FOR IMMEDIATE RELEASE

East Central Regional Human Rights Authority
ResCare/Community Alternatives of Illinois
Report of Findings
Case #18-060-9013

The East Central Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission voted to pursue an investigation of ResCare/Community Alternative of Illinois after receiving the following complaints of possible rights violations:

Complaints:

1. **The provider restricted the consumer's communication and personal property rights by not allowing the consumer to have access to her personal telephone after 9pm. The provider is not paying the consumer's telephone bill as agreed.**
2. **A dispute between a staff member and the consumer resulted in an altercation. During the altercation the consumer was punched in the chest and required medical attention.**

If the allegations are substantiated, they would violate protections under the Mental Health and Disabilities Code (405 Ill. Comp. Stat. Ann. 5/2-103, 104, and 112) and the Illinois Administrative Code (59 Ill. Admin. Code 115.320; 59 Ill. Admin. Code 50).

Investigation

Because the second complaint alleged abuse by staff, the HRA followed mandated reporting requirements and reported the alleged abuse incident to the Department of Human Services' Office of Inspector General (OIG). Thus, the HRA did not investigate the abuse incident itself but reviewed issues peripheral to the abuse allegation, including abuse reporting.

The HRA proceeded with the investigation after having received written authorization from the consumer's state appointed guardian. To pursue the matter, the HRA visited the facility and the program representatives were interviewed. Relevant practices, policies, and sections of the consumer's record were reviewed.

ResCare is a corporation overseeing disability homes nationwide. The Illinois division of ResCare is called Community Alternatives Illinois (CAI). CAI has Community Integrated Living Arrangements (CILAs) all over the state. Staff also noted that there has been a recent name change for CAI and significant administrative staff changes in the last 6 months.

The HRA notes that ResCare/Community Alternative of Illinois (CAIL) was not cooperative in completing the investigation. The HRA had difficulty contacting administration, documents were not provided in a timely manner, documents were not provided as requested, and staff were not available to conduct in-person interviews at the times that were scheduled. At the scheduled site visit, on June 6, 2018, neither the Executive Director or the Program Manager were available as scheduled. The Area Supervisor stated that she had been instructed to meet with the HRA to review finances and was unaware of the specific allegations.

Interviews:

On June 6, 2018 at 1:30pm, the HRA arrived at the ResCare/Community Alternatives of IL (CAIL) office at 215 N Convent St Bourbonnais, IL. Neither the Executive Director or the Program Manager were available as scheduled. The Area Supervisor stated that she had been instructed to meet with the HRA to review finances and was unaware of the specific allegations. The meeting began with introductions, a review of HRA procedures, and a review of the allegations being addressed in this investigation. (At 2:40pm the Program Manager arrived at the meeting and reviewed the questions and answers provided by the Area Supervisor.)

CAIL stated that they have several Community Integrated Living Arrangement (CILA) homes in Illinois. All staff working in the home have received the Direct Service Provider (DSP) required training on rights and regulations as well as abuse/neglect. CAIL added that the staff member that was present on the date of this incident is no longer employed by CAIL.

CAIL reported that all consumers have access to telephones within the CILA home. All consumers residing in the home have access to a house phone located in a shared area. Staff report that, all the consumers residing in this location also have personal cell phones. The personal phones are not provided to the consumers by CAIL and CAIL is not responsible for cell phone payments.

CAIL stated that they are the payee for the consumer involved in the complaint and the consumer's service plan does include fiscal management tasks. Staff report that the house manager is responsible for paying bills for any consumers that are unable to manage their own money, however, this consumer becomes agitated when told that she cannot have her money. In February staff gave the consumer her entire budget and let her spend it as she wanted because "that is her right." The HRA attempted to explain to the staff that the consumer's right to manage her own finances was properly restricted in the last service plan and as evidenced by the consumer's restriction of rights page in the ISP stating the consumer has restricted access to money. The restriction states "Group account and money is kept at CAIL office. CAIL acts as representative payee for [the consumer]. [The consumer] has a limited concept of money and its value. (The consumer) is not able to maintain a checking account or pay bills. [The consumer] has a money program to increase her money skills and become more independent." CAIL is responsible for monitoring the consumer's money and bills. During this discussion staff became upset and said "if I keep money from [the consumers] you will be out here investigating me for taking away someone's right to their own money".

