

# **These Are God's People Too**

## **EGREGIOUS ABUSE AND NEGLECT RESULTS FROM AGENCY'S ONGOING FAILURES**

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

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## **These Are God's People Too**

### **EGREGIOUS ABUSE AND NEGLECT RESULTS FROM AGENCY'S ONGOING FAILURES**

In August 2003, Equip for Equality issued a report regarding the agency These Are God's People Too, entitled "Why Does an Agency That Profited from Exploiting Persons with Disabilities Remain Taxpayer Funded?" The report documented the agency's financial improprieties, a history of abuse and neglect, serious programmatic deficiencies, and environmental safety hazards. Equip for Equality recommended that the Department of Human Services (the Department) revoke the license for Community Integrated Living Arrangements (CILA) services, deny the certification for the developmental training program, terminate the contract with the agency, and conduct an investigation into the agency's use of state funds.

Since the issuance of the report, the Department authorized a financial audit and programmatic review, and established a work group, including Equip for Equality, to review the agency's progress in meeting its obligations and to make a recommendation to the Secretary about whether to extend its contract. Furthermore, the agency received countless hours of free consultation and assistance regarding financial, programmatic, and behavioral programming issues from an experienced and highly respected provider. Twice the work group recommended continuation of the contract, with Equip for Equality opposing those actions. The Secretary renewed the agency's contracts twice through June 2004.

The agency has also secured a not-for-profit status and a name change to Southwest Disabilities Services and Support. By submitting an application to the Department on January 6, 2004, the agency secured certification and a license for Southwest Disabilities Services and Support to provide developmental training and CILA to people with disabilities.

In spite of the extensive training that These Are God's People Too received, Equip for Equality continues to have serious concerns regarding the licensing and certification of the agency, due to the agency's inability to protect individuals with disabilities from abuse, neglect, and serious injury. A review of state records and an investigation conducted by Equip for Equality's Abuse Investigation Unit staff has documented these incidents over the past seven months: individuals sustained serious injuries, the agency failed to report harmful incidents to the Department's Office of the Inspector General (OIG) as required, and the agency failed to submit to the Department notification regarding administrative action it took to keep individuals safe and to prevent future occurrences of abuse.

Incidents reviewed include one in which a resident sustained a serious injury resulting from an altercation with another resident, one in which a resident alleged inappropriate sexual behavior by a staff member, and incidents in which residents sustained injuries resulting from abusive behavior inflicted by agency staff. These types of incidents illustrate the agency's continued failure to keep residents safe and free from harm, its

failure to provide effective behavioral programming and services for residents, and its failure to train staff in effectively de-escalating behavioral situations or teaching residents coping strategies as alternatives to maladaptive behavior.

The seven incidents that follow highlight and illustrate:

- The agency's failure to establish and implement a systematic review and analysis of incidents and injuries and corresponding corrective action.
- The agency's failure to provide direction and leadership by developing and maintaining an environment and culture which continually evaluates itself and strives to improve and enhance services to people with disabilities.
- Ongoing serious programmatic, behavioral, and staff training issues.
- Ongoing serious abuse and neglect of the residents and individuals whom the agency purports to serve.

### **Failure to Keep Residents Free from Harm**

In December 2003, an incident occurred between two individuals who participate in These Are God's People Too residential and day programs that resulted in one of the individuals sustaining a dislocated shoulder and a fractured humerus (upper arm). The resident was brought to a hospital by two staff from These Are God's People Too for treatment. The initial emergency-room diagnosis was a dislocated shoulder and a spiral fracture of the upper arm. Confronted with an injury of a suspicious origin, emergency room hospital staff contacted Equip for Equality.

Prior to initiating its own investigation, Equip for Equality contacted OIG regarding the incident in order to coordinate investigative efforts between the two offices. An investigation by OIG determined that there was insufficient evidence indicating abuse by a staff member to warrant further investigation. The OIG investigation was closed.

