FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
CHARLESTON TRANSITIONAL FACILITY— 17-040-9007
HUMAN RIGHTS AUTHORITY South Suburban Region

INTRODUCTION

The Illinois Guardianship & Advocacy Commission, the Human Rights Authority Division, has completed its investigation into allegations concerning Charleston Transitional Facility. The complaint stated that a resident was not provided with timely medical care for a yeast infection. Additionally, the complaint stated that the facility failed to notify a guardian of the resident's injuries. If substantiated, these allegations 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).

Charleston Transitional Facility provides housing, employment, vocational, counseling and advocacy services to persons with developmental disabilities and behavioral health needs. This agency also manages 12 Community Integrated Living Arrangements with a total population of about 80 residents.

METHODOLOGY

The complaint was discussed with the Facility Vice President of Operations, the Regional Network Director, and the Associate Director of Operations in closed session at the South Suburban Regional Authority public meeting. A site visit was conducted at which time the Associate Director of Operations 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 a resident was not provided with timely medical care for a yeast infection. It was reported that the resident had been scratching in her genital area and had a foul odor and was urinary incontinent. However, the facility did not address her workshop staff's concerns about this issue until her guardian intervened. Additionally, the complaint stated that the guardian learned about the resident's scratches on her legs from a workshop employee on August 9th, 2016.

FINDINGS

Information from the record, interviews and program policy

According to the record, the resident has been a client in the facility's Community Integrated Living Arrangement (CILA) program for more than nine years. She is diagnosed with Profound Mental Retardation, Epilepsy and is visually impaired She is non-verbal and attends a workshop managed by another agency. Her record documented that the Office of State Guardian

(OSG) is appointed as her legal guardian. An email, dated on March 2nd, 2016, addressed to the Facility's Associate Director of Operations and a workshop employee from the guardian caseworker indicated that she had been informed during a visit to the workshop that the resident had been scratching in her genital area. She had urinated on self during transport on February 29th, 2016. And, she had been urinating often during programming and a foul odor was noticed. According to the guardian caseworker's email, the workshop had made attempts to notify her CILA staff about their concerns, and she instructed the facility to follow up regarding this issue. On March 4th, the guardian caseworker sent the email above to the same facility's staff person because of an error concerning her email address in the previous message dated on the 2nd. On that same day, the Facility's Associate Director of Operations replied to the guardian caseworker's email and said that the resident would be taken to an urgent care center. On the 7th, the Facility's Associate Director of Operations informed the guardian caseworker that the resident was diagnosed with a yeast infection and antibiotics were prescribed on the 4th. The guardian caseworker forwarded a copy of the facility's email above to a workshop employee and she replied "See we knew something was wrong. She has been like this for about a month now. Thank you so much for following up."

An injury report indicated that a residential Direct Support Person (DSP) saw blood on the resident's head upon entering her bedroom on May 21st, 2016. According to the injury report, the DSP applied pressure to the resident's head injury, and the facility's nurse and a Qualified Intellectual Disabilities Professional (QIDP) were notified. She was transported to a nearby hospital's emergency department and received two staples for her head wound. The injury report documented that the nightstand located on the side of her bed would be removed because she might have hit her head on the object. It stated that the staff would continue to assist her to the bathroom at night. A medical report documented that the staples were removed from her scalp four days later. There was no indication that the guardian caseworker was notified about her injury found in her record.

An email addressed to the Facility's Associate Director of Operations and the guardian caseworker from a workshop employee was reviewed. According to the email, the resident was dressed in shorts upon her arrival at her workshop on August 9th, 2016. Her arms and legs were bloody and pictures were provided. Her wounds were cleaned and she was dressed in a pair of pants. The Facility's Associate Director of Operations replied to the workshop employee's email and said that the resident's CILA staff would be picking her up soon and taking her to an urgent care center. There was no indication that the guardian caseworker was notified by the facility. The guardian caseworker told the HRA that she had called the facility upon notification from the workshop.

An incident/injury report indicated that a residential DSP had noticed a bruise on the individual's lower buttock area back while assisting her with showering on August 13th, 2016. It was documented that a facility's supervisor and a nurse were notified. The nurse instructed that the resident should be monitored for signs of pain. The DSP who had observed the bruise did not know how the injury had occurred. An environmental check did not reveal any potential risks for falling. Some of the other CILA staff reported that the resident had been agitated on the morning of the 13th and was jumping up and down on the hard dining room chairs in the home. An email written by a workshop employee indicated that a bruise was observed on the resident's back during toileting at her workshop on August 15th. The facility's QIDP and the guardian caseworker were notified and pictures of her injury were provided. An injury report would be forwarded by her workshop. The incident/injury report, completed by the facility,

documented that the QIDP informed the guardian caseworker upon notification from her workshop on that same day. However, the HRA found no documentation that the facility had provided guardian notification before the 15th.

An incident/injury report dated August 29th, 2016 stated that the resident had woke up during the night and did not go back to sleep. She was described as being agitated and self-injurious and a supervisor and nurse were notified. The DSP was instructed to give the resident some Tylenol medication and to send her to a nearby hospital's emergency department to rule-out possible medical problems. According to an email, on that same day, the QIDP informed the guardian caseworker that the resident had been crying and screaming on that previous night and was taken to the hospital for medical care. She was checked for a urinary tract infection and was diagnosed with constipation. A dental appointment would be scheduled to rule-out any dental problems.