Staff reported that there is no policy regarding cell phone payments and/or usage because the consumers have the right to use their own money and the right to have their own property. The provider does not have a policy stating that consumers must turn in their cell phones at 9pm. However, some of the residents in the home are required to turn in their phones at 9pm due to guardian directives. Staff believe that this consumer was turning her phone in willingly because other residents were being asked to turn theirs in. Staff reported that the consumer "has never been forced by staff to turn in her cell phone".

CAIL stated that on 3/7/18 the consumer was upset and attacked a staff member. Police were called to the home and the consumer was evaluated. Staff reported that this was not unusual behavior for the consumer since arriving at this CILA and provided the HRA with incident reports. The HRA reviewed the incident report for 3/7/18 with staff. This incident report stated that the consumer "was asked to turn in her cell phone." Staff stated that she was unaware of why the consumer would be asked to turn in her phone. The incident report also states that the consumer told the police that staff tried to "jump her." The HRA asked if OIG had been notified of the accusation and staff stated that OIG was not called because that is not what happened.

Records Reviews:

The HRA reviewed the following records provided by CAIL:

An Individual Service Plan (ISP) dated 5/17/17 states that the consumer has a diagnosis of Moderate Intellectual and Developmental Disability (IDD) with some secondary mental health diagnoses and indicates that the consumer cannot manage her own finances. There is one financial goal in the ISP for the consumer to learn how to check the balance on her link card regularly. The consumer has a restriction of rights page in the ISP stating the consumer has restricted access to medication and money and is prescribed psychotropic medication. Access to money states "Group account and money is kept at CAIL office. CAIL acts as representative payee for [the consumer]. [The consumer] has a limited concept of money and its value. (The consumer) is not able to maintain a checking account or pay bills. [The consumer] has a money program to increase her money skills and become more independent." The ISP also states that there is no restriction of communication.

A Behavior Management Plan indicates that the consumer has a history of aggression and inappropriate use of her cell phone (sending inappropriate texts, pictures or communications). The plan for inappropriate cell phone use states that staff should model appropriate use and that she should be reminded about appropriate use. It also notes that "it is important to remember that we cannot tell her what to do but only give her suggestions." The plan for aggression is attention being given appropriately and escape (such as breaks). The plan has additional Reactive Procedures that include safety and safety of others but does not include any restraint and or physical force of any kind.

Partial financial statements were provided to the HRA. Receipts indicate that a cell phone was purchased 12/21/17 (and service was paid through 1/21/18). There is also a receipt that a new phone and service were purchased on 3/17/2018. The bill was paid again on 4/18/18 and a

receipt was provided. There was no documentation for a cell phone bill being paid for from 1/21/18 to 3/17/18. An email from CAIL staff dated 5/10/18 stated "All of (the consumer's) cell phone bills have been paid to current as evidenced by the receipts except for February. In February she chose to spend her money on other items as evidenced by the ledger and receipts she brought back. She did not alert anyone as to her phone being off. I also did not receive a request from the area supervisors to submit a request so she could have additional money if needed."

Incident reports for January 2018 to May 2018: 3/7/18 staff documented that the consumer was asked to turn in her cell phone and the consumer refused. "Staff stood in her doorway and requested phone again." After that, the incident report goes on to state that the consumer made threats and charged at staff. Staff tried to block the consumer from advancing towards staff and then the police were called. It was also documented that the consumer told the police that "staff jumped her" and then threatened to call OIG. Unrelated incident reports were filed for 4/22/18, 4/23/18, and 5/8/18. There are no incident reports prior to 3/7/18. There is no documentation that any of the Incident reports were sent to Office of Inspector General.