However, during the course of the Abuse Investigation Unit's investigation, information was discovered related to this case that highlights the agency's culpability in providing appropriate supervision for program participants, its failure to effectively review incidents internally, and a lack of competence by staff in successfully addressing and resolving behavioral issues, and in providing for the safety and well-being of the individuals served. Additionally, during the course of the Unit's investigation, agency administrators thwarted the investigation process and influenced information provided by agency staff.

Investigation unit staff interviewed These Are God's People Too staff and reviewed available relevant documents, including staff-written statements and agency documentation regarding the incident. When the Investigation Unit staff arrived at the day site to conduct the interviews, agency staff directed them to a room that did not have floor-to-ceiling walls, did not have a door, and had a steady stream of staff traffic in and out of the room that contained the agency's fax and copy machine. In addition, the room was located directly next to the work area for several agency administrators. Requests to secure a more private room for the interviews were turned down by agency personnel.

Details surrounding the incident, such as who was involved, what occurred, when it occurred, where it occurred, and how it occurred, varied among agency staff:

A male staff member (staff A) who accompanied the resident who was injured to the hospital indicated to hospital staff that the resident had pulled the fire alarm **in the DT program** causing participants to be taken outside and placed on a bus because it was cold. According to staff A, **only the bus driver was present on the bus with the program participants.**

When the program director informed the resident's guardian of the incident, she stated that there had been an altercation between two residents **outside the building following the fire-alarm incident.**

Another male staff member (staff B) initially alleged that the **injury occurred inside the building while the resident was waiting for the DT program** to begin. His written statement indicated that the individual "seemed somewhat agitated while waiting for the DT to begin."

In a subsequent interview, this same staff member (staff B) changed his statement and alleged that the incident occurred **on the bus on the way to the DT program.** In an interview with the OIG investigator, this staff member provided yet another version when he indicated that **after the fire alarm** was pulled, he and another staff member were on the bus with two residents who were agitated with each other while other program participants waited outside. According to staff B, **while on the bus**, one resident reached out and grabbed and pulled the other resident's left arm, causing the first resident to fall to the floor with the second resident falling on top of her.

A female staff witness alleged that the injury to the resident occurred **at the DT program after the participants had entered it** and that the "resident was fine" on the bus ride to the program. She also alleged that the resident pulled the fire alarm located on the **second floor of the DT program outside of the reception area**, and that the resident was **taken by ambulance** to the hospital. However, this witness gave a conflicting statement to OIG investigators by indicating that the incident occurred **on the bus after the fire alarm was pulled.**

Both staff B and the female staff witness submitted typed statements to the Investigation Unit interviewers but indicated that their original statements had been handwritten and turned in to their supervisor, one of the top administrators of the agency, who in turn had typed their handwritten statements. Neither staff member knew what became of their handwritten statements.

When interviewed, the agency nurse reported that the DT staff contacted her when the injured resident complained that her arm hurt and that she examined the resident and recommended emergency-room treatment when she heard a "click." When asked how the resident was **transported to the hospital**, the nurse indicated that she **did not know** even though she had **earlier stated that she "stayed" with the individual.**

Internal agency documents identify the time of the incident as **9:30 a.m.** The records from the fire department that responded to the fire alarm pull indicate the time of the fire alarm as **8:06:49 a.m.** Fire department records confirm that the fire alarm that was pulled and needed to be reset was by the north stairwell on the **first floor, not on the second floor as indicated by agency staff.** Additionally, there was **no record of an ambulance transporting the recipient to the hospital.**

Although These Are God's People Too initially indicated that an internal investigation into the matter would be conducted, when asked by the Investigation Unit for the final investigative document, administrators submitted the original accounting of the incident as reported on the OIG Incident Report Form. When asked for clarification, These Are God's People Too staff indicated to the Investigation Unit that that was their report, as they had not found any additional information necessitating further investigation. Agency administrators seemed satisfied with the explanation provided on the incident form that another resident had caused the injury and seemed unaware of the conflicting information provided by their staff to the Investigation Unit and OIG.

