supervisor who reports an unusual incident must complete an incident report form as soon as possible. A completed incident report form must be submitted to the Program Director within 24 hours or [upon] discovery of the incident. A copy of the incident report will be provided to the agency's Executive Director and the Human Right Committee Chairperson within three days.

According to Trinity Services "Injury or Serious Illness of Program Participants" policy,

A) The staff person who observes an incident or injury or serious illness is responsible for:

1. Administering first aid and accompanying the resident for emergency care if needed.
2. Reporting injuries in categories 2 through 4 by phone to the supervisor on duty or on call and completing follow up as directed.
3. Noting the injury or illness and follow up on the daily observation sheet.
4. Completing a draft report for all injuries listed in categories 1 through 4.

B) The supervisor on duty is responsible for:

1. Assessing the injury or illness and coordinating any treatment and follow up necessary.
2. Completing of the Final Injury Report and submitting the report to the Program Director on that next business day.
3. Notifying the Program Director or designee of any category 3 or 4 injuries immediately. These injuries requires evaluation/treatment by a physician or results in the person being admitted to a hospital.
4. Notifying the resident's family or guardian if appropriate.

Additionally, the policy includes procedures for the Program Director/designee, the nursing staff and the agency's Medical Quality Assurance Committee. It states that the Committee's Chairperson is responsible for reviewing trends and patterns that would indicate issues related to recurring injuries concerning the same individual, issues with agency-wide safety/health practices, and follow up actions to address prevention of future occurrences.

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 115.320 (g) of the CILA Rules state that,

> The agency shall have written policies and procedures for handling, investigating, reporting, tracking and analyzing unusual incidents through the agency's management structure, up to and including the authorized agency representative. The agency shall ensure that employees demonstrate their knowledge of, and follow, such policies and procedures. Unusual incidents shall include, but are not limited to, the following:
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> A) Sexual assault;
> B) Abuse or neglect;
> C) Death;
> D) Physical injury;
> E) Assault;
> F) Missing persons;
> G) Theft; and
> H) Criminal conduct.

Section 115.250 of the Administrative Code states that individual entering a CILA program shall be informed of the following:

> (a-1) The rights of individuals shall be protected in accordance with Chapter II of the Code….

The agency's "Statements of Rights" policy states the same.

Section 5/2-102 (a) of the Code states that,

> 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 Sections 5/11a-17 and 5/11a-23 states that,

> The personal guardian shall make provision for the ward's support, care, comfort, health, education and maintenance. In doing so, every health care provider and other person (reliant) has the right to rely on any decision or direction made by the guardian…as though the decision or direction had been made or given by the ward.

The investigation revealed that the agency is not clear regarding the guardian's expectations about notification of injuries and incidents. According to the QIDP, the guardian did not want to be notified about incidents reported by the resident if there were no visible injuries. She said that the guardian changed her request concerning notification in September of 2015. The guardian told the HRA that she had previously requested to be notified about all injuries and incidents according to the OSG's guidelines. She said that she had reminded the QIDP via email about notification in August of 2015. However, we found no documentation concerning any communication with the guardian regarding the seven incidents reviewed in the resident's record. Regarding the complaint incident, the guardian reported that she first learned of the resident's bruises during a visit to her workshop on September 9th, 2015. A corresponding injury report stated the resident told the staff that she had fallen on September 7th. The injury

report was completed by the agency's Team Leader two days after the occurrence, which violates the program policy. We noticed that the injury report was completed on the same day that the guardian reportedly had called the agency about the resident's injuries. At the site visit, the agency's Network Director interviewed acknowledged that the guardian should have notified about the incident above.

Additionally, the staff's reported that an injury report is not completed when a resident reports that she has fallen and injuries are not visible. The program policy does not support this. The policy directs that all employees must immediately report any unusual incident that they observe or is told of involving a recipient of services.

The complaint stating that the agency failed to notify a guardian of the resident's injuries is substantiated. The agency violates Section 115.320 (g) of the CILA Rules and program policy.

RECOMMENDATIONS

1. Ensure that unusual incidents are investigated, addressed, reported and documented pursuant to the Illinois Administrative Code Section 115.320 (g) and program policy.
2. Complete incidents reports timely as required by program policy. Also, the staff shall report residents' injuries to their guardians when appropriate and follow the guardian's direction under the Illinois Probate Act, Section 5/11a-23.
3. Discuss reporting and guardian notification with the program staff and provide documentation to the HRA.

SUGGESTIONS

1. Trinity shall revise its injury policy to include the level of communication desired by guardians concerning residents' injuries under the Illinois Administrative Code Section 115.320 (g) (1).
2. The level of communication desired by guardians concerning residents' injuries should be discussed during the ISP "Individual Service Plan" meetings and documented in residents' plans.

3. Review the resident's retirement request as part of treatment planning with the resident and guardian. In addition, consider any mobility aids, accommodations or evaluations to help address the falls.