

THESE ARE GOD'S PEOPLE TOO
A For Profit Social Service Agency

**Why Does An Agency
That Profited From Exploiting
Persons With Disabilities
Remain Taxpayer Funded?**

**A Special Report by the
ABUSE INVESTIGATION UNIT
Equip for Equality**



Advancing the human and civil rights of
people with disabilities in Illinois

MISSION

Established in 1985, the mission of Equip for Equality is to advance the human and civil rights of people with disabilities in Illinois. Equip for Equality is a private not-for-profit legal advocacy organization designated by the Governor to operate the federally mandated protection and advocacy system (P&A) to safeguard the rights of people with physical and mental disabilities, including developmental disabilities and mental illnesses.

ABUSE INVESTIGATION UNIT

Abuse Investigation Unit works to prevent abuse, neglect and deaths of children and adults with disabilities in community-based programs, nursing homes, and state institutions. Works with public investigatory agencies to improve their performance and coordination with each other; conducts investigations of abuse and neglect cases; alerts service providers to dangerous conditions and practices. Funded by Congress as national demonstration project.

OTHER SERVICES, PROGRAMS & PROJECTS

Equip for Equality is the only comprehensive statewide advocacy organization for people with disabilities and their families. All individuals with a disability in Illinois (as defined by the ADA) are eligible for services, including children, senior citizens, and individuals in state-operated facilities, nursing homes, and community-based programs.

Self-Advocacy Assistance offers free, one-on-one technical assistance to inform individuals about their rights, alternative options and strategies, and steps they may take to advocate on their own behalf or on behalf of a family member.

Legal Services provides free legal advice and representation in administrative proceedings and federal and state court. Also engages in systems and impact litigation.

Training Institute on Disability Rights provides education through seminars for people with disabilities and their families. Seminar topics include rights and responsibilities under the Americans with Disabilities Act, protections against employment discrimination, guardianship, advance directives and special education rights.

Public Policy Advocacy achieves changes in state legislation, public policies and programs to safeguard individual rights and personal safety, enhance choice and self-determination, and promote independence, productivity, and community integration. Drafts and secures passage of state legislation and participates in state regulatory and policymaking processes. Also undertakes in-depth policy research and reform projects on complex issues that have a significant impact on the lives of people with disabilities.



THESE ARE GOD'S PEOPLE TOO
A For Profit Social Service Agency

**Why Does An Agency
That Profited From Exploiting
Persons With Disabilities
Remain Taxpayer Funded?**

**A Special Report by the
ABUSE INVESTIGATION UNIT
Equip for Equality**

This publication is made possible by funding support from the *Centers for Medicare and Medicaid Services*, the *Illinois Department of Public Health* and the *Illinois Department of Human Services*. The contents of this publication are solely the responsibility of Equip for Equality and do not necessarily represent the official views of any of these agencies.





THESE ARE GOD'S PEOPLE TOO
Why Does An Agency That Profited From Exploiting Persons
With Disabilities Remain Taxpayer Funded?

**SUMMARY OF ACTIVITIES, FINDINGS, AND
RECOMMENDATIONS**

These Are God's People Too is a for-profit provider of community integrated living arrangements (CILAs) and developmental training services for individuals with developmental disabilities. The Abuse Investigation Unit of Equip for Equality conducted an in-depth examination of the agency during a 15-month period from March 2002 until June 2003 after learning that the Executive Director recommended pulling all of an individual's teeth to prevent him from chewing on his hand. The Abuse Investigation Unit documented serious and long-standing problems threatening the safety, health, and well-being of the individuals purportedly served by this agency, along with problematic expenditures of public funds by agency staff.

The problems documented by the Abuse Investigation Unit illustrate the ineffectiveness of the current enforcement system in this state to address problematic facilities by either compelling prompt improvements or closing the facility, and demonstrate the urgent need for a reexamination of the system by which providers are reviewed and sanctions are determined and imposed. The enforcement system was established to ensure that timely steps are taken to remove public support from providers that flagrantly ignore basic human needs and dignity or endanger the health and safety of the people being served. The information revealed by this investigation suggests that the current system does not have an effective enforcement mechanism with sufficient resources to implement swift changes.

Since 1999, the Department of Human Services (the Department) has cited **These Are God's People Too** on numerous occasions for serious health and safety violations of state regulations at each of the agency's seven facilities. In spite of the numerous citations, and even the loss of state funding for a brief period during 2002, **These Are God's People Too** did not remedy the deplorable conditions that existed in its facilities. The very same unsafe, unsanitary, and deplorable conditions identified by the Department at both the residential facilities and the developmental training site were also documented by the Abuse Investigation Unit.

The individuals whom this agency serves have been compelled to live in residences furnished with **worn, torn, filthy, and broken furniture, foul-smelling rooms with no light, lights with no light bulbs, walls smeared with dried feces, and bathrooms with no toilet paper or towels; their safety has been jeopardized**



by blocked exits, dilapidated and unsafe environmental conditions; and neither the residences nor the training site have materials or supplies, books or magazines, games or equipment available for appropriate programming or leisure activities designed to meet the needs of each of the individuals.

When mandated by the Department to address a problem at one of its buildings, the agency would fix only what the Department specifically identified at that site and ignore the very same problem at its other sites, perpetually leaving its residents at risk. While allowing such deplorable conditions to continue, These Are God's People Too expended more than \$200,000 of state funds to provide key agency staff with leased cars and cell phones, and provided staff with offices that were clean and decorated with furniture that was in good repair.

In February 2003, based upon the serious problems documented by the Abuse Investigation Unit, Equip for Equality recommended that the Department of Human Services revoke the license for CILA services, deny the certification for the developmental training program, terminate the contract with These Are God's People Too, and conduct an investigation into the agency's use of state funds. The Department of Human Services responded to this recommendation by conducting a full licensure survey and a review of all of the agency's facilities, along with a financial investigation into the agency's use of state funds.

In spite of several weeks' advance notice of the licensure survey, the survey team found serious safety, accessibility, environmental, and programmatic deficiencies, and cited the agency for repeated violations of state regulations regarding resident assessment, individualized goals, and service plans. Among other serious deficiencies, the survey team identified a lack of toilet paper, a bathroom without even a toilet seat, inadequate lighting, lights without light bulbs, a lack of cleanliness, broken furniture, foul-smelling rooms, and an inoperable stove.

Not until the Department deployed the resources of three separate divisions to confront These Are God's People Too with a comprehensive financial audit, a full licensure survey, and a review of each of its facilities, with the potential loss of its license, in response to Equip for Equality's recommendations, did the agency begin to provide its residents with toilet paper and lights, and make other modest improvements to its facilities.

