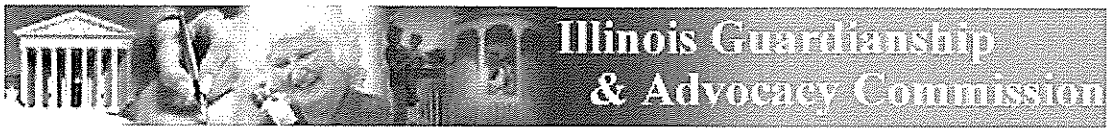

FOR IMMEDIATE RELEASE

East Central Regional Human Rights Authority
Shapiro Center
Report of Findings
Case #20-060-9011

The East Central Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission (IGAC) voted to pursue an investigation of Shapiro Center in Dwight after receiving the following complaints of possible rights violations:

Complaints:

1. **Inadequate treatment.**
2. **Provider failed to keep the consumer free from abuse resulting in the consumer being injured on multiple occasions by multiple peers.**
3. **Unnecessary Restriction of Rights.**
4. **Unsanitary living conditions.**

If the allegations are substantiated, they would violate protections under the Mental Health and Disabilities Code (405 ILCS 5/2-102, 405 ILCS 5/2-112, 405 ILCS 5/3-211 and 405 ILCS 5/2-103), and the Code of Federal Regulations (42 C.F.R. § 483.80).

Complaint Summary: The complaint alleges the consumer's peers harassed and threatened the consumer and the consumer's guardian. Both the consumer and guardian are allegedly afraid to be at the facility. The consumer has reportedly been injured by peers on several occasions. The complaint alleges the staff minimize the injuries despite photographs and medical documentation that show the severity. Furthermore, staff reportedly do not take action to prevent further injury or treat the effects of the abuse. The complaint alleges the staff will not allow the guardian in the consumer's home and have issued a restriction of rights for the consumer that limits the guardian's contact. The complaint stated the unit that the consumer resides in is not cleaned, including the stove, range, fridge, and cafeteria area.

Investigation

To pursue the matter, the HRA conducted a site visit via WebEx and program representatives were interviewed. Relevant practices and policies were reviewed.

Interviews

On December 16th, 2020 at 2 pm, the HRA met with Shapiro Center staff members, including: the unit social worker and the center director. The meeting occurred via WebEx. The meeting began with introductions and a review of HRA procedures.

Shapiro staff stated that each building is considered a unit. There are different floors in each unit. Staff reported that unit 514 has two floors. Visitors can enter the unit to go to an individual's room or to a visitor's room. Each building has a visitor's room for private meetings.

Staff explained that the individual's guardian was restricted from going onto unit 514 and was notified of this restriction by letter on 12/16/19. The reason Shapiro restricted the guardian from being on the unit is because of the guardian's behavior on 12/15/19. On 12/15/19, the guardian brought the individual back from a home visit. When the guardian entered the unit with the individual, Shapiro staff asked the guardian to take a certain path to get to the individual's room. Staff did not state why the guardian was asked to take this path. There are two paths to get to the individual's room. The guardian became upset and called the staff member a derogatory name. The guardian then taunted and threated a peer that the individual was having issues with and attempted to provoke this peer to hit the guardian. The peer did not hit the guardian; however, the peer feared the guardian would harm him. The guardian was then redirected by staff to the individual's room. Upon the guardian's arrival to the individual's room, the guardian called the Illinois State Police (ISP). The guardian wanted to spend the night in the individual's room, which the guardian has never done and is not allowed at Shapiro Center. ISP informed the guardian that she could not spend the night and directed her to leave the building. Staff explained they restricted the guardian from entering the unit for the protection of staff and residents. The guardian was only restricted from entering the unit and was not restricted from seeing or communicating with the individual. Staff explained the guardian could return to the unit, if she did not threaten people. Staff was not sure the time frame for the restriction; however, the restriction was lifted.

