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REPORT OF FINDINGS
WE CARE DEVELOPMENT—— 08-040-9002
HUMAN RIGHTS AUTHORITY— South Suburban Region

[Case Summary— The Authority made corrective recommendations regarding one of two allegations that were accepted by the service provider. The public record on this case is recorded below; the provider did not request that its response be included as part of the public record.]

INTRODUCTION

The Human Rights Authority (HRA) has completed its investigation into allegations concerning We Care Development located in Matteson. According to the complaint, the agency was not following Community Integrated Living Arrangement (CILA) requirements for a resident's medication management. Additionally, the complaint alleged that the agency failed to provide the resident with adequate programming in regard to personal hygiene and structured activities in the home. If substantiated, these allegations would be violations of the Illinois Administrative Code (CILA Rules, 59 Ill. Admin. Code 115.100 et seq.), (Medication Rules 59 Ill. Admin. Code 116.110 et seq.) and the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102 [a]).

This agency manages four CILAs which consist of 18 adult residents with disabilities.

METHODOLOGY

To pursue the investigation, the HRA conducted a site visit to the CILA mentioned in the complaint and interviewed an Administrator, the Director of Growth and Development and the House Manager. A telephone conference was held with the agency's nurse. The complaint was discussed with the legal guardian of the person by telephone. Portions of the adult resident's record were reviewed with written consent. Relevant program policies were also reviewed.

COMPLAINT STATEMENT

The complaint stated that a resident's guardian was given the wrong medications for a home visit. Although the guardian reportedly returned the medications without incident, the agency's administration failed to assure her that it would not happen again. The complaint alleged that the guardian was given three days worth of medications for a four day visit because medication is dispensed from the pharmacy in bubble packs of 30 pills. There was not enough medication to cover the visit that occurred in a month with 31 days, but dosages were not missed because the guardian had some pills left over from a previous supply. It was reported that the agency refused to replace the medication given because of the shortage. Additionally, the

complaint stated that the resident was not shaved for a scheduled home visit, and the home lacked structured activities after day training program.

FINDINGS
Information from the record, interviews and policy

The resident's February 21st, 2007 Individual Services Plan (ISP) indicated that he was diagnosed with Mild to Moderate Mental Retardation, Schizophrenia and some physical problems. He was prescribed Seroquel 250 mg in the morning and 275 mg nightly and Depakote Extended Release 1000 mg nightly for behavior management. There was no documentation that the wrong medications were given to the guardian, but the medication error was confirmed by the agency's Administrator. An employee disciplinary form dated July 21st, 2007 was subsequently provided to the HRA. It also confirmed that the employee gave the resident's guardian another client's medication for a home visit, and the medication error was discovered by the guardian.

The medication error was discussed with the agency's nurse. She reported that all direct care residential staff members have completed the medication training program. She described the training for non-licensed staff to become authorized to give medication as follows: 1) two days of classroom training, 2) reviewing physician's orders, 3) on site visit with the direct care staff person, and, 4) documenting in residents' records. They are also trained to identify the resident by name and cross check the person's identity on the Medication Administration Records (MARs) and the original labeled container (bubble pack). The MARs are reviewed by the nurse during each visit to the CILAs, and the Home Manager also checks them.

According to the nurse, medication dispensed from the pharmacy in a bubble pack clearly identifies the medication, dosage and frequency. The nurse reported that medications are removed from their original labeled containers and packaged in plastic containers for home visits. The name of the medication, color and shape are reportedly used to help the resident's responsible person to identify the medication during home visits. This information is written on a piece of paper and placed inside of the plastic bag in the plastic container. For example, the person would be informed that the blue pill is (name of the medication). According to the nurse, the rationale for taking the medication out of its original labeled container for visits is money. She said that replacing one or two pills would cost less money than replacing the entire bubble pack, if the medication was lost.