In July 2003, the Department conducted an additional announced survey that it had scheduled with the agency in advance. In that survey the Department did not find deficiencies warranting termination of the agency's contract or closure



of its facilities. However, one week earlier an unannounced site visit by the Abuse Investigation Unit again revealed bathrooms without toilet paper or holders, along with inadequate amounts of food to meet nutritional needs, and dilapidated and dangerous conditions at the CILA residences, demonstrating that this agency is unable to sustain even modest improvements over time and that any improvements it chooses to make are timed to meet its scheduled visits by the Department.

Equip for Equality is the independent, private not-for-profit organization designated by the Governor in 1985 to administer the federally mandated Protection and Advocacy System (P&A) to safeguard the rights of people with disabilities in Illinois. In October 2001, by securing additional resources, Equip for Equality was able to establish an Abuse Investigation Unit to address systemic issues of abuse and neglect affecting individuals with disabilities in any service provider or residential setting, licensed or unlicensed, including state-operated facilities, community agencies, and nursing homes.





BACKGROUND

These Are God's People Too, serves approximately 40 individuals with developmental disabilities in its day program, 30 of whom also reside in one of its six 24-hour CILA programs.

Since becoming a provider in 1998, These Are God's People Too has had a long and problematic history. The agency has routinely ignored the welfare of the individuals whom it serves, leading to the death of one individual in 2000, the existence of deplorable living conditions at its residences, and a pervasive lack of even the most basic services or supplies to meet the needs of the individuals, including adequate lighting, appropriate nutrition, housekeeping, routine maintenance, or toilet paper.

This agency came to the attention of the Abuse Investigation Unit in March 2002 following a review of information regarding an incident some months earlier in which an individual who lived in one of the agency's CILA residences and attended the developmental training program sustained an injury to his hand and developed a serious infection that required amputating part of the injured hand. In response to the individual's tendency to engage in self-injurious behavior, by biting the injured hand, the Executive Director recommended that all his teeth be extracted. Fortunately, the dentist to whom the provider referred the individual declined the procedure.

In March 2002, as a result of the incident involving the partial amputation, Equip for Equality's Abuse Investigation Unit made an unannounced visit to the agency's day program, where the Executive Director and other key staff were interviewed and the facility toured. In response to questions raised during the interview, agency staff indicated, among other things, that physical restraints such as holds and takedowns were regularly utilized as methods of behavioral interventions. Staff did not acknowledge an understanding of the inherent dangers related to such interventions or identify any appropriate training before employing such interventions.

During the tour of the developmental training facility, Abuse Investigation Unit staff observed a variety of environmental deficiencies and serious safety concerns, including locked exit doors without readily accessible keys; lack of physical access for individuals using wheelchairs to various parts of the building, including the dining area; walls with holes and cracks; and filthy conditions throughout the building and program areas. Additionally, virtually no material or programming supplies appeared available to the participants at the facility, which was only sparsely furnished. For example, a room used for leisure activities as a



reward for individuals who had not had any "behaviors" during the week did not have any leisure activity supplies, such as board games, cards, or other supplies for independent activity. Likewise, classrooms, which were furnished with desks only, lacked any academic materials.

Following the initial visit to the developmental training facility, the Abuse Investigation Unit determined to expand its review of the agency to include unannounced site visits to each to the CILA residences, a review of the available information concerning the agency, licensure and certifications surveys, reports from the Department of Human Service's Bureau of Quality Assurance and System Improvements (BQASI), abuse and neglect incident reports, financial reports, relevant policies and procedures, and the programming and services provided by the agency.

INFORMATION REVEALED BY STATE RECORDS

A review of licensure survey records reveals that approximately one year after These Are God's People Too became a licensed provider, the Department conducted a full licensure survey of the agency. At that time the agency received one of the highest survey results for community providers of services for individuals with developmental disabilities in the state. However, within four months of the survey, the agency began to be cited regularly by the Department of Human Services. Thereafter, multiple citations of deficiencies, ongoing site visits, and loss of funding did not compel the agency to remedy the environmental and safety issues identified by the Department of Human Services. By 2000, the agency's overall rating of compliance dropped significantly below the compliance ratings of virtually all other community providers of services for individuals with developmental disabilities.

HEALTH, SAFETY, AND WELL-BEING DEFICIENCIES DOCUMENTED BY EQUIP FOR EQUALITY

On seven separate occasions from March 2002 to June 2003, the Abuse Investigation Unit made unannounced site visits to These Are God's People Too, touring both the day program and the CILA sites at different times. Equip for Equality communicated various concerns to the Department's Office of Developmental Disabilities, some of which were in turn referred for follow-up to the Department's Bureau of Quality Assurance and System Improvement and the



Bureau of Accreditation, Certification and Licensure. The Abuse Investigation Unit documented the same problems and substandard conditions at the agency's facilities as cited by the Department repeatedly in various reports since 2000.

During the site visits, the Abuse Investigation Unit documented serious concerns impacting the safety of the individuals residing in the residences or attending the day program, including blocked and inaccessible exits from buildings and deplorable and dangerous living conditions. In some instances, exit doors were locked, requiring the location of staff in possession of a key in order to exit the door. In other instances, wood placed across doors made exit impossible. The Abuse Investigation Unit also documented fire pull boxes needing repair and fire extinguishers needing to be charged, readily accessible chemicals and cleaning supplies, broken windows, and loose and missing porch and deck planks.

The Abuse Investigation Unit continually noted a pervasive level of filth and unsanitary conditions in the residences. Those conditions included an oven that was unusable because the door was stuck closed by the amount of grease and grime, shelves with such filth that cans were stuck, basements with standing water and mold, open sewers, foul-smelling rooms, dirty tubs and showers, and unkempt yards strewn with garbage.

Several of the CILA residences were sparsely furnished and lacked personal items, and when furnished, individuals had to use worn, dirty, and broken furniture, with dressers missing drawers or handles. The agency routinely failed to provide toilet paper or towels for the individuals. CILA residences in some locations were dimly lit because fixtures had no light bulbs, creating blackened stairwells leading down to dark basements where residents did their laundry. The Abuse Investigation Unit noted that the CILA residences often lacked sufficient food to meet the nutritional needs of the individuals living there. Leisure materials or programming supplies were noticeably absent from the CILA residences. Items such as books, magazines, games, puzzles, arts and crafts supplies, recreational equipment, or other materials were not available for the individuals living there. Small television sets appeared to be this agency's primary form of programming and activities.

In June 2003, within one week of a critical survey by the Department, which the agency had notice of, the Abuse Investigation Unit observed bathrooms without toilet paper, inadequate amounts of food to meet nutritional needs, smeared feces, dilapidated and dangerous conditions at some of the residences, and a paucity of available supplies or material at the programming site.