Staff stated there was a peer to peer incident at the vocational center between a peer and the individual. This was the same peer that the guardian confronted and threatened on the unit. The individual had been in the break room and said something negative to the peer. The peer then hit the individual and staff intervened. The individual accused the peer of taunting and teasing him but in fact it was the individual that was taunting and teasing the peer. Staff explained that seating changes were made to separate the individual and the peer. The vocational center is the only time that the peer and individual are typically together as they have separate bedrooms and do not dine together. Staff explained that the individual had other incidents with other peers, but the individual was always the aggressor taunting and teasing his peers. This is addressed in the individual's behavior program and the staff speaks with the individual about using the offensive speech. Staff explained that the individual would make false allegations against his peers for incidents, when in fact it was the individual that caused the incident.

The individual did have minor altercations with peers that resulted in scratches. The guardian never provided any pictures of bruises or serious injuries to the individual. Staff conducted an injury report anytime the individual was injured from an altercation. Staff explained there have been numerous Office of Inspector General (OIG) reports. Staff stated anytime there is a peer to peer altercation, an incident report is completed as well as an injury report. The guardian was notified of any injuries or altercations.

Staff explained that the individual's guardian would take the individual out to eat at restaurants and the individual would get to go home a few days a week. The individual would tease his peers because he got to do these things. The individual would brag about being "wined and dined" when he goes home, and this upset his peers. The individual attended a weekly social skills class that had approximately 12-15 residents in the class. Staff addressed with the class how not to tease or brag to peers. Staff also would speak to the individual in private to remind him not to tease his peers.

The individual is diagnosed with autism and would share his "good news" repeatedly. Staff explained that the individual's "good news" was that he was going home or out to eat. The individual would repeat the same information, so the staff developed a system for the individual to share his "good news". The individual could tell one staff member per shift about his "good news" for a total of 3 times per day. The staff would document when the individual would share his "good news" and remind him of what would occur if he attempted to share his "good news" again. Staff explained that they had to limit the individual from telling his "good news" repeatedly because the individual would become very upset if he could not share his statement right away and this would lead to the individual having behaviors. The individual had an anger management program in which the staff would ask the individual a set of 10 questions to help the individual with acting out.

Staff explained that the guardian would prevent or rescind any of the individual's programs that were working to help the individual with his behaviors. Staff explained once the program was changed the individual's behaviors would increase again.

Staff explained the process for restricting a person's rights. Generally, restrictions can be done on an emergency basis. The staff complete forms and notify the guardian of the restriction and why the restriction is necessary. The team will meet to discuss the restriction to see if the behavioral plan needs to be updated. Any restriction of rights are reviewed by Shapiro's behavioral intervention committee and the human rights committee.

Staff explained that there is a housekeeper that is responsible for keeping the units clean, including cleaning the bathrooms, showers, sweeping/mopping the floors, and trash collection. The residents and housekeeper keep the bedrooms clean. Staff explained that the Illinois Department of Public Heath (IDPH) conducted an unannounced review of the facility with no findings. The facility has been monitored and evaluated by IDPH, Office of Inspector General (OIG) and the local fire department regularly. The Shaprio Center also has an internal peer review process to monitor cleanliness.

Records Reviews:

The HRA reviewed the Individual Support Plan (ISP) dated 11/22/19 which states in summary that the individual is a 46-year-old male with a diagnosis of intellectual disorder, autism spectrum disorder and bipolar disorder. The individual has a guardian and enjoys time with her and goes home often. He has been at Shapiro since 2010. The ISP states that the individual has "no restrictions regarding visitors, off campus visits or home visits" and adds he may participate with guardian authorization. Then there is a revised statement added 12/17/19 that says the

individual's "visitors were restricted in that his guardian may not visit the individual on living area 514B from 12/17/19 to 2/17/20" but does not state why. The ISP stated the guardian is responsible for all communications from Shapiro and is informed regarding the day to day events as needed and she maintains an interest in these events. The guardian maintains contact with the individual through visits, off campus visits, and phone calls. The ISP states, "the guardian wants to be notified of all injuries and illnesses and wants to be informed of all medical appointments."