The agency did not conduct a further analysis of the situation even though a resident had been seriously injured at a time when clearly there were insufficient staff present to prevent such an incident wherever and however it may have occurred. Even agency staff described the fire alarm evacuation as "chaotic." The agency's failure to adequately train staff and residents to calmly evacuate the building in an orderly manner again illustrates the agency's inability to deem paramount the safety of the individuals it serves and to prioritize resident safety for its staff. This failure is further emphasized by the response of the facility nurse who said that upon arriving on the scene and finding individuals outside the building in cold weather, she obtained clearance from the fire department to enter the building and proceed to her office rather than ensuring that the residents were safe.

According to agency staff discussions related to the incident, analysis of events and steps taken to reduce the likelihood that a similar incident or injury would happen again did not occur. Other opportunities for agency improvement, such as adequate supervision, resolution of potential conflicts between residents, and a review to determine if changes in the individual treatment or behavior plans were warranted were missed and not perceived as opportunities for improvement by the administration of this agency. Clearly, the culture and focus of the organization has not shifted to the health and well-being of the residents.

Although the OIG investigation ultimately concluded that the resident sustained her injuries as a result of another resident grabbing and pulling her arm, causing her to fall to the floor with the other resident falling on top of her, the Abuse Investigation Unit concluded that no one at the agency really knew the exact time of the fire alarm, where all staff and residents were, who was supervising whom, how the incident happened, where it had happened, or the circumstances surrounding the incident.

The incident illustrates the agency's failure to protect residents from harm and to fully cooperate with the investigation. Most alarmingly, it highlights the agency's failure to analyze the situation and take the corrective steps necessary to prevent future occurrences.

### **Other Pending Investigations**

Three other allegations of serious abuse and neglect by staff are under investigation by OIG. Two incidents involve the same resident, who sustained bruising in one incident and broken bones in the other incident. The third incident relates to the resident identified earlier who sustained a broken arm in December 2003. In June 2004, the resident was brought to the hospital for an assessment, where hospital staff discovered over 200 contusions about the resident's body, including arms, legs, and face.

### **Staff Assault and Resident Injury**

In **October 2003** at a These Are God's People Too CILA program, a resident sustained multiple severe bruises to the face, leg, and cheek areas and a fractured toe, resulting from an agency staff member repeatedly hitting her with fists and a wooden pole approximately five feet long and 1½ inches in diameter, according to an OIG investigation.

A female staff member working at the time and witness to the incident asked the male staff member who was assaulting the resident if he was OK, and after staff indicated he was OK, the female staff waited a few minutes and then left the CILA. The female staff member failed to intervene during the assault on behalf of the resident, failed to examine the resident for injuries, failed to make sure that the resident had appropriate medical care, and failed to report the abuse.

The investigation conducted by OIG reveals that the incident began when the resident requested her breakfast and was directed by the female staff to return to her room to make her bed. The resident returned to her room but soon returned again requesting something to eat. The female staff member reports that the resident said, "am gonna go off," prior to flipping over furniture on her way to her bedroom.

The male staff member, rather than utilizing de-escalation techniques, quickly became involved in a power struggle with the resident, telling the resident to pick up the furniture. When the resident failed to comply with the request, the male staff member further escalated the situation by following the resident and instructing the resident, who was now sitting on the floor by her bedroom door, to get up. When she refused to comply, witnesses report that the male staff member repeatedly hit her with his fists and soon escalated to using the wooden pole to hit her repeatedly on the left side of her body.

When interviewed by OIG, the male staff member indicated that he became upset when the resident began throwing furniture around, and he admitted wrestling her to the ground

and hitting her with a wooden pole. During the interview, he stated that he “lost it” and that he took his anger out on her.

### **Inadequate Programming**

Staff “losing it” is symptomatic of broader programmatic, supervisory, and training issues within an organization that have not been sufficiently addressed. It is indicative of an agency that has failed to provide staff a framework within which staff are guided in interactions with residents. Absent are individualized treatment and behavioral intervention plans. Absent is the documentation system essential in determining the overall effectiveness of the plan and the effectiveness (or ineffectiveness) of the intervention strategies. Absent is the training for staff in the uniqueness of the individual as reflected in the plans, and absent are the brainstorming opportunities by the team that lead to increased understanding, strategizing, and energy to “problem solve” the conflict leading to improved resident coping mechanisms and services. In the absence of these “resources,” staff can experience mounting frustration that can surface as anger, oftentimes directed toward the resident.