Case note documentation from 3/7/18 reports that the consumer was asked to turn in her phone. She refused and attacked staff so the police were called.

Timekeeping and training records indicate that all staff present at the CILA on 3/7/18 have completed training titled "Rule 50- Supporting a Non-Abusive, Non-Neglectful Environment - Incident Management/Documentation". Each staff member signed a sheet indicating that they understood their responsibilities in an Abuse and Neglect situation and completed a competency Quiz. In the quiz portion, each of the staff members answered questions indicating that they understood the definition of abuse, the importance of reporting, and the timeframe for reporting to OIG.

CAIL provided their Abuse, Neglect, and Exploitation Policy. The policy states that "any employee who suspects an individual is the victim of abuse, neglect, or exploitation will immediately notify this suspicion to their supervisor. The supervisor will then notify the Executive Director, and /or designee, who will begin the investigation process and/or contact OIG." The policy also states that "All allegations of abuse/neglect and death shall be reported to OIG within the following required time frames: Four-hour reporting- within four hours after the initial discovery of an incident of alleged abuse or neglect, all allegation shall be reported to OIG's Hotline number…".

The HRA reviewed records provided by the Office of State Guardian (OSG):

A 3/15/18 case note states that the consumer told OSG staff "she didn't want to turn her phone in at 9 because she thought it was unfair as other residents don't have to turn their phones in at that time and can do so later. She said the staff person grabbed her arm and punched her in the chest. She said while at the hospital the xray showed bruising to her chest on the inside. She said the staff called the police and they took her to the hospital. She said she was being aggressive but she was defending herself." In addition, there is a statement later in the note that the provider "won't pay her phone bill".

The HRA completed Freedom of Information Act requests for the Kankakee Police, The Village of Bourbonnais Police, and the Kankakee County police. All three departments responded and stated that they do not have any record with the consumer's name, address, or date of birth from January 2018 to May 2018.

The HRA received documents from the local hospital for records relating to the consumer from January 2018 to May 2018. The consumer has been hospitalized on 1/9/19 and 3/7/18 and all requested records were provided and reviewed. According to hospital records, on 3/7/18 the consumer was brought to the Emergency room after an altercation with CAIL staff over a cell phone. The consumer reported to the hospital that she does not want to turn in her cell phone and gets angry when asked to do so. The consumer told the hospital that the CAIL staff started the altercation that resulted in the consumer being pushed into a dresser resulting in injury to the chest and a scratch on the consumer's arm. Nursing documentation does note that the consumer presented with a 3mm scratch on her arm and was "moderately tender over the sternum and costochondral". A Chest x-ray was completed and results were negative. The hospital staff also documented that there is a discrepancy in the stories, the consumer stated that "she hit me first" but the CAIL staff states tells the story "the other way around". Behavioral Health Services notes dated 3/8/18 report that the consumer was "brought in by a group home member after (the consumer) had reportedly gotten into an altercation with staff members. This is a similar story to presentation about a month ago." On 1/9/18 documentation states that consumer was brought in after running away from the CAIL home. The consumer reported to the hospital the following: "(consumer) stated she was on the phone with her mom when staff took away because she refused to do her chores. (consumer) stated staff hit her. (consumer) stated staff tripped her with staff's foot. (consumer) stated staff did this on purpose told her she deserved it and was laughing when it was done." The nursing note also states that the CAIL staff were with the consumer in the ER and confirmed that the consumer "got her phone taken away this evening while she was on the phone with her mother because she refused to do her chores".