The HRA was provided a copy of the Behavior Intervention Plan (BIP) dated 1/2/2020 which states the following in summary; the Maladaptive Behavior Assessment was completed on 11/20/19 which indicates that the individual has issues in the following areas: aggression towards others, disruptive behavior, stereotypic behavior, socially offensive behavior, inattentive behavior, uncooperative behavior, untrustworthy behavior, leaves the designated area, inappropriate sexual behavior, eating disorder, and hyperactive behavior. It is noted that the individual has not caused any injury due to physical aggression since his admission to Shapiro in 2010. The plan outlines descriptive behaviors and preventative measures. The behavioral summary states that "the individual had a turbulent year." The BIP notes an increase in sexual behaviors, threatening to get staff fired, leaving the designated area, and inappropriate verbalizations. Revisions were put in place to reduce those behaviors. The last statement in the summary states "In addition, a preventative measure was created to use visual aids to have [the individual] reduce the frequency of him telling his good news."

The HRA reviewed progress notes dated 9/23/19 which indicated that there was discussion the guardian and staff had regarding obtaining the correct medication for tooth pain control and the guardian stated that she would call the shift coordinator. Another progress note dated 9/23/19 noted the guardian contacted the staff and reported that the individual stated that the staff at the vocational program had thrown books at him because they were tired of hearing his "good news." The injury report for 9/23/19 notes that while at the vocational center last week, staff threw books at the individual because they were tired of hearing his "good news." The report indicates that there is no visible injury to the body.

A progress note dated 9/26/19 documented that the individual's guardian contacted the facility to allege that the staff physically abused the individual and pushed him off the chair and pulled on his shirt. The individual was assessed and had a superficial scratch on upper arm, redness to right axillary area, and no visible injuries to the rest of the body. The note stated that an injury report was completed but none was provided to the HRA.

A progress note dated 10/9/19 stated that "Shapiro received an anonymous OIG intake report on behalf of the individual and an investigation was started." Staff notified the guardian on 10/10/19 of the intake report.

An injury report dated 12/2/19 stated that "another peer hit the individual in the stomach" but there was not any visible injury to the abdomen area.

Another injury report dated 12/5/19 stated that "an anonymous caller stated that staff slapped the individual on the face." The report indicated no visible injury.

The injury report dated 12/11/19 stated that the individual "was hit in the stomach by another peer." The report indicated no visible injury to the individual.

Documents supplied by the guardian:

The guardian reported that the individual was punched in the stomach around 12/3/19 resulting in the bruise on the right abdomen. The guardian provided a picture of a bruise to the individual. The guardian reported this was not the first time that this peer has assaulted the individual.

The guardian reported to the HRA that the individual was punched in the stomach on 12/11/19 resulting in the bruise on the left side of the abdomen. The guardian stated that a conference call was held on 12/13/19 and the guardian was told that there was no injury.

The guardian reported to the HRA that on 12/16/19 around 8pm she was at the Shapiro Center returning the individual from a home visit on and the guardian was served the restriction of rights paperwork. Staff told the guardian that they would arrest the guardian, in front of the individual if she went onto the individual's unit. The individual screamed for a minimum of 20 minutes after this because he was afraid to death to go upstairs with the staff and officer as he thought they were going to murder him. The individual suffered horrible nightmares after this occurred.

The guardian emailed Shapiro staff on 12/2/19 stating that she "was concerned? that a peer had hit the individual in the stomach 3 times." The guardian was further concerned because this peer has done this before, and the peer is teasing and harassing the individual. The guardian was concerned that the peer has not been removed from the group. The email also notated the guardian's concern that when the guardian calls the unit to talk to the individual, the guardian hears them announce that it is the individual's guardian and then the staff hang up the phone. The guardian then stated that she is concerned for the individual's safety and worries that he will lose "another joint" because the individual was not being kept safe by staff.