An email, dated on August 30th, 2016, documented that the facility's interdisciplinary team would be meeting to discuss the resident's medical problems and injuries on the 31st. On that next day, a summary of the meeting discussion sent to the guardian caseworker indicated that the resident had been exhibiting agitation and was seen by a physician three times since August 15th. She was seen for bruises on her back and buttocks twice and for constipation one time. Also, she was seen by a neurologist on August 25th and medication for anxiety was prescribed. On the morning of September 1st, she was transported to a local hospital's emergency department because she started yelling upon her arrival to her workshop. She was diagnosed with a gum infection and medication was prescribed. She was seen by a dentist on that next day. The email documented that the resident would be checked for injuries in the morning and at night. She would be seen by the psychiatrist on September 17th. A behavioral plan would be developed if needed. The staff would be retrained on the facility's protocol concerning injuries and notification.

When the complaint was discussed with the facility, the HRA was informed that the resident's workshop did not notify her CILA staff about any medical concerns. The facility's staff explained that the workshop staff said that they had tried calling her CILA home but no one answered the phone. The guardian caseworker's email, dated on March 2nd, 2016, about her workshop's concerns was sent to the wrong email address as previously mentioned in the report. The resident was seen by a physician upon receipt of the guardian caseworker's email on March 4th. The facility's staff said that the resident did not have vaginitis and that medication was not given. However, her discharge instructions from a hospital's emergency department documented vaginitis.

According to the facility's QIDP, she was assigned to the resident on or around March of 2016. She said that she did not notify the guardian caseworker because she did not know the facility's protocol concerning this issue. She reported that training on unusual incidents including notification was provided on or around September of 2016. Guardian notification should be documented in the comment section of the incident/injury report form. The facility's staff reported that a team meeting was held to address better communication with the workshop staff on or around September of 2016. The resident's workshop staff and the guardian caseworker were at the meeting. According to the facility's staff, the guardian caseworker said that she only wanted to be notified about serious injuries. She requested that the workshop staff should notify the CILA staff about any concerns prior to contacting her. The guardian caseworker told the HRA that she wanted to be notified about all serious medical problems and injuries as well as provided with incident reports. She said that phone numbers were updated at

the team meeting in September and that the facility has been notifying her about incidents and injuries since the meeting.

The facility's "Nursing Policy & Protocol" states that nursing services shall be available to individuals served by the facility. The facility's protocol for head injuries due to falls or other kind of trauma includes: 1) to notify the nurse, 2) to apply pressure if blood is observed, 3 and 4) to monitor the individual's vital signs and level of consciousness, 5) to notify the residential facility if the incident occurred at the day training program, and, 6) to complete an incident report and document all actions taken. The facility's protocol for complaints of burning during urination, reddened/rash in the groin area, and vaginal itching includes: 1) washing the area thoroughly with soap and water twice daily for one day, 2) notifying the nurse for instructions, 3) observing the individual for 24-hours, 4) the individual may soak in a warm bath, 5) checking the individual's underwear and/or bedding for vaginal discharge, 6) encourage fluids, 7) do not apply ointments, 8) notify the residential facility if the problem was first noticed by the day training program staff, and, 9) document the medical problem in the individual's chart.

According to the facility's "Unusual Incidents Policy," it is the facility's policy to take preventive measures, investigate and take remedial actions, report, track, and analyze unusual incidents through its management structure. The facility will provide training and employees will demonstrate their knowledge and follow such policies and procedures. Any unusual incident will be reported within applicable timeframes to the individual's guardian, the facility's designee and other parties as required and will be documented. The facility's staff will take appropriate steps to ensure the ongoing safety and well-being of the individual involved in the incident. Its interdisciplinary team will review and make recommendations to minimize future occurrences of unusual incidents. This will include: 1) an examination of circumstances and data to determine how and why the event occurred, 2) identification of risks that contributed to the event, 3) identification and communication of actions to prevent similar events, and, 4) examination of events as well as systematic trends and patterns of events. The facility will investigate any unusual incident and/or assist other appropriate authorities in their investigation.

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;
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> 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….

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 recipient to the extent feasible and the recipient'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 complaint stated that the resident was not provided with timely medical care for a yeast infection. The investigation supports that the workshop staff had noticed that the resident had been scratching in her genital area and was urinary incontinent and had a foul odor as reported in the complaint. The guardian caseworker first learned about this issue during a visit to her workshop on March 2nd, 2016. Her workshop told the guardian caseworker that they had made attempts to notify her CILA staff by phone but no one had answered their calls. On that same day, the guardian caseworker sent the facility an email requesting that the workshop's concerns should be addressed but there was a problem with the transmittal. On March 4th, the email was sent again to the facility and medical care was provided on that same day. Her record indicated that she was diagnosed with vaginitis. An email written by a workshop's employee stated that the resident might have had this medical problem for about a month before medical care was provided. Why the CILA staff did not know that something was wrong with the resident before the guardian caseworker's email was received on the 4th is unclear. However, the HRA finds that the facility provided adequate and humane care upon notification about her workshop's concerns. The HRA cannot substantiate the complaint. The Authority finds no violations of Section 5/2-102 (a) of the Code and the facility's "Nursing Policy & Protocol."

The complaint stating that the facility failed to notify a guardian of the resident's injuries is substantiated. For 2016, the resident's record documented that she required two staples for a head injury on May 21st. She had bruises on her legs and arms when she arrived at her workshop on August 9th. Four days later, a CILA staff person noticed a bruise on the resident's lower buttock. However, there was no indication found in her record that the guardian caseworker was

notified about the resident's head injury. And, she first learned about two of the three injuries from her workshop. The agency violates Section 115.320 (g) of the CILA Rules and program policy.

RECOMMENDATIONS

1. Ensure that unusual incidents are reported and documented pursuant to the Illinois Administrative Code Section 115.320 (g) and program policy.

2. Ensure that the staff shall report residents' injuries to their guardians when appropriate as required by program policy and follow the guardian's direction under the Illinois Probate Act, Section 5/11a-23.

3. The HRA requests documentation concerning the training on injuries and notification that was reportedly provided on or around September of 2016.