

WRITTEN RESPONSE TO THE OFFICE OF INSPECTOR GENERAL

Name of Service Provider: Ann Kiley Developmental Center [REDACTED]

OIG Case No.: 4518-0097

- I. For this case, was there a finding of substantiated allegations? Yes No
 Were there Other Observations by OIG, requiring a Written Response? Yes No

II. NOTICE TO INDIVIDUAL AND LEGAL GUARDIAN (for substantiated cases). The individual and guardian (if a guardian exists) have been notified that the reported allegation was substantiated. Yes No Date: 7/11/18

III. SERVICE PROVIDER'S RESPONSE TO OIG FINDINGS/RECOMMENDATIONS.

DIRECTIONS FOR EACH COLUMN (Please use additional pages of this form if necessary to complete the report.)

- **SERVICE PROVIDER'S RESPONSE.** Summarize your action for each finding/recommendation.
- **PERSON RESPONSIBLE.** Identify the person(s) responsible for each action, by name and/or job function.
- **DATES.** Provide the date(s) when each action will be (1) initiated and (2) completed.

OIG FINDINGS/RECOMMENDATIONS	SERVICE PROVIDER RESPONSE	PERSON(S) RESPONSIBLE	DATES FOR IMPLEMENTATION/COMPLETION	
Based on the facts in this case the following was concluded: The allegations of neglect, against [REDACTED], as defined by the Illinois Administrative Code, Title 59, Chapter I, Part 50, Section 50.10, is substantiated.	On August 9, 2018, a pre-disciplinary hearing was held for [REDACTED], [REDACTED] for job performance-failure to maintain supervision, job abandonment and substantial case of neglect.	[REDACTED]	7/11/18	8/31/18
The allegations of neglect, against [REDACTED] and [REDACTED], as defined by the Illinois Administrative Code, Title 59, Chapter I, Part 50, Section 50.10, is unsubstantiated.	On August 7, 2018, a pre-disciplinary hearing was held for [REDACTED] due to job performance-failure to maintain supervision.	[REDACTED]	7/11/18	8/7/18

IV. APPROVAL BY AUTHORIZED REPRESENTATIVE. I have reviewed the above Written Response. I hereby approve it as the plan for correcting the Findings/Recommendations identified in the OIG investigation for this Case Number.

SIGNATURE: <i>Authorized Representative</i>	DATE:	DHS Review:	Date:

WRITTEN RESPONSE TO THE OFFICE OF INSPECTOR GENERAL

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OIG FINDINGS/RECOMMENDATIONS	SERVICE PROVIDER RESPONSE	PERSON(S) RESPONSIBLE	DATES FOR IMPLEMENTATION/COMPLETION	
<p>However, the Office of The Inspector General recommends the following: The facility address staff's failure in following the supervision requirement sheet, must implement a strategy to inform staff of changes to guidelines and monitor staff routinely.</p> <p>The facility also address [REDACTED] altering the assignment accountability log and supervision check list.</p> <p>The facility address uncertified [REDACTED] being assigned to individuals, with increased supervision level requirements.</p>	<p>On April 9, 2018, [REDACTED] were trained on ensuring supervision levels are correct and ensuring proper follow up/re-checking.</p>	[REDACTED]	4/9/18	4/9/18
	<p>On April 25, 2018, [REDACTED] and [REDACTED] were trained on clear communication with the staff for all changes occurring in the homes.</p>	[REDACTED]	4/5/18	4/25/18
	<p>On April 2, 2018, all staff involved in this case were trained on maintaining supervision levels and on appropriate reporting requirements for breaks in supervision.</p>	[REDACTED]	4/2/18	4/2/18
	<p>A pre-disciplinary hearing will be held for [REDACTED] for job performance-falsifying documentation.</p>	[REDACTED]	7/11/18	8/31/18
	<p>During the probationary period, [REDACTED] complete on-the-job training, which allows them to work as a [REDACTED] during their probationary period. Typically, trainees work</p>	[REDACTED]		

	<p>a minimum of 2 months before they can work independently as a [REDACTED]. In this case, [REDACTED] had been working as a [REDACTED] for more than six months.</p>			
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IV. APPROVAL BY AUTHORIZED REPRESENTATIVE. I have reviewed the above Written Response. I hereby approve it as the plan for correcting the Findings/Recommendations identified in the OIG investigation for this Case Number.

<p><i>SIGNATURE: Authorized Representative</i></p> <p>[REDACTED]</p>	<p><i>DATE:</i></p> <p>8/10/18</p>	<p><i>DHS Review:</i></p> <p>[REDACTED]</p>	<p><i>Date:</i></p> <p>8/10/18</p>
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Ann M. Kiley Center
Documentation of Training

Title: Supervision Sheets	Dept.: [REDACTED]	Begin Date:	4.9.2018
	U/Hm Unit 2 & 5	Expected End Date:	4.11.2018
		Actual End Date:	

Training in Response to:
 Administrative Review (IDPH# [REDACTED])
 DPH PoC (Date:00/00/00) Supervisor Initiated
 PoC (other - _____) Other (specify)

Target Group: record the title of the groups designated for training (e.g. MHTs, RSS, RN, MD) or CWT

Routing:

Original	Staff Development
Copy	QE
Supervisor's File	Yes

Related To/Description: record a complete description of the training

Ensure that all supervision sheets (home schedule, clinical record, program book and 3rd shift book) have correct information and are current. Also ensure that supervision is updated on the 15/30-minute check and accountability log.

