| 1617-0198 | **Report Date**<br><br>January 29, 2018 | **Investigator Name**<br><br>XXXXX |
|---|---|---|
| **Agency Name**<br><br>Esperanza Community Services | | |
| **Agency Address**<br><br>520 North Marshfield<br>Chicago, Illinois 60622 | | **Location**<br><br>XXXXXXXXXXXXXXXXX<br>XXXXXXXXXXXXXXXXX |

## Allegation

On October 5, 2016, the Office of the Inspector General received a reported allegation of neglect from Esperanza Community Services. It was alleged XXXXX failed to put up XXXXX bed rails and he fell out of his bed onto the floor on October 3, 2016.

## Synopsis

On October 3, 2016, XXXXX failed to put up the side rails on XXXXX' bed. XXXXX left him unattended for a few minutes and he fell off the bed unto the floor. XXXXX was notified of his fall around 9:30 a.m. XXXXX instructed XXXXX to take him to his scheduled appointment at the wound care clinic of Illinois Masonic Hospital and did not instruct XXXXX to call the agency nurse, call 911 or immediately transport him to the closest emergency room. Medical records show XXXXX was presented at the emergency room of Illinois Masonic Hospital on October 3, 2016 at 12:28 p.m., almost three hours after sustaining the laceration to his forehead.

## Findings

Based on the facts in this case the following was concluded: The allegation of neglect is substantiated against XXXXX and XXXXX.

## Recommendations for Agency/Facility:

The Office of The Inspector General recommends Esperanza Community Services address the following:

- The agency should address the failure to report the allegation of neglect in a timely manner, which is a violation of 20 ILCS 1305/1-17(k). Willful failure to comply with OIG's reporting requirements is a Class A misdemeanor.
- Ensure current staff is retrained on the use of bedrails to prevent fails, and ensure all new staff are trained on the use of bedrails at the time of hire.