Shapiro staff emailed the guardian on 12/3/19 and stated that staff have addressed the peer to peer incident that occurred yesterday and reminded staff that the individual and the peer are not to be in the same group during vocational services. The email stated that the staff will address one peer's inappropriate actions towards the guardian and remind staff to redirect the peer if it happens again. The email also addressed another peer who is not in the same group as the individual but may interact briefly. The staff assured the guardian that the staff will conduct rounds to check on these things. The staff member also reassured the guardian that the phone etiquette would be reviewed with the peers.

The guardian emailed staff on 12/5/19 and stated that the individual was showing signs of depression. The email stated that the individual is staying in the time out room for the entire day. While in the time out room, a peer comes over to the area and says negative things to him and the individual acts out in anger. The guardian had concerns that the individual may be having suicidal thoughts as he has in the past.

Shapiro staff emailed the guardian on 12/11/19 and stated that there was a plan to keep the individual safe after another incident at the vocational program today. There was additional

discussion of scheduling a meeting soon to review the incident and Shapiro's plan to keep the individual safe and prevent anything else from occurring.

The guardian responded to the previous email on 12/12/19 and stated that the guardian is available for a meeting on Friday. Also, in this email was a statement by the guardian that the individual was still not getting privacy for phone calls as evidenced by the fact that the peers were laughing at the individual while on the phone with the guardian and the individual was telling the guardian about the peer abuse. The guardian requested that the individual not be sent to vocational today because of concerns for the individual's safety. The guardian also expressed that the guardian believed that staff did not like the guardian, and they may be making things more challenging for the individual because of their dislike. On 12/12 Shapiro staff replied and stated that the other staff spoke with the guardian and the issues appeared to be sorted out for now.

The guardian provided a copy of the restriction of rights dated 12/17/19 that stated "Due to inappropriate interactions of your guardian you are hereby notified that your guardian is not authorized to visit you on living area 514B at any time or for any reason. When your guardian picks you up for a home visit you will come downstairs to the 514-lobby on the 1st floor, when you return staff will meet you on the 1t floor and take you back to living areas 514. Visits at the facility with your guardian will be held in the breakroom. The restriction is to prevent your guardian from inappropriate interactions with people served and staff on living area 514B and reasonably necessary to protect you and others from harm."

The HRA reviewed an email dated 12/23/19 from the guardian to Shapiro which stated that the guardian continued to not be allowed upstairs and while they were abiding by this and sent another family up to the room, the guardian heard staff yell that "the doors should have been locked to not allow the family is up on the unit " The guardian reiterated that she remained on the first floor to be harassed by the security guard, however, the consumer should still be allowed to have visitors as it is a basic human right." On 12/23/19 staff from Shapiro responded that the security guard had been informed of the restriction.

Office of Inspector General Reports:

The HRA reviewed a report from the Office of Inspector General (OIG) which was unfounded for an incident that allegedly occurred on 12/3/19. An anonymous caller reported that staff slapped the individual in the face, however, during the investigation the individual stated the allegation was a lie, and this did not occur

Another OIG report was unfounded for an incident that allegedly occurred on 9/26/19. It was reported that a staff member pushed the individual and ripped his shirt. The investigation concluded that the individual was having some behavioral issues and ripped his own shirt and then lied about it to not upset his mother.

The HRA reviewed a report from the OIG which was unfounded for an incident that occurred on 6/6/19. It was reported that staff hit the individual. When being interviewed, the individual stated

that the incident did not occur and that the individual had "hallucinated it all". Staff denied hitting the individual.

Another OIG report was substantiated for an incident that occurred on 2/9/19. It was reported that the individual was among others that were not properly supervised when a staff member left the unit and could not get back in.

The HRA reviewed a report from the OIG which was unfounded for an incident that occurred on 3/20/19. It was reported that staff struck the individual in the face so hard that he fell to the ground. The staff member did not work on the unit, so they did not interact with the individual.