HIGHLY QUESTIONABLE USE OF PUBLIC FUNDS BY AGENCY STAFF

Given the substandard condition and deplorable maintenance of the property and buildings, the sparse and broken furnishings, and the absence of any program or recreational supplies, the Abuse Investigation Unit questioned the manner in which state funds were being expended. The financial information that the agency supplied to the Department's Office of Contract Administration on an annual basis included the following expenditures during the below described years:

EXPENSES	1999	2000	2001	Totals
Telecommunication	\$11,967	\$47,042	\$38,631	\$ 97,640
Supplies	\$12,788	\$17,773	\$27,350	\$ 57,911
Professional Fees	\$ 3,439	\$30,562	\$20,920	\$ 82,071
Dietary Technician Salary	N/A	\$31,304	\$59,206	\$ 90,510
Dietician	\$24,024	N/A	N/A	\$ 24,024
Automobile Leases	\$23,295	\$35,898	\$35,593	\$ 94,786
Automobile Expenses	\$4,929	\$21,980	\$6,512	\$33,421
Rent	\$12,788	\$47,990	\$119,438	\$180,216
Equipment Purchase and Rental	\$30,589	\$15,699	\$3,162	\$49,450
Transportation to and from School	\$4,929	\$21,980	\$6,512	\$33,421
Travel and Training	N/A	\$2,401	\$8,971	\$11,372
Housekeeping, Laundry Supplies	\$5,849	\$8,902	\$1,470	\$16,221

Based upon a review of these reports, the Abuse Investigation Unit requested a written explanation from These Are God's People Too regarding certain expenditures for fiscal years 1999-2001. In response, a certified management accountant, responding on behalf of the agency, offered the following explanations:



- Telecommunication costs were for cellular telephones for “key staff members.”
- Professional fees were for services performed for These Are God’s People Too by outside professionals, including legal fees.
- The salary paid to the dietary technician represented not only compensation for performing dietician functions but also for supervision of the residential operations.
- The cost of the leased vehicles resulted from monthly lease payments for four staff positions and ranged in price from \$495 for QMRP, \$561 for Residential Director, and \$513 for Vice President to \$761 for Executive Director.
- The increased travel and training costs were the result of additional classes required by the Department of Human Services in order to maintain accreditation.
- The increased housekeeping and laundry supply costs during 1999 and 2000 resulted from an increase in residents; however, more “economical means” were adopted in 2001, which resulted in a decrease in the cost of housekeeping and laundry supplies.

Analysis of this information indicated that the agency’s fiscal expenditures, priorities, and decision making warranted closer scrutiny. During the years 1999 through 2001, this provider received \$3,289,416 primarily in state and federal funding. During those same years, the provider stated that less than \$58,000 was used for the purchase of program supplies for its program participants.¹ Conversely, during those same three years, the provider reported using more than \$225,000 to lease automobiles and pay automobile expenses for four staff members and to provide cell phones for “key staff.” Moreover, during those same three years, the rent paid by the provider on six properties increased by approximately 934%, during which time the property tax records of Cook County reveal that individuals with the same last name as the Executive Director maintained an interest in three of those properties. Finally, in spite of repeated complaints and cited deficiencies related to filthy living conditions, this provider chose to reduce its expenditures for cleaning and laundry supplies by approximately 84%, to a meager \$1,470 for five houses, one apartment building, and a program site.

In essence, this provider allocated substantial resources to benefit key staff that did not benefit the program participants in any significant way. Clearly, quality services and clean and safe environments for people with disabilities are not a concern of this agency’s leadership.

¹ The accuracy of the figure given is questioned, due to the absence of available supplies in the residential day program.



AVERSIVE AND DANGEROUS BEHAVIORAL INTERVENTIONS EMPLOYED BY AGENCY STAFF

The behavioral interventions recommended and implemented by this agency begin at the most aversive and restrictive levels, and were neither consistent with customary practices in the field nor designed to address maladaptive behaviors in an appropriate manner. In response to an individual's self-injurious biting behavior, teeth extraction was recommended. Toilet paper and paper towels are withheld from residents in response to resident behavior. Physical holds and takedowns are a method of behavioral intervention used at the day program. The agency's Human Rights Committee, designated as the entity to safeguard an individual's rights and to ensure that aversive and restrictive techniques are used only when all other options have been attempted and have failed, is chaired by a relative of the Executive Director who, as Chair, supported the recommendation for teeth extraction.

The agency's use of physical holds and takedowns in response to behavioral difficulties is even more serious and problematic given the agency's unwillingness to provide for the most basic needs of its residents and its failure to address serious safety problems agency wide. Although trained in a crisis prevention model that does not include physical takedowns, agency staff are employing such procedures without understanding the dangers associated with their use. The staff seemed unaware of the complexity of significant factors to consider in connection with such procedures, such as the individual's medication, medical history, possible history of abuse, the physical symptoms associated with episodes of struggle and exertion that frequently accompany the use of restraint, or the increased risk of injury or death.

The Abuse Investigation Unit requested information from the Executive Director in March 2002 and April 2002 for the agency's policies and procedures related to the use of takedowns and physical holds. Not until the agency received a Sanction Notice from the Department of Human Services indicating that funding was being withheld because it had failed to submit a Plan of Correction related to substantial deficiencies at its developmental training site and several CILA sites, did the agency begin to submit information in response to the Abuse Investigation Unit requests.



HISTORY OF COMPLAINTS AND DEFICIENCIES AGAINST THESE ARE GOD'S PEOPLE TOO

A review of complaints made to the Department illustrates that this agency routinely falls below even minimum standards in providing services to individuals with disabilities. Critical areas related to participant safety, such as crisis prevention intervention trainings, staff background checks, the development of policies and procedures regarding medication management, environmental improvements, and appropriate programming, were addressed only after the Department of Human Services identified the problems and forced corrective action. Even then, the agency's "Plan of Correction" often involved nothing more than providing very basic services, such as housekeeping, routine maintenance, adequate lighting, and appropriate nutrition. The following details the history of specific complaints and deficiencies by location since 2000:

FACILITY: **24-Hour CILA - A**

Incident #1: Neglect-Death

Date: 2000

Report By: BQASI

Violation:

An allegation of neglect regarding the CILA, in which staff failed to administer CPR to a program participant who became unresponsive while his wheelchair was pushed to the van. Staff noticed that the individual's hands and lips were discolored and checked for pulse and respiration, with negative results. One staff person called 911 while the other pushed the individual's wheelchair to the home's front door, where she waited for the ambulance. The individual died of a pulmonary thromboembolus.

Incident #2 Failure to report timely

Date: 2001

Report By: Individual's mother/guardian

Violation:

In 2001, the Office of the Inspector General (OIG) received an inquiry from an individual's guardian as a result of the agency's failure to provide information as required by the Illinois Administrative Code regarding how the recipient had sustained a head injury.



