OFFICE OF THE INSPECTOR GENERAL		INVESTIGATIVE REPORT
Case No.	**Report Date**	**Investigator Name**
9517-0052	August 03, 2018	XXXXX
Facility/Agency Name		
Ludeman Developmental Center		
Facility/Agency Address		**Incident Location**
114 N. Orchard Park Forest, IL 60466		XXXXX

Allegation

On May 10, 2017, the Office of the Inspector General received a reported allegation of neglect from Ludeman DC. It is alleged that XXXXX and XXXXX failed to provide proper supervision to individual XXXXX, when he began to have suicidal ideations and eloped from the home on May 10, 2017 at 9:05 p.m.

Synopsis

On May 10, 2017, XXXXX was assigned to provide supervision for XXXXX. According to his Individual Service Plan (ISP), XXXXX was to receive 1:1 (arm's length) supervision 24 hours a day. However, the Residential Accountability Sheet, for May 10, 2017, documented his supervision level as Visual Observation (within view). XXXXX took a break, without notifying the supervisor, which violated Elisabeth Ludeman Center Standard Operating Policy and Procedure (SOPP) #384, which requires the assigned staff to never leave their assigned group for breaks unless another assigned staff person is present and has taken this responsibility. XXXXX was checking on another individual in the home, when XXXXX began having suicidal ideations and eloped. XXXXX was in the community for an unspecified amount of time, before being located by XXXXX. XXXXX was transported to XXXXX and treated for suicide ideations.

Findings

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

Recommendations

The Office of The Inspector General recommends the following: The facility addresses the discrepancy in the level of supervision documented in XXXXX's Individual Service Plan and Residential Accountability Sheet.