Policy Reviews:

The HRA reviewed Shapiro's Behavior Intervention Program Policy which states "It is the policy of Shapiro Center (SC) that positive approaches to behavioral change are utilized with individuals who exhibit maladaptive behaviors. Behavior intervention programs must emphasize the development of adaptive, appropriate behaviors to replace the maladaptive behaviors and contain the least restrictive procedures necessary to maximize the individual's growth, development, and overall adaptive behavior." The policy further states "Every support plan of an individual who exhibits significant maladaptive behavior is to include provision to teach the individual the circumstances, if any, under which the behavior can be exhibited adaptively, to teach the individual how to channel the behavior into similar, but adaptive expressions, or to replace the behavior which behavior that is adaptive."

The HRA was given a copy of Shapiro's Environmental/Physical Plant Checklist. The purpose of the documents states "To document the results of the environmental/physical plant checks of living areas." The form is to be completed by the Living Unit Administrator (LUA) and Unit Director. The LUA is to "complete 2 checklists per month; on the 2nd and 4th week of the month, Information on the form should reflect the condition of living area at the time of the LUA's physical inspection of the area, and If an item receives a NO, the LUA is to record the reason for the NO and the immediate action taken to correct the issue." The unit director "reviews each checklist to ascertain whether the records accurately reflect the condition of the living area at the time of the LUA's/Charge's review, comments on the last page of the checklist when appropriate and forwards the completely reviewed and initialed checklist to the Center Director/Assistant Center Director's Office with weekly reports."

The HRA reviewed Shaprio Center's Medical Services Injury Report policy. The purpose of the policy states "to ensure injuries to individuals are promptly reported, examined, treated and recorded by medical/nursing personnel and assessed for preventative action. Also, to provide individuals who reside at Shaprio Center a safe environment in which the risk of injury is minimized. Injury reports shall be completed for all injuries to individual's and for all situations which may potentially reveal an injury to an individual later." The injury report procedure states "Completion of an injury report is required for every injury or potential injury an individual incurs no matter how minor the injury may appear." Under reporting injuries it is stated "All injuries, regardless of how minor, related to an allegation of abuse, neglect or mistreatment or that appear to have a suspicious origin must be reported: to Office of the Inspector General

(OIG) phone hotline within 4 hours and to IDPH within 24 hours of discovery... all serious injuries requiring medical treatment that do not involve abuse, neglect, or mistreatment and all induvial-to individual acts of physical aggression, resulting in the initiation of a visible or non-visible injury report, must be immediately reported via telephone to the center director or designee, and require a completion of the SODC Report. Protocol, Significant Event Report (620) ..."

Shapiro Center shared their policy on "Rights of Individuals" which the HRA reviewed. The policy states "Shaprio Center is responsible for protecting and affirming the rights of individuals who reside at the Center in accord with the Illinois Mental Health and Developmental Disabilities Code. Individuals who reside at the Shaprio Center shall not be deprived or any of their rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, of the Constitution of the United States solely because he/she is a recipient of services." Furthermore, under "Rights that may be limited by clinical and administrative procedures include: Rights of individuals to communicate (this is a use of telephone, for both local and long distance calls); send or receive mail in privacy; receive visitors; to have personal property; freedom of movement; privacy, and to manage his/her financial affairs. Where limitation or restriction of the above specified rights are considered necessary, the following procedure must occur: each limitation or restriction of an individual's rights must be discussed in a meeting of the Interdisciplinary Team and documented in the Individual Support Plan, in accord with the Mental Health and Developmental Disabilities Code... The guardian is given a written copy of the individual's ISP including Section IV...If a restriction/limitation must receive approval from the Behavior Intervention Committee and Human Rights Committee and consent from the person served or his/her guardian, if applicable, prior to implementation of the plan...The affected individual or others acting on his/her behalf are given an opportunity to object to the proposed limitation or rights."