Incident #3: Welfare concerns – substandard physical environment
 Date: 2001
 Report By: An anonymous call to BQASI on 7/24/01
 Violation:

An anonymous call regarding the CILA's state of dilapidation and "what goes on there at night," alleging that the air conditioning is either broken or not operating; the new patio has large holes and presents hazards to the residents; at night, screaming, crying, and obscenities are heard emanating from the home, and when the neighbor went to the CILA to complain, boyfriends of staff members came to the door in various states of attire; and individuals are carried from the home to the transport vehicles rather than using their wheelchair.

BQASI Response: Visited the CILA on two separate occasions and verified that the deck was being reconstructed and the foundation was exposed and sectioned off.

Incident #4: Environmental Issues
 Date: 5/09/02
 Report By: Equip for Equality & BQASI
 Violation:

An Equip for Equality visit made in conjunction with BQASI revealed that the kitchen was dirty, the oven and the stove were caked with grease, the refrigerator lacked sufficient quantity and variety of food for all residents, and food cabinets were empty; that there were sharp, jagged edges of glass remnants left in the bottom section of the doorframe of the front door; that a picture in a consumer's bedroom had cracked glass; that a ceiling beam over the beds in the bedroom was sagging, coming away from the wall at both ends and at the middle support hook; that a dresser was missing a drawer; that the living room sofa had ripped cushions; that the house lacked appropriate lighting, especially in the kitchen and dining area; that there were open over-the-counter medications that did not have a label on them indicating which participant they belonged to, and liquid medications were stored with pill medications; that the basement had standing water and smelled of mildew; and that there were discarded household items in the backyard.

BQASI Response: Sent These Are God's People Too a letter on 6/05/02 requesting a Plan of Correction be submitted by 6/26/02; a Second Notice was sent 7/02/02; a Sanction Notice was sent 7/26/02; a Plan of Correction was submitted 8/22/02 with a follow-up review by BQASI on 9/06/02 for compliance to the Plan of Correction.



Incident #5: Environmental Issues

Date: 10/01/02

Report By: Equip for Equality

Violation:

The outside deck floorboards were either cracked, loose, or missing; cigarette butts littered both the front and back yard; a second decorative beam in the bedroom ceiling that was over participants' beds and was coming away from the ceiling supports had not been removed when the first beam was removed earlier in the year; These Are God's People Too staff indicated that the stove did not work; the kitchen was poorly lit; there was some water on the basement floor; the panels on the bathtub surround were loose, with a visible gap; there was congealed blood in the bottom of the freezer in the basement.

Incident #6: Environmental Issues

Date: 04/02/03

Report By: Equip for Equality

Violation:

In the bathroom, contact paper was peeling from the wall, a shower stall wall was buckling, there was a light bulb and pull chain in the wall of the shower, and there was no plate covering the hole; a ceiling tile was missing in the hallway; the floor in the basement by the washer was wet, and there was mold along the floor in the same area in the basement; a light bulb at the base of the stairs leading into the basement needed to be replaced; the basement was dark; the light over the pool table did not work, and staff were not able to locate a light switch; there was a pipe leaning against a discarded stove in the basement; there were holes in floorboards of the deck; and the patio furniture cushions were dirty, and the arm rests of the furniture were rusty.



Incident #7 Environmental Issues
 Date: 06/25/03
 Report By: Equip for Equality
 Violation:

Access to the interior of the home was denied because staff reported being without any keys. On the outside of the building we noted: a gutter that was on its side; glass on the ground behind the railing in the front of the building; garbage cans with no lids; screens on the windows were torn and/or loose; the lawn furniture still had rusty arms and dirty cushions; there were still holes in the deck floor and floorboards that were loose and uneven; there were sticks and garbage strewn across the yard; there was a piece of bread left on the deck railing; the wooden grate over the drain by the window was loose, exposing nails; the barbecue grill used by the residents was extremely dirty and caked with grease; there was a bucket on the patio filled halfway to the top with cigarette butts; a disposable lighter was also in this bucket; and a portion of the brick half-wall by the driveway was cracked and falling apart.

FACILITY: 24-hour CILA - B

Incident #1: Environmental Issues
 Date: 7/29/02
 Report By: Equip for Equality
 Violation:

A visit identified many serious deficiencies at this residence, including, but not limited to, the following:

Lack of lighting throughout the house; the light fixture in the ceiling fan in the living room did not have any light bulbs in it; in the same room, the two wall sconces did not have any light bulbs; a bedroom on the first floor did not have a light; the bathroom light fixture that was hanging from the ceiling with exposed wiring did not have a light bulb; in the same room, a fixture above the sink had only two of the eight 25-watt bulbs working; bedrooms on the second floor did not have any lighting (one room had a small light bulb inside a ceramic jack-o'-lantern as the main light source); the ceiling fixture in this room did not have a light bulb;

Dressers in almost all the rooms were either missing drawers or missing the front panel to the drawer;



Several doors in the house were missing doorknobs; one bedroom door had a metal loop that was used to pull the door open and closed where a doorknob should have been;

Bathrooms did not have toilet paper or paper towels; a bathroom on the second floor did not have a shower curtain; in a first-floor bathroom the rod that held the shower curtain was not properly anchored; there was scum on the mat in the bathtub;

The fire extinguisher in the living room did not have a label, and the fire pull box in this room was locked, and staff was not aware where the key was kept;

Bedroom carpeting and a comforter were badly stained; rooms had an odor; a resident's mattress was on the floor, as there was no box spring; closet doors were off the hinge; curtains were falling off the curtain rod;

The kitchen was dirty; cabinets hanging over the stove had a significant amount of grease; the freezer compartment of the refrigerator was empty; the refrigerator section had leftovers in containers that were not covered; the freezer in the room was dirty; there was ice with congealed blood from foods that had previously been stored in the freezer; cans stored in the cabinets stuck to the cabinet and did not have a store label; and a garbage can in this room did not have a lid;

There were holes in the wall or holes that had been patched but not painted in the stairwell to the second floor; the fire extinguisher in this area had not been charged or labeled;

Medications were improperly stored with toilet bowl cleaner, bleach, and starch;

A grate over an opening in the floor in the hallway outside of the bathroom contained dirt and debris;

The dining area did not appear to have adequate seating for all residents to eat together;

The only fire extinguisher on the second floor had not been charged or labeled, and the fire alarm pull box needed repair;

The basement had no lighting and a bad smell; two areas of water were noted on the floor; the lock to the garage door was broken, and the door did not stay closed; and the garage had a bad smell.