Conclusions

1. **The provider restricted the consumer's communication and personal property rights by not allowing the consumer to have access to her personal telephone after 9pm. The provider is not paying the consumer's telephone bill as agreed.**

The Mental Health and Developmental Disabilities Code (405 Ill. Comp. Stat. Ann. 5/2-103) states "(c) 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. When communications are restricted, the facility shall advise the recipient that he has the right to require the facility to notify the affected parties of the restriction, and to notify such affected party when the restrictions are no longer in effect." Section 5/2-104 states that "Every recipient who resides in a mental health or developmental disabilities facility shall be permitted to receive, possess and use personal property and shall be provided with a reasonable amount of storage space therefor, except in the circumstances and under the conditions provided in this Section. (a) Possession and use of certain classes of

property may be restricted by the facility director when necessary to protect the recipient or others from harm, provided that notice of such restriction shall be given to all recipients upon admission. (b) The professional responsible for overseeing the implementation of a recipient's services plan may, with the approval of the facility director, restrict the right to property when necessary to protect such recipient or others from harm. (c) When a recipient is discharged from the mental health or developmental disabilities facility, all of his lawful personal property which is in the custody of the facility shall be returned to him". The consumer's Individual Service Plan dated 5/17/17 states that there is no restriction of communication. During the interview with the HRA, CAIL staff reported that the consumer "has never been forced by staff to turn in her cell phone". An incident report completed by CAIL staff stated that on 3/7/18 the consumer was upset and attacked a staff member because the consumer "was asked to turn in her cell phone".

Section 5/2-201 states " (a) Whenever any rights of a recipient of services that are specified in this Chapter are restricted, the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction or use of restraint or seclusion and the reason therefor to: (1) the recipient and, if such recipient is a minor or under guardianship, his parent or guardian; (2) a person designated under subsection (b) of Section 2-200 upon commencement of services or at any later time to receive such notice; (3) the facility director; (4) the Guardianship and Advocacy Commission, or the agency designated under "An Act in relation to the protection and advocacy of the rights of persons with developmental disabilities, and amending Acts therein named", approved September 20, 1985,[1] if either is so designated; and (5) the recipient's substitute decision maker, if any." The consumer's ISP states that the consumer is unable to pay bills but staff stated in February that she was provided her entire budget, which in turned caused her telephone bill to not be paid due to the consumer spending her budget.

After completing the interviews, records reviews, and assessing applicable mandates, there is evidence to support the complaint. CAIL staff were forcing the consumer to hand over her cell phone to staff at 9pm. In addition, there is evidence that staff were using the cell phone as a reward/punishment tool by taking the phone away when the consumer did not complete tasks in the home as requested. While the consumer's access to communication was not impeded because there is a phone in the home that can be used at all times, the consumer's right to her own property was violated. CAIL also documented that the consumer is unable to manage her own finances but proceeded to allow the consumer to manage her own money in order to avoid an altercation and the cell phone bill went unpaid. There appears to be confusion and miscommunication between the CAIL staff that are having daily interactions with the consumers and the management staff. The ISP, Behavioral Plan, and Rights Restrictions are being put in place but are not being followed. And, if a treatment or behavioral plan is not effective to the point of police involvement, it should be revised with the involvement of the consumer and guardian.

Based on the findings above the East Central Human Rights Authority concludes that the consumer's rights were violated and, therefore, the complaint is substantiated. The HRA makes the following recommendations:

1. CAIL staff review the Code Sections 5/2-103 and 5/2-104 and assure that all staff are trained on consumer's rights to communication and to property. Provide the HRA with evidence of that review.

2. CAIL staff review Code Section 5/2-201 which clarifies what a provider should do when a Restriction of Rights is necessary. All CAIL staff should be trained on rights restrictions and how to follow them properly. In the event that a consumer requires a restriction, the plan should include detailed descriptions of the concerns/behaviors that are warranting the restriction as well as detailed service planning tasks that aim to correct the behavior (when possible). Provide the HRA with evidence of that training.

3. CAIL develop a way to regularly communicate and review service planning tasks with the staff at the CILA in order to ensure that the consumer's plans for services, behaviors, and restrictions are being followed by the staff in the home. Provide evidence that a review process has been established.