The Investigation Unit’s review of approximately one-third of resident case records at These Are God’s People Too in November 2003 revealed numerous programmatic issues. The review noted inconsistencies in the records related to the severity and frequency of the residents’ behavioral difficulties and the need for and use of aversive techniques, including restraints. Some plans provided for the use of physical restraints when the residents’ behaviors were described by staff as mild, infrequent, or not problematic. It noted treatment plans that appeared to be “standardized,” with little variety in established goals and techniques, or identification of techniques that the team had deemed effective in working with that individual. The data collection system was minimal and oversight, especially as it applied to the use of dangerous, aversive techniques, was nonexistent. Reports were generated only if a resident was injured. Given these systemic failures, one can conclude that staff were not trained or required to demonstrate competency in the implementation of the individual treatment or behavioral plan. Staff were “authorized” to independently resolve complex resident issues without the appropriate resources and supervisory leadership. Nothing has been presented by the agency that would suggest that these systemic failures have been remedied to ensure appropriate implementation of effective individualized programming.

### **Failure to Comply with State Regulations**

#### **Failure to Provide a Written Response:**

Based on the facts of the above case, the investigation of the incident by the OIG determined a “substantiated” finding regarding the physical abuse by the male staff member and determined a “substantiated” finding of neglect regarding the behavior of the female staff member. The Inspector General’s investigation also recommended that the agency address the female staff member’s failure to report the incident of abuse.

Pursuant to Illinois Administrative Code Title 59, Section 50.60 (a)(5)(c), providers are required to submit a Written Provider Response in cases in which an allegation is substantiated. The provider is expected to respond by stating the administrative action taken to protect individuals and to prevent recurrences, and to eliminate any problems identified during the investigation. To date, These Are God's People Too has failed to submit the required Written Provider Response, which had a December 18, 2003, deadline, to the director of the Division of Developmental Disabilities of the Department of Human Services.

### **Failure to Report:**

In **March 2004**, the OIG received a complaint of sexual abuse in which it was alleged that a staff member touched a resident's breast and asked her to perform oral sex on him.

Although the **program director** overheard residents discussing the alleged incident and had a conversation with the alleged victim, she failed to report the allegation of sexual abuse as required by Illinois Administrative Code Title 59, Section 50.20 (a)(1), (2)(a), to OIG. In its investigative report, OIG recommended that the facility address the program director's failure to report the allegation involving one of the residents and a staff member. To date, the agency has not responded.

### **Neglect**

In **January 2004**, an individual diagnosed with severe mental retardation and autism, who has limited verbal skills and a known history of elopement, was missing in below-freezing temperatures (22 degrees Fahrenheit with a wind-chill factor of 10 degrees Fahrenheit, with light snow) during an **unauthorized** trip to Joliet, purportedly for counseling services through These Are God's People Too/Southwest Disabilities Services and Support day program.

The investigation of the incident conducted by OIG determined that at approximately **1:00 p.m.** the individual walked away from a counseling center in Joliet, Illinois. He was found shortly thereafter by the Joliet police about two blocks away, not wearing a coat and unable to communicate his name or address. However, agency staff did not discover that he had not returned from the counseling center until the end of the day at the DT program when at approximately **3:30 p.m.** agency buses were being loaded to take individuals to their residences and the individual could not be found.

An agency administrator contacted the resident's CILA provider, a provider independent of the agency, to report that the individual was **missing from the Matteson DT site** and that the Matteson police had been contacted.

When the residential manager arrived at the DT site to assist in searching for him, she discovered that there had been a trip in which various individuals went to Joliet, Illinois. She complained to OIG that staff at her CILA site were not notified of the trip, that they

were lied to when agency staff claimed that the individual had been accounted for after returning from Joliet and that a head count had occurred both at the DT site and at the conclusion of the trip, and that the Matteson Police Department had been contacted, when agency staff knew the resident was actually in Joliet.