BQASI Response: A follow-up review on 8/08/02 verified that areas identified in the EFE complaint had been addressed and in addition requested that: a policy and procedure be developed for the fire pull box located in the living room that was enclosed in a plastic case that was locked, requiring a staff member to locate the key, and that the key be placed where all staff could access it; and a policy and procedure approved by the Human Rights committee regarding the reason that toilet paper and paper towels are not available in the bathrooms and documentation in each individual record regarding why these items are not available.

Incident #2: Environmental Issues
 Date: 10/01/02
 Report By: Equip for Equality
 Violation:

Two months later, Equip for Equality noted: A fire extinguisher in the kitchen was charged but not tagged, and the fire extinguisher in the basement needed to be charged; cleaning supplies were stored in an unlocked cabinet; the doorknob on a bedroom door was loose; the doorframe to a bedroom was loose; the carpeting on the stairs to the second floor was loose and needed to be tacked down, as it posed a tripping hazard; there were holes in the wall on the second floor; one dresser had a section of a curtain over the drawers of the dresser, and another dresser had a drawer with a loose front; the pull box in the basement was broken; the cabinets were in need of having the shelves repaired, as they sagged and appeared to be ready to break; there was garbage on the lawn, and it had an appearance of being unkempt.

Incident #3: Environmental Issues
 Date: 04/02/03
 Report By: Equip for Equality
 Violation:

Equip for Equality noted the following: a broken dining room chair (the back of the chair had bamboo coming away from the frame); the bedroom needed painting over the patchwork; the basement fire extinguisher needed to be charged, and the fire pull box in the basement needed repair; there was standing water by the water heater; there was a significant number of cobwebs in the garage ceiling ductwork; in the basement a smoke detector hung from a wire; and the fire pull box in the living room was broken.



Incident #4: Program relocation without notification

Date: 06/25/03

Report By: Equip for Equality

Violation:

Access to the interior of the home was denied because staff reported being without any keys. Equip for Equality requested access to the CILA, at which time These Are God's People Too staff informed Equip for Equality staff that residents from that CILA-B had been moved and were now residing at a CILA-C. The Department of Human Service's Bureau of Accreditation, Certification and Licensure had not been informed by These Are God's People Too and did not have record of the program move or the new program location.

FACILITY: 24-Hour CILA - C

Incident #1: Environmental Issues

Date: 06/25/03

Report By: Equip for Equality

Violation:

The Executive Director, although present at this new CILA location, indicated that he did not have keys to the residence; in the back yard there was a large piece of broken glass with jagged edges and a basketball net, hoop, and pole that was lying on its side on the ground; on the front lawn near the sidewalk and driveway was the rusted, jagged edged bottom of the metal basketball hoop pole; the back of the house had a greenhouse that was very dirty and in a state of severe dilapidation appearing unused for many years, but a door leading into the greenhouse from inside the residence was visible.



FACILITY: 24-Hour CILA - D

Incident #1: Failure to report timely

Date: 2000

Report By: BQASI

Violation:

At the CILA the provider failed to report to the Office of the Inspector General in a timely manner an incident in which a CILA resident was hit in the eye, resulting in a black eye, and failed to provide treatment for the injury until the following day.

Incident #2: Substandard physical environment; lack of individual service plan or inadequate service plan

Date: 2001

Report By: Resident's guardian

Violation:

A guardian complained about the condition of the CILA site and alleged that the ward was scheduled to move to a newer CILA soon after he moved into These Are God's People Too, but still had not moved; that the resident was not bathing regularly and the clothes and bed linens were always dirty; that there was not a working electrical outlet in the bedroom; that the chest of drawers was falling apart; and that the resident had sores on his scalp from not washing his hair. On a visit, case management staff did not see any active treatment being provided to the resident.

BQASI Response: Visited the site and noted environmental deficiencies in the bathrooms in the CILA, including dried feces behind the toilet bowl, in the corner near the door, and on the wall above the sink; no mirror on the medicine cabinet; no towel racks; no toilet paper and no toilet paper holder; no soap, and shower tiles that were missing or had mold; a loose toilet and broken and hanging shower fixtures; a hole in the wall; loose base trim and variance from approved standards for water temperature;

BQASI staff found the employees' bathroom was clean, contained toilet paper and soap and was nicely decorated, and reported, "This bathroom was in good condition;"

In the bedrooms, the following problems were identified: The door was misaligned, there was a foul odor in the room, feces were smeared on three of the four walls, there was a large sunken hole in the middle of the mattress,



the box spring was broken, there was dust on the vent and ceiling, the chest was broken, there were loose cable wires on the floor, a plastic shade was nailed to the window, the top covering of the bed was dirty, there were two holes in the wall, the chest was missing a handle, the bed appeared to be for a juvenile, the mattress was longer than the box spring, there was a heavily stained love seat in the room, and the top linen was dirty;

In the dining room, chairs were too small for the individuals;

In the kitchen, there were no fresh or frozen fruits and vegetables and an inadequate amount of food stored in the pantry and the refrigerator for seven individuals.

Incident #3: Environmental Issues
 Date: 5/09/02
 Report By: Equip for Equality and BQASI
 Violation:

Five months after a December 2001 site visit by BQASI, an EFE visit made in conjunction with BQASI documented that some of the same problems continued to exist in that all five bathrooms still lacked towels and toilet paper, rooms had no personal items, the kitchen stove was dirty, there was no food in the cabinets, no fresh fruit or vegetables were evident, no juice or other items to drink were available, there were no screens on the second-floor windows, there were vacant, boarded-up buildings next to and across the street from the CILA, and the first floor of the building remained vacant with security bars over the windows and doors that were locked;

The program is staffed with a security guard in the CILA 24 hours a day, seven days a week due to the gang activity in the neighborhood. Outside activities at the home are not possible due to the unsafe neighborhood as well as the lack of a back yard or recreational area.

BQASI Response: Sent These Are God's People Too a letter on 6/05/02 requesting a Plan of Correction be submitted by 6/26/02; a Second Notice was sent 7/02/02; a Sanction Notice was sent 7/26/02; a Plan of Correction was submitted 8/22/02 with a follow-up review by BQASI on 9/06/02 for compliance to the plan of correction.



Incident #4: Environmental Issues

Date: 10/01/02

Report By: Equip for Equality

Violation:

A visit by Equip for Equality five months later revealed: Tiles were missing from the bathroom shower stall and in other areas in two of the bathrooms, one of the bathrooms did not have toilet paper, a bathroom floor was buckling, one of the ceiling fans in the bedroom was missing two blades, there was a piece of cardboard that was used as packing material around the air conditioner, there was a strong odor of gas that was reported to the staff and recommended that the gas company be called, and there was a hole in the door to the storage room.