In addition, the HRA makes the following suggestions:

1. For current and emerging behaviors, CAIL completes a baseline to evaluate the types and frequency of behaviors as part of behavior plan development.

2. The HRA questions the involvement of law enforcement for behaviors related to an individual's disability. The HRA strongly urges the provider to address behaviors through the treatment planning process that involves the consumer and guardian, including a review of when it is appropriate to call the police.

3. CAIL ensure the use of positive behavioral approaches (e.g. rewards for appropriate behavior, education, etc.) versus negative reinforcement or punishment (e.g. taking items away).

4. CAIL ensure that consumers have access to any needed professional resources related to behaviors. For example, behaviors that might put a consumer at risk via sexual texts may warrant access to sexuality and safety education and related professional services through a counselor, sexual assault center or health center.

5. CAIL ensure that incident reports and behavioral plans are reviewed by the behavior and human rights committees.

2. **A dispute between a staff member and the consumer resulted in an altercation. During the altercation the consumer was punched in the chest and required medical attention.**

Regulations that govern the OIG (59 Ill. Admin. Code § 50.20) state that "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, community agency or facility shall report the allegation to the OIG hotline according to the community agency's or facility's procedures. The employee, community agency or facility shall report the allegation

immediately, but no later than the time frames specified in subsections (a)(2) and (3).” CILA regulations (59 Ill. Admin. Code § 115.320) state that “Each agency shall have and use a process for reporting and handling instances of abuse and neglect in accordance with applicable standards, regulations and laws that shall include notification of the individual allegedly abused or neglected and his or her guardian or parent of the allegation within 24 hours after receiving the allegation”. Section 115.320 states “g) Unusual incidents 1) 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: A) Sexual assault; B) Abuse or neglect; C) Death; D) Physical injury; E) Assault; F) Missing persons; G) Theft; and H) Criminal conduct. 2) Within 24 hours of occurrence the agency shall report any incident which is subject to the Criminal Code of 1961 [720 ILCS 5] to the local law enforcement agencies. 3) The agency shall ensure that suspected instances of abuse or neglect against individuals in programs which are licensed by the Department are reported to the Office of Inspector General (Section 6.2 of the Abused and Neglected Long Term Facility Residents Reporting Act [210 ILCS 30/6.2]).” The consumer’s statements documented by CAIL staff on 3/7/18 indicated that the consumer reported that “staff jumped her” and that the consumer threatened to call OIG. There is no CAIL documentation that staff notified OIG as required.

After completing the interviews, records reviews, and assessing applicable mandates, there is evidence to support that the consumer’s rights were violated. All records concur that there was an altercation on 3/7/18. An incident report was completed but there is no documentation that the information was properly forwarded to OIG.

Based on the findings above the East Central Human Rights Authority concludes that the consumer’s rights were violated and, therefore, the complaint is substantiated. The HRA makes the following recommendations:

1. CAIL staff be required to attend additional training on Abuse and Neglect reporting, including, but not limited to, Unusual Incident procedure. Provide evidence of the training.

2. CAIL staff submit the incident report for 3/7/18 to OIG for investigation. Provide evidence of the report submission.

Lastly, the HRA is recognized by its enabling legislation and the Mental Health and Developmental Disabilities Code as the authorized entity to investigate disability rights complaints. The HRA strongly suggests that the provider cooperate with the HRA’s investigation process to ensure that the consumer it serves receive the required protections for which they are entitled by law. Educate staff accordingly and/or invite an HRA representative to educate staff about the HRA.

RESPONSE

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

Community Alternatives Illinois
Response to HRA Case No. 18-060-9013

Complaint #1 – The provider restricted the consumer's communication and personal property rights by not allowing the consumer to have access to her personal telephone after 9pm. The provider is not paying the consumer's telephone bill as agreed. – Substantiated.

Recommendation:

1. CAIL staff review the Code Section 5/2-103 and 5/2-104 and assure that all staff are trained on consumer's rights to communication and to property. Provide the HRA with evidence of the review.