When interviewed, the bus driver and the teacher supervising the outing report that they took **eight** individuals to Joliet, with the teacher reporting that he had conducted a “visual” head count, not paying attention to exactly who was going because the facility did not have a policy regarding checking a roster before loading a bus and he did not have a roster for the trip. The bus driver, an employee of the agency, reported that he did not complete a head count or a visual check because his only job responsibility was to drive the van. Agency administrators, including day and residential program directors, indicated that it was not the responsibility of the bus driver to monitor the recipients.

When asked for a list of individuals who went to Joliet, the agency program manager, after the fact, created a list identifying **nine** individuals.

The teacher and the bus driver also reported following the individuals into the building and remaining in the recreation area **playing billiards** while the individuals participated in therapy or leisure activities in different rooms. Neither staff member assumed responsibility for the well-being of the individuals or provided monitoring and supervision of the individuals. Agency administrators failed to develop a policy regarding supervising and monitoring individuals while on trips or outings and failed, in the absence of a formalized policy, to communicate any expectations to staff regarding their responsibility to the individuals to monitor and keep them safe.

Although the agency program manager indicated that the missing individual went to the counseling center for an evaluation, the chief executive officer of the counseling center reports in her interview that the individual had previously been evaluated for services but was deemed inappropriate for counseling center services because of his functioning level and his lack of communication skills and that this had been communicated to the program manager in December 2003.

In addition, the individual’s CILA provider indicated that the agency was not authorized by the CILA to take the individual on the trip. The CILA house manager indicated that the agency had not notified the CILA provider that they had taken the individual for an evaluation or services and that it was the responsibility of the CILA provider and not the agency to coordinate services for the individual. When questioned, the agency program manager failed to give a reason why the agency had never informed the CILA of what they were doing.

OIG’s investigation determined a substantiated finding of neglect regarding the staff member for not providing adequate care, taking the individual on an unauthorized trip, and failing to monitor his whereabouts, and **substantiated neglect against provider These Are God’s People Too/Southwest Disabilities Services and Support** for not

having policies denoting staff member responsibilities when escorting recipients on trips or outings.

Clearly, the investigation reveals and highlights an agency that is ill-equipped, incompetent, and unaware of the responsibilities and the managerial functions required in administering a program. It illustrates an agency that has significant shortcomings and that fails to **organize** all operations to benefit the individuals it serves, **plan** for the services it provides, **staff** accordingly, **direct** staff in providing services, and **control** variables within its purview to ensure the individuals' safety and well-being.

### **Conclusion**

Whether the agency is named These Are God's People Too or Southwest Disabilities Services and Support or whether the agency is for profit or not for profit, the individuals receiving services from this agency are at significant risk. The magnitude of the errors and failures emanating from the top of the agency down to the direct care staff compel the continuation of significant and ongoing monitoring by the Department **if** this agency is to continue providing services to people with disabilities.

Even though provided an extraordinary amount of consultation and technical assistance over the past seven months, the agency has repeatedly demonstrated an inability to learn from mistakes and generalize solutions to different situations, effectively administer a program, adhere to state reporting requirements, and, when investigated, provide honest information.

While under extensive scrutiny, this agency has ignored its obligations to report incidents of abuse and to submit plans of correction. Whatever changes have been made by outside consultants, the most recent incidents and the agency's refusal to comply with state regulations clearly demonstrate that this agency will not comply with the basic rules required of providers to ensure the safety and well-being of the people it purports to serve.

Given the overall lack of competencies and the pervasive nature of the agency's failures, as documented by OIG and the Abuse Investigation Unit investigations, it is clear that even with extraordinary support, the agency "can't do it right." Continuing to fund this agency at the level necessary to ensure the safety of the individuals is simply a useless and wasteful expenditure of scarce public funds, particularly in light of the number of successful and competent community providers that could provide appropriate services without placing people with disabilities at serious risk of harm.

Despite the "hands on" technical support provided by the consultant in developing new policies, procedures, and other protocols, from the perspective of the residents, nothing has changed, and the CILAs continue to be void of meaningful programming and not safe places to live.