Incident #5: Environmental Issues

Date: 04/2/03

Report By: Equip for Equality

Violation:

The fire extinguisher in the kitchen needed to be recharged, and the burners on the stove did not light, requiring individuals to use a match to light the burners; the doorknob on the closet door of the bedroom was missing; there was a hole in the bedspread in the bedroom by the TV room; the fabric lining the underside of a chair in the TV room was torn and touching the floor; there were no towels or paper towels in the second bathroom, and the towel bar was off the wall; the doorknob on the bedroom door off the dining area was loose; another bedroom had cardboard and tape covering the window pane; the ceiling had a patched area that was not painted; the bathroom near the back had patched areas that were not painted, and the shower handle plate behind the faucet and the drain cover were loose; another bathroom had patched areas that were not painted and a faucet that did not shut off, resulting in water constantly running, as the handles did not work; the fire alarm panel indicated a system problem; staff did not know what the problem might be or how to address it; there were no screens for any of the windows; staff did not know how to check smoke detectors; and there was a pile of garbage outside the CILA.



Incident #6: Environmental Issues

Date: 06/25/03

Report By: Equip for Equality

Violation:

Access to the interior of the home was denied because staff reported being without any keys. Equip for Equality staff arrived at the CILA site to find the outside door slightly ajar, unlocked, and without a door handle or knob; the residence appeared to be open but without a staff member, as there was no response to the knocking on the door and calling out; a man (not wearing a security uniform) who later appeared at the door indicated he was security and that he had not heard us because he was in the back by the air conditioning.

Inside the residence, we noted that the refrigerator did not have enough food for 6-8 individuals; there was no juice, no fruit, one half gallon of milk, a head of cabbage, and a container of leftover spaghetti in the refrigerator; there were two packages of bread that had been opened and had approximately 1/3 of a loaf left in each on top of the refrigerator; the fire extinguisher in the kitchen was charged but was not tagged; the front door of the CILA was missing the hinge on the inside of the door; the light on the alarm system indicated "trouble;"

The first bathroom had a window open but had no screen; the third bathroom had a plugged sink, the hot and cold faucets in the shower were coming off the wall, and the bathroom had a distinct odor; the bathroom off the back TV room had no shower head, the floor and the mat outside the shower stall were soaking wet, and the wooden floor was squishy and possibly rotting due to the water that had accumulated under the floor tiles because there was no finishing baseboard and the tiles were not flush against the shower stall; there was no toilet paper or toilet paper holder; another bathroom near the back had no towels and no toilet paper, and the toilet paper holder was off the wall; and the shower pipe was not secured in the wall, so that one could pull the pipe back and forth.

The first bedroom had blinds hanging off the window; the bedroom had no screen, and the window was open even though the air conditioning was on; the bedroom off the back TV room had a ripped screen, approximately 12 inches of ceiling tape hanging from the ceiling, and a dried feces stain on the floor by the foot of the bed; the ceiling fan did not have blades;

and programming supplies for the CILA consisted of three bottles of finger paints.



FACILITY: 24-Hour CILA - E

Incident #1: Environmental Issues

Date: 5/13/02

Report By: Equip for Equality

Violation:

Problems identified by Equip for Equality included dimly lit rooms; the kitchen stove was dirty and the oven door did not have a handle, making it inoperable for cooking purposes; the freezer section of the refrigerator was empty; there was a water damage stain in the ceiling in the kitchen; there was a boarded-up section of the wall in the bathroom on the second floor; the bedroom had chipped paint along the floorboards, and the floor was dirty, with dirt caked by the baseboards; the dresser in the bedroom did not have handles on any of the drawers—drawers were opened by pieces of yarn tied through the screw holes on the drawers; radiators did not have covers; there was no light bulb in the fixture in the staircase leading to the basement or the second floor, and there were no additional light bulbs available at the site; the basement had a mildew smell; furniture in the day area was ripped and torn; the back porch had an old stove and a garbage can with a board on it, making it unsafe for residents to use for recreational purposes, and the yard had overgrown grass, weeds, and dead tree branches lying about.

Incident #2 Environmental Issues

Date: 10/01/02

Report By: Equip for Equality

Violation:

A second Equip for Equality site visit five months later indicated an absence of home improvements and identified new concerns, including two exits from the building had brackets in which a two-by-four was horizontally placed in order to secure the door; in addition, the door on the second floor off the sitting area and the front screen door were also locked with a key, which required locating staff in possession of the key in order to exit the door;

The fire pull box located in the kitchen was broken and the oven door still did not open; the kitchen cabinets were hard to open and in disrepair, and the pantry was dirty; the water damage area in the kitchen ceiling was plastered and not painted;



Dressers still did not have handles, and yarn was still used to open the drawers;

There was no light in the pantry, and a single lamp without a lampshade lit the kitchen; and there were empty light bulb sockets in the bathroom fixture;

In a bedroom, a mattress on the bed was sunken in the middle; the screen in the bedroom window was ripped, and there was a crack in the windowpane; there was dirt in the corners of the room and along the baseboard; paint was peeling on the trim and along the ceiling;

The outside porch still had items that had been discarded;

The stairway into the basement where residents do their laundry had holes in the walls, and the stairs were in need of repair; some sections of the basement wall had studding without wallboard, while other sections had areas of broken wallboard in place, a piece of wood was angled to keep the door shut, and there was an odor in the basement similar to sewer gas and mold; there was a large area of standing water near the water heater, which appeared to be rusty; and lighting for the basement consisted of two bare bulbs in a ceiling fixture;

The bathroom was dirty, and there was a hole in the wall that was covered by a board; the floor had an uneven surface, and many of the tiles were broken; the bathtub was dirty; and

There were many holes in the walls in various areas of the house, including areas that had been plastered and not painted in the kitchen and the ceiling in the upstairs bedroom.

BQASI Response: A follow-up visit on 10/23/02 verified all concerns and further described the conditions in the following manner: The kitchen cabinets were dirty, and it appeared that the cobwebs and old grease made the cabinet doors hard to open;

In the bedroom, there was a strong smell of urine, which permeated the room, and staff observed dried blood on the bed; the mattress was longer than the box spring; there appeared to be feces smeared on the wall next to the closet; there were cobwebs on the ceiling and dirt and debris found in the corners and along the baseboards in the room;



In another bedroom, there was no knob on the closet door; there was dried blood on the linen, and the linen was dirty; the molding around the door was cracked; there was a crack in the ceiling and paint spots on the floor; there was dirt and debris in the corners and along the baseboard in the room;

In a second-floor bedroom, the bed had dried blood stains on the pillow; there was one outlet in this room, and there was an extension cord connected to another extension cord that was supplying power to the TV, VCR, and stereo; the TV cord appeared to have been cut off and spliced together with another extension cord, and the tape used to splice the cords together did not appear to be electrical tape;

Another bedroom on the second floor did not have any curtains on the window and there was an odor;

In the second-floor bathroom, there appeared to be dried feces on the wall across from the toilet, and the toilet seat was cracked; the bathroom window was dirty; the light fixture had two of the three light bulbs missing; the shower had a build-up of soap scum and grime;

The first-floor dining-area-room seat cushions were heavily soiled, and the table was unstable; the sofa in the second-floor family room was heavily stained;

The hallway had a musty/mildew odor, and there were no working lights;

The Plan of Correction due 11/19/02 was not submitted by deadline.