2. CAIL staff review Code Section 5/2-201 which clarifies what a provider should do when a Restriction of Rights is necessary. All CAIL staff should be trained on rights restrictions and how to follow them properly. In the event that a consumer requires a restriction, the plan should include detailed descriptions of the concerns/behaviors that are warranting the restriction as detailed service planning tasks that aim to correct the behavior (when possible). Provide the HRA with evidence of that training.

3. CAIL develop a way to regularly communicate and review service planning tasks with the staff at the CILA in order to ensure that the consumer's plans for services, behaviors, and restrictions are being followed by the staff in the home. Provide evidence that a review process has been established.

Response:

1. Staff will be trained on the Illinois Mental Health and Developmental Disabilities Code sections 5/2-103 and 5/2-104 for the protection of consumer's rights to communication and property by 12/15/18. CAIL will submit evidence of the training by 12/15/18.

2. Staff will be trained on the Illinois Mental Health and Developmental Disabilities Code section 5/1-201 to ensure that restrictions are handled correctly in accordance with the code by 12/15/18. CAIL will submit evidence of the training to the HRA by 12/15/18.

3. A standing agenda and training form has been developed and implemented for all monthly house meetings with staff that address individual's service plans, behavior plans, and restrictions to ensure that they are reviewed with staff on a monthly basis. See the attached email from CAIL's Quality Assurance Manager to all Area supervisors requesting the new training form (also attached) be implemented immediately.

Suggestions:

1. For current and emerging behaviors, CAIL completes a baseline to evaluate the types and frequency of behaviors as part of behavior plan development.

2. The HRA questions the involvement of law enforcement for behaviors related to an individual's disability. The HRA strongly urges the provider to address behavior through the treatment planning process that involves the consumer and guardian, including a review of when it is appropriate to call the police.

3. CAIL ensure the use of positive behavioral approaches (e.g. rewards for appropriate behavior, education, ect.) versus negative reinforcement or punishment (e.g. taking items away).

4. CAIL ensure that consumers have access to any needed professional resources related to behaviors. For example, behaviors that might put a consumer at risk via sexual texts may warrant access to sexuality and safety education and related professional services through a counselor, sexual assault center or health center.

5. CAIL ensure that incident reports and behavioral plans are reviewed by the behavior and human rights committees.

Responses:

1. Spring Health Behavioral Health and Integrated Care provides behavioral supports to individuals, including the development of behavior plans, tracking of efficacy, and modifications. CAIL will relay the HRA's suggestions to their BCBA.

2. CAIL agrees that law enforcement should only be contacted as a last resort when someone is at risk of harm. Management staff will review when law enforcement contact is appropriate on a monthly basis during their monthly house meetings. Please see the attached standard training form for monthly meetings.

3. CAIL will relay the HRA's suggestions to the BCBA for Spring Health Behavioral Health and Integrated Care.

4. The QIDP will research the available service resources in the area, and will make referrals when appropriate to outside service providers.

5. The QIDP will provide the Behavior Management Committee with a summary of behavior data for the period which includes frequency and severity of target behaviors, as well as, any emerging behaviors.

Complaint #2 – A dispute between a staff member and the consumer resulted in an altercation. During the altercation the consumer was punched in the chest and required medical attention. - Substantiated.

Recommendation:

1. CAIL staff be required to attend additional training on Abuse and Neglect reporting, including, but not limited to, Unusual Incident procedure. Provide evidence of the training.

2. CAIL staff submit the incident report for 3/7/18 to OIG for investigation. Provide evidence of the report submission.

Response:

1. CAIL staff will be re-trained on Abuse and Neglect reporting including the Unusual Incident procedure by 12/15/18. CAIL will provide evidence of the training to the HRA by 12/15/18.

2. CAIL has reported the alleged incident that occurred on 3/7/18 to OIG. OIG Incident Report Form attached.

Lastly, CAIL respectfully requests that the HRA provide technical assistance and training to staff. Thank you.