The HRA reviewed Shaprio Center's policy on their Human Rights Committee, which states "The Human Rights Committee (HRC) is established by the Shapiro Center to ensure that the human, civil and legal rights of all individual who reside at Shapiro are safeguarded and supported. The committee ensures that the Interdisciplinary Team has reviewed each individual's rights and established supports and procedures and practices which affect the rights of individuals living at the Center." Furthermore, the policy states "The Human Rights Committee shall review and must approve, prior to the implementation those individual plans designed to minimize inappropriate behaviors which may be considered, utilize controversial procedures or are directed toward controversial goals."

The HRA reviewed Shapiro's "Individual Support Plan" policy which states "Each individual admitted to the Shapiro Center shall have an Individual Support Plan designed by an appropriate constituted Intermediary Team. An IDT meeting is held within 72 hours of admission, then within 14 days of admission and at least annually within 365 days thereafter." Furthermore, the policy reviews the definition of an Individual Support Plan as well as the definition, compensation and function of the Intermediary Team. The policy states "In an Intermediary Team meeting, all members are equal, each member expertise is acknowledged, ownership of problems is shared, and each member participates actively."

Shapiro Center provided the HRA with a copy of their "Workplace Violence Prevention and Reporting" which states "It is the policy of the Illinois Department of Human Services (IDHS) to prevent the Division of Mental Health (DMH) and the Division of Developmental Disabilities (DD) employees from being injured at workplace." The policy also goes over the reporting procedures, workplace violence prevention plan as well as training for staff.

Conclusions

Complaint 1: Inadequate treatment

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) states "(a) 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 complaint alleges that the individual was not allowed to share his "good news" with staff. Staff explained that they had to limit the individual from telling his "good news" repeatedly because the individual would become very upset if he could not share his statement right away and this would lead to the individual having behaviors. The HRA reviewed the individual's Behavioral Intervention Plan (BIP) which stated "In addition, a preventative measure was created to use visual aids to have [the individual] reduce the frequency of him telling his good news.

After completing the interviews, records reviews, and assessing applicable mandates, the HRA discovered that the individual's guardian had accused staff of not allowing the individual to speak to her, but outside of the allegation, the HRA did not see evidence that this occurred and additionally, the HRA did not see evidence that staff threw books at the individual. The HRA saw that the individual had a behavior plan and the staff had a practice in place attempting to limit repeated behaviors by the individual. Based on the findings above the East Central Human Rights Authority concludes the complaint is **unsubstantiated**. No recommendations or suggestions are being made in relation to this complaint.

Complaint 2: Provider failed to keep the consumer free from abuse resulting in the consumer being injured on multiple occasions by multiple peers

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-112) states "Freedom from abuse and neglect. Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect."

The Mental Health and Developmental Disabilities Code (405 ILCS 5/3-211) states "Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a recipient of services indicates, based upon credible evidence, that another recipient of services in a mental health or developmental disability facility is the perpetrator of the abuse, the condition of the recipient suspected of being the perpetrator shall be immediately evaluated to determine the most suitable therapy and placement, considering the safety of that recipient as well as the safety of other recipients of services and employees of the facility."

There was an incident between the individual and a peer while at the vocational center. Staff

took appropriate action to separate the peer and the individual and put in place precautions to prevent further incidents. Staff addressed the peer to peer incidents that occurred and reminded staff that the individual and the peer are not to be in the same group during vocational services.

After completing the interviews, records reviews, and assessing applicable mandates, there is no evidence to support the complaint. The HRA reviewed incidents related to the individual and behaviors documented in the behavior plan. It appears the individual provokes incidents with his peers that cause the individual to be harmed. Based on the findings above the East Central Human Rights Authority concludes the complaint is **unsubstantiated**.

The HRA requested any polices on peer versus peer violence. However, none were provided to the HRA. The HRA **strongly suggests** that Shaprio Center develop policy and procedures to address peer versus peer violence.

Complaint 3: Unnecessary Restriction of Rights.

The Mental Health and Developmental Disabilities Code (405 ILCS 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."