Incident #3: Environmental Issues
 Date: 04/02/03
 Report By: Equip for Equality
 Violation:

A bedroom on the first floor off the dining room had a smoke detector chirping even though staff indicted that the smoke detectors are hard wired to the fire department; there was no hot water in the bathroom on the first floor; the fire pull box in the kitchen was broken; the fire alarm control panel did not have any lights indicating whether the system was working and staff did not know what the problem might be or how to address it; there were no screens for any of the windows; the railing to the basement was loose; in the basement there were holes in the paneling; there was some studding without dry wall in the front area of the basement by the windows; the upstairs door in the day area still needed a key in order to exit; there was



mold on the basement ceiling by the back door; there was a fixture in the basement that did not have a light bulb; although the washer/dryer area is the only area used, due to the design of the area, it would be very dark, and additional lighting would be needed; although staff indicated that a supply of toilet tissue is located in the office in the front of the building, EFE staff did not observe any toilet paper; there was, however, toilet paper rolls with remnants of toilet paper in a storage area in the basement; this room had mold in many areas.

FACILITY: **24-Hour CILA - F**

Incident #1: Environmental Issues

Date: 5/13/02

Report By: Equip for Equality

Violation:

A visit indicated water leakage and an uncovered sewer in the basement, laundry and cleaning supplies not stored in a locked cabinet, and a refrigerator that was no longer used stored unlocked in the basement.

Incident #2: Environmental Issues

Date: 10/01/02

Report By: Equip for Equality

Violation:

Five months later, Equip for Equality visited the residence and identified deteriorating conditions, including the baseboard in the bathroom was pulling away, the overhead light did not work, the light above the sink had no cover, and tiles were missing; the sofa fabric was dirty; the fire extinguisher in the living room needed to be charged; the trim around the door leading to the garage was loose, with an exposed nail; there was a radio in the bathroom on the counter near the sink that could pose a safety hazard for the residents; the sewer in the basement was uncovered; there were skids in the basement stored on their sides in violation of safety regulations; the food in the freezer was not labeled with dates or contents; and the door trim was missing from the door to the bedroom.



Incident #3: Environmental Issues

Date: 04/02/03

Report By: Equip for Equality

Violation:

The fire extinguisher in the living room needed to be recharged; the fire alarm control panel indicated "system trouble"; staff at all locations did not know what this meant, or how to respond to it

Incident #4 Environmental Issues

Date: 06/25/03

Report By: Equip for Equality

Violation:

Access to the interior of the home was denied because staff reported being without any keys. In walking around the perimeter of the residence, we noted that the front window appeared to be broken, missing a rope or a chain to keep it open; a stick similar to a small broom handle was also visible in this window; the other small window next to the big picture window was open and had a screen that was punched in; the drapes visible in the front picture window were falling off the curtain rod; there was an unattached antenna on its side in the back yard; there were segments of downspouts that were unattached to the gutter in various locations of the building; gutters were full of mud, dirt, and debris, and had weeds growing in them; garbage cans did not have lids; the chimney to the building was cracked, and many of the bricks needed to be replaced; the siding above the garage easement was falling off, and the garage door was broken; the bricks in front of the front window that created a flower box area were loose and falling apart; the area had weeds rather than flowers; the mailbox was lying on the ground, unattached to the building.



FACILITY: 24-Hour CILA - G

Incident #1: Environmental Issues

Date: 5/13/02

Report By: Equip for Equality

Violation:

Concerns included water on the floor in the basement and a lack of fresh fruit and vegetables.

Incident #2: Environmental Issues

Date: 10/01/02

Report By: Equip for Equality

Violation:

Five months later, on an Equip for Equality visit, there was standing water in the basement and it smelled of mildew; cardboard was used as packing material around the air conditioner in the living room window; the bathroom was dirty; there was a window broken out in the bathroom, and the surround by the bathtub was peeling; food in the freezer had freezer burn; and the furniture in the living room was worn and had holes.

Incident #3: Environmental Issues

Date: 04/02/03

Report By: Equip for Equality

Violation:

There was a water heater with some water around it in the basement; rust was also noted; the basement was used for storage of some old mattresses and other furniture; the fixture at the bottom of the stairs was missing a light bulb; the fire alarm system box indicated "system trouble"; staff indicated it had just been repaired and were not sure what "system trouble" meant or how to address it; there were no screens for any of the windows; a cord ran over the threshold of the front door, presenting a tripping hazard.



Incident #4: Environmental Issues
 Date: 06/25/03
 Report By: Equip for Equality
 Violation:

Access to the interior of the home was denied because staff reported being without any keys. We arrived at the CILA to find that a house manager was not there as originally indicated by These Are God's People Too. In walking around the building, we noted that gutters were filled with mud, dirt, and debris to the point that weeds were growing in them; garbage cans did not have covers; the back lawn was overgrown; there was cardboard as a packing agent around the air conditioner located in the front window; there was only one intact screen at this residence; other windows were missing screens or had screens that were torn; and the wood around the front picture window on the front of the building was rotting.

FACILITY: Developmental Training Program - H

Incident #1: Safety concerns – egress, physical environment
 Date: 6/15/01
 Report By: BQASI
 Violation:

The hot water temperature was 140 degrees, a ceiling tile was missing in a classroom, the women's restroom had two holes in the wall, and the fire drills exceeded four minutes.

Incident #2: Programmatic & Environmental Issues
 Date: 3/21/02
 Report By: Equip for Equality
 Violation:

Virtually no programming supplies were available to participants; as a result of certain behavioral issues, staff "take down" participants one to two times per month; there were narrow steps from the first floor to the lunchroom in the basement, where a hot lunch program that was not licensed or certified was located; and there were holes in the walls, and areas that were patched but not painted.



Incident #3: Environmental Issues
 Date: 5/9/02
 Report By: Equip for Equality and BOASI
 Violation:

The stairway to the basement had several large holes in the wall; there was a board blocking the panic bar on the fire door in the basement; a room downstairs was flooded; the area smelled of mildew; the door leading from this area to the outside was deadbolted and required the location of staff with the key in order to exit; there was no panic bar on this door, no fire alarm pull box was located in this area, and only one fire extinguisher; and the door to an area that was restricted for program participants did not close and did not fit into the door frame.