- These documents must include ONE SUPERVISION LEVEL. If an individual has a fading plan to decrease their supervision the 15/30-minute check and accountability log will indicate the enhanced supervision with + for the stipulation. For example, John Doe's supervision level is same room first and second shift and with staff on third. The accountability log and 15/30 check should have SR+ next to his name. The green supervision sheet in the clinical record will clearly indicate the meaning of the + (in this is example with staff on 3rd sheet).
- The 15/30-minute check and accountability log documents must include any applicable code such as: Other Codes: P= PICA or Mouthing or otherwise at risk for swallowing inedible' s. (indicate after individuals name if they exhibit such behavior). E= Elopement risk (indicate after individuals name); C=Osteoporosis (indicate after individuals name); DNR=Do not perform CPR (indicate after individuals name) Refer to Program Book or Clinical Record for further details and stipulation information.

Training Signatures: sign below (if multiple trainers, initial the appropriate column to indicate who you trained).

Print/Type Name	Trainer Signature	Print/Type Name	Trainer Signature
[REDACTED]	[REDACTED]		

Ann M. Kiley Center
Documentation of Training

Title: Supervision Sheets	Dept.:		Begin Date:	4.9.2018
	U/Hm	Unit 2 & 5	Expected End Date:	4.11.2018
			Actual End Date:	

No.	Print Last & First Name	Signature	Unit/Area	Title	Date
1					4/9/18
2					4/9/18
3					2/9/18
4					5-9-18
5					4-9-18
6					4/9/18
7					4/9/18
8					4/9/18
9					4/9/18
10					4/9/18
11					4/5/18
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Documentation of Training

Title: Clear communication with staff	Dept:		Begin Date:	4/5/18
	U/Hm	C-5	Expected End Date:	4/5/18
			Actual End Date:	

Training In Response to:
 Administrative Review [redacted] or AKC # _____)
 IDPH PoC (Date:00/00/00) X Supervisor Initiated
 PoC (other – IDPH) Other (specify) _____

Target Group: record the title of the groups designated for training (e.g. MHTs, RSS, RN, MD) or CWT

Mental Health Technicians

Routing:

Original	Staff Development
Copy	Unit Administrator
Supervisor's File	Yes

Related To/Description: record a complete description of the training

Communicating changes in the home.

When an individual's supervision has changed you are not to communicate that information with the staff UNTIL ALL paperwork has been updated and in the home.

When all of the paperwork is completed by designated team members and it is communicated to the PC then the paperwork needs to be put into the home and the information communicated to the staff.

Training Signatures: sign below (if multiple trainers, initial the appropriate column to indicate who you trained).

Print/Type Name	Trainer Signature	Print/Type Name	Trainer Signature
[redacted]			

No.	Print Last & First Name	Signature	Unit/Area	Title	Date

Documentation of Training

Title: Clear communication with staff	Dept:		Begin Date:	4/5/18
	U/Hm	C-5	Expected End Date:	4/5/18
			Actual End Date:	

No.	Print Last & First Name	Signature	Unit/Area	Title	Date
1					4-25-18
2					4-25-18
3					4-25-18
4					4/25/18
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6					4/25/18
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**Ann M. Kiley Center
Documentation of Training**

Title: Break In Supervision, maintaining supervision and reporting a break in supervision.	Dept:		Begin Date:	4/2/18
	U/Hm		Expected End Date:	4/8/18
			Actual End Date:	

Training In Response to: <input checked="" type="checkbox"/> Administrative Review ([redacted] or AKC # _____) <input type="checkbox"/> IDPH PoC (Date:00/00/00) <input type="checkbox"/> Supervisor Initiated <input type="checkbox"/> PoC (other – _____) <input type="checkbox"/> Other (specify) _____	
Target Group: record the title of the groups designated for training (e.g. MHTs, RSS, RN, MD) or <input type="checkbox"/> CWT 	
Routing:	
Original	Staff Development
Copy	[redacted]
Supervisor's File	
Related To/Description: record a complete description of the training	

**Ann M. Kiley Center
Documentation of Training**

Title: Break In Supervision, maintaining supervision and reporting a break in supervision.	Dept:		Begin Date:	4/2/18
	U/Hm		Expected End Date:	4/8/18
			Actual End Date:	

A "BREAK IN SUPERVISION" is when the group leader or assigned responsible person fails to adhere to the current supervision level established by the Habilitation Team.

When a staff is aware there is a break in supervision they are required to call the PC immediately and report

While the primary responsibility for people's safety rests with Direct-support Staff assigned to individuals, the safety of persons residing at the Ann M. Kiley Center is everyone's responsibility at all times

Staff are expected to be vigilant in ensuring people are protected from harm, intentional or accidental

Throughout the duration of an assigned staff person's work shift, he/she is to maintain an accurate accounting of each person for whom he/she has responsibility until he/she verifies another person/staff has assumed this responsibility

Know the level of supervision required for each of his or her assigned individuals. This applies if the group leader is assigned to his or her regular group or is assigned to another group.

Know the location and activity of each person for whom he or she is assigned responsibility throughout the duration of his or her work shift, or until he or she verifies another person (delegated responsible person/another assigned staff person) has taken this responsibility.

Prior to leaving an area, obtain another staff person to supervise his or her assigned individuals if it becomes necessary to leave the group area.

Ensure that his or her assigned individuals leave the home/ living area only in accord with the level of supervision specified in each individual's Service & Support Plan.

**Ann M. Kiley Center
Documentation of Training**

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	U/Hm		Expected End Date:	4/8/18
			Actual End Date:	

Training Signatures: sign below (if multiple trainers, initial the appropriate column to indicate who you trained).			
Print/Type Name	Trainer Signature	Print/Type Name	Trainer Signature

No.	Print Last & First Name	Signature	Unit/Area	Title	Date
1					4/4/18
2					4/17/18
3					4-4-18
4					4-17-18
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