The Shapiro Center notified the guardian and the individual of the rights restriction and the reason for the restriction. The guardian was only restricted from coming onto unit 514 due to safety concerns for the residences and staff. The guardian was not restricted from seeing or communicating with the individual. Based on the findings above the East Central Human Rights Authority concludes the complaint is **unsubstantiated**.

However, the HRA **strongly suggests** that in the future Shaprio Center provide more detailed information within the restriction notice on what "inappropriate interactions" are to both the individual and the guardian. The HRA also encourages HRC reviews of situations like this.

Complaint 4: Unsanitary living conditions.

The Code of Federal Regulations (42 C.F.R. § 483.80) states "The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections."

The staff explained that there is a housekeeper who is responsible for keeping the units clean, including cleaning the bathrooms, showers, sweeping/mopping the floors, and trash collection. The residents and housekeeper keep the bedrooms clean. Staff explained that the Illinois

Department of Public Heath (IDPH) conducted an unannounced review of the facility with no findings.

The HRA requested a copy of the unannounced review conducted by IDPH as well as Shaprio Center's cleaning policy. However, the HRA was not provided these documents so the HRA must assume the policy does not exist. Based on the findings notated above the East Central Human Rights Authority concludes the complaint is **substantiated**. The Human Rights Authority makes the following **recommendations**:

1. The Shapiro Center establish and maintain an infection prevention and control program to follow the Code of Federal Regulations (42 C.F.R. § 483.80).
2. The Shapiro Center train all staff on the policy's and/or plans developed.

The HRA respectfully requests that Shapiro Center provide the HRA with evidence of the plans/policy's established as well as evidence that staff have been trained as recommended.

RESPONSE

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

JB Pritzker, *Governor*

Illinois Department of Human Services

Grace B. Hou, *Secretary*

Shapiro Center
100 East Jeffery Street • Kankakee, Illinois 60901

April 19, 2021

Illinois Guardian and Advocacy Commission
2125 South First Street
Champaign, Illinois 61820
Attention: Kelli Martin, Chairperson

RE: Human Rights Authority Case #20-060-9011

In response to your review and recommendation in the above case; Shapiro Center's response is as follows:

Complaint 2; the HRA strongly suggests that Shapiro Center develop a policy and procedures to address peer versus peer violence.

- Shapiro Center has policies and procedures in place to support individuals and prevent incidents of peer to peer aggression. When an incident of aggression occurs between peers, immediate corrective actions and preventative measures are taken including, an incident report being completed, peers are separated to ensure no further incidents occur, medical assessments completed, and counseling regarding the incident occurs with each peer, etc. Unit leadership staff and other disciplines, as appropriate conduct a review of the incident and steps to reduce or prevent the probability of future occurrences of peer versus peer aggression. The review focuses on the past behavior of individuals, and addresses problem solving and problem prevention through a review of the systems and processes surrounding the incident. In addition, the Injury Review Committee reviews conducts a review of the incident/injuries and Executive Council reviews and discusses incidents.

Complaint 3; the HRA strongly suggests that in the future, Shapiro Center provide more detailed information within the restriction notice on the "inappropriate interactions" are to both the individual and guardian.

- Shapiro Center will include provide more detailed information of inappropriate interaction(s) within a restriction.

Complaint 4; this complaint was based on unsanitary living conditions; specifically citing the stove, range, refrigerator, and cafeteria area.

- As discussed in the WebEx meeting, Shapiro Center has an internal review process to monitor cleanliness. Shapiro Center will continue to maintain its infection and

prevention and control program which is designed to provide a safe, sanitary, and comfortable environment.

- Attached are the following documents to support the verbal discussion held during the Webex meeting on December 16, 2020:
    - The Illinois Department of Public Health complaint compliance review completed on October 10, 2019.
    - Shapiro Center's Housekeeping manual and Housekeeping sanitation manual.

Respectfully submitted,

Lynne C. Gund

Lynne C. Gund
Center Director