FACILITY: Developmental Training Program - I

Incident #1: Environmental Issues
 Date: 10/01/02
 Report By: Equip for Equality
 Violation:

The new DT location had virtually no programming supplies; however, the administrative offices appeared to have new office equipment, such as computers, at all of the administrative office desks as well as a new TV in the Executive Director's office.



Incident #2 Environmental Issues
Date: 04/02/03
Report By: Equip for Equality
Violation:

Equip for Equality inquired if These Are God's People Too had a second work training site located in the community as indicated in a recent Office of the Inspector General report. This location appears not to have been previously disclosed by These Are God's People Too. A staff member indicated that the agency no longer has a second program location but that the individuals who participated saw a psychiatrist and if individuals had good behavior, they would receive a pop or cigarette or money; the individuals were there for a couple of hours a day every day of the week and would eat their lunch there. The program had been "tried for 30 days." Any additional information regarding why the program closed (over 30 days ago) needed to be obtained from the Executive Director.

DT staff indicated that the participants had just finished lunch and therefore we would not see active programming. The rooms had 10-13 individuals per room and seemed crowded. We did not observe any programming materials in the room or any group. One individual was observed vacuuming, another individual appeared to be collecting garbage, and another individual was sitting at a table across from staff and appeared to be crying; staff did not seem to notice or inquire from this individual as to the reason for the crying.



AGENCY'S FAILURE TO DISCLOSE SIGNIFICANT PROGRAMATIC AND RESIDENTIAL CHANGES

In June 2003, the Abuse Investigation Unit discovered that the agency was sending some individuals to an alternative developmental training program. Every morning the agency sent one group to the alternative program while the others remained at the original program site until the afternoon, when the two groups switched. During the June 2003 unannounced site visit by the Abuse Investigation Unit, a key agency staff member in charge of the developmental training program was interviewed. The staff member indicated that program participants were sent to such an alternative program sometime during the spring of 2003, but that it had been discontinued by the Executive Director. Although responsible for the programming provided by the agency, the staff member had never visited the alternative program, could not describe its components other than the fact that the participants saw a psychiatrist and were rewarded with cigarettes and soda pop, and did not know why the agency was no longer utilizing the program. In response to questions regarding any other substantial changes in the services or programs offered by the agency, the same staff member indicated that the agency had closed the 24 hour CILA-B and moved five individuals to CILA-C, where it had opened a new site.

In spite of extraordinary attention focused on this agency by the Department's Bureau of Systems Improvement and Quality Assurance, the Bureau of Licensure and Accreditation, and Equip for Equality's Abuse Investigation Unit, at no time did the agency voluntarily disclose that it had substantially changed the programming and services offered to its participants or that it had moved its residents to a new facility. Even when the Department specifically cited the agency for substantial deficiencies as a result of its failure to develop appropriate programming goals and service plans for the participants, the agency did not disclose and the Department remained unaware that the agency had an alternative program, that the residents had been suddenly uprooted from their home to a new residence that had not been reviewed or inspected by the Department prior to the move.

While the Abuse Investigation Unit requested access into the new CILA site, as well as the other CILA sites during its June visit, key agency staff, including the Executive Director and the Director of Residential Services, claimed that no one had keys to the houses. When pressed for information as to how the residents would get into their homes, key staff and the Executive Director claimed that only "house managers" have keys and that none of the managers were available.



CONCLUSIONS AND RECOMMENDATIONS

The Abuse Investigation Unit's examination of These Are God's People Too revealed extremely serious concerns about the services provided by this agency to individuals with disabilities and the failure of this agency to meet and maintain minimum quality residential and day programming standards. The level of scrutiny and resources that needed to be employed before this agency would even begin to provide toilet paper or lights for the individuals with disabilities whom it was to be serving, or otherwise marginally meet their basic human needs, compels the conclusion that public funds should not be utilized to support These Are God's People Too. Equip for Equality strongly recommends that the state Department of Human Services cease to do business with this agency, close its facilities and programs, and transition the individuals to other community based settings in which the needs of the individuals are met and services are provided in a clean, safe, and humane environment.

The ineffectiveness of the current enforcement system, as illustrated by this investigation, is a problem that has existed in this state across many departments for a great number of years. It is not a reflection of the commitment or capability of those responsible for working within that system. Rather it is a reflection of the low priority placed on oversight and investigative functions in state departments, as demonstrated by the allocation of resources to those functions by governors and the legislature and the extent to which decisions may be impacted by issues unrelated to the care and treatment of individuals with disabilities. Without sufficient funding and the ability to make decisions governed solely by the interests of individuals with disabilities, the Department's ability to swiftly and effectively deal with the most problematic providers is severely compromised.

Only through interventions at the highest level of government and the commitment of sufficient resources to support truly effective oversight, monitoring, investigative, and enforcement mechanisms will the system by which we protect our most vulnerable citizens, both young and old, become anything other than an illusion of safety and humane care.

As a result of the serious and longstanding findings revealed in the investigation of These Are God's People Too, Equip for Equality recommends a comprehensive review of the Department of Human Services' oversight and enforcement system be conducted, preferably by an independent entity, which includes the following:



- An assessment of the resources necessary to provide an effective system;
- The development and implementation of a process to ensure consideration of all aspects of a provider's programs and services in response to licensure and certification issues, and allegations of inadequate services, unsafe and inappropriate environments, or abuse and neglect;
- The development of a more severe, more expedient, and less discretionary sanction process against those providers that are repeatedly cited for minimal or unsatisfactory compliance with standards;
- The creation of incentives for those providers that consistently exceed expectations; and
- A report, with recommendations, to the Secretary of the Department of Human Services, the Governor, and the General Assembly on the steps that need to be taken to reform the Department of Human Services' system to perform more effectively its oversight and enforcement responsibilities.



Michael A. Parks, *Chairman of the Board of Directors*
Zena Naiditch, *President and Chief Executive Officer*

ILLINOIS REGIONAL OFFICES

Northeastern Region (Chicago)

20 N. Michigan Ave., Suite 300
Chicago, Illinois 60602
312/341-0022
800/537-2632
800/610-2779 TTY
312/341-0295 FAX
Se habla Español

Northwestern Region (Rock Island)

1612 Second Ave., P.O. Box 3753
Rock Island, Illinois 61204
312/786-6868
800/758-6869 Voice/TTY
312/786-2393 FAX

Central/Southern Region (Springfield)

427 E. Monroe St., P.O. Box 276
Springfield, Illinois 62705
217/544-0464
800/758-0464 Voice/TTY
217/523-0720 FAX

Website: www.equipforequality.org
e-mail: contactus@equipforequality.org

Please contact Equip for Equality for permission to reproduce this publication or for information regarding other publications.