The nurse said that she talked to the employee about the medication error, and she determined that additional training was not needed. She said some direct care staff members have been retrained and the severity of the medication determines whether more training is needed. The Administrator said that the error was reported as required under the CILA rules, and a copy of the agency's new Psychotropic Medication policy was provided. She further asserted that the employee who made the error had been retrained on administering medication but later reported that he was discharged from the agency for unrelated reasons that same month.

According to the agency's new policy (dated August 13th, 2007), psychotropic medication will be identified first by classification in the medication administration record of each consumer. These medications will also be identified by a green colored highlight placed over psychotropic medications of similar or identical chemical class. Direct care staff members will receive medication administration training upon employment with the agency and training annually on psychotropic medication.

In response to the complaint about adequate medication for home visits, the HRA reviewed twenty-seven visitation records for 2007. These visits were usually during the day, and notice was given on that same day. Documentation on March 20th, 2007 stated that the guardian called the agency five minutes before picking up the resident for a day visit. The HRA also noticed that information such as the pick up or return date on many of the visitation forms were lacking. A special team meeting report, dated April 3rd, 2008, stated that the guardian voiced concerns about adequate medications for home visits occurring at the end of the month for example from April 26th through May 2nd. She was concerned that she would be given five days of medications for the seven day visit because the agency's nurse must inventory the new medications.

The nurse told the HRA that she was present when the guardian picked up the resident for several visits. She reported that the guardian requested medications but was not sure about his return date. She said that the direct care staff person tried to explain the agency's medication policy to the guardian. According to the agency's Administrator and the nurse, the guardian wanted more medication to cover visits than needed. They said that the guardian would bring the resident back to the CILA sometimes before scheduled, but medications were not returned. The number of pills given for his next visit was reportedly reduced to compensate for those not returned to the agency. The House Manager also added that the guardian would sometimes extend the visit and request more medications. There was only one visitation record to support the staff's statement found in the record. Documentation on February 3rd, 2007 stated that the resident did not return on February 5th, 2007 as planned. His visit was extended until February 7th, 2007 and more medications were provided.

The nurse was asked about the agency's systems in place for providing adequate medication to residents during periods of planned absence from the home. She explained that the medication cycle runs 30 days, which corresponds to the number of pills in a bubble pack. New medications usually are delivered from the pharmacy at a minimum of five days before the cycle ends, but direct care staff members cannot unlock the box before she inventories the medications. According to the nurse, she must confirm that the medications are correct and that they have not been discontinued before administered. The nurse said that she would ask the pharmacy if the medication could be delivered earlier for extended visits or lost medication. The nurse repeatedly stated that the agency's goal is to make the resident's visit enjoyable, and she would make every attempt to accommodate this. Additionally, the guardian reportedly told the nurse that she had medications left over from the resident's previous placement. She was advised not to administer the medications because they were probably expired. The nurse was also concerned because his medications had been changed.

In response to the complaint about inadequate programming for grooming and structured activities in the home, the resident's February 21st, 2007 plan indicated that he needed prompting to complete hygiene, dressing and grooming tasks. He was able to get around the house without assistance and enjoyed watching television. The resident reportedly preferred community activities such as eating at restaurants and attending church. He attended a day training program Monday through Friday from 8:30 a.m. to 4:00 p.m. managed by another agency.

According to the House Manager, the resident was sometimes non-compliant with medications as well as being uncooperative, but redirectable. He was willing to complete daily hygiene tasks such as bathing, grooming and hair care at times. The House Manager said that maybe the resident did have a little hair growth on his face because the guardian would pick up the resident without calling. The complaint alleged that the visit in question had been scheduled. She also said that the guardian picked up the resident at his workshop several times without notification. The investigation team could not observe the resident's grooming because he had been discharged prior to the site visit. The House Manager said that the resident would call his mother when he returned from day programming. She stated that the resident's participation in activities depended on his mood. The resident reportedly stayed to himself in the home and usually listened to music or watched television.

The agency has an Activity Coordinator and a written activity calendar for 2007 was provided to the HRA. The investigation team noticed that there was only one activity listed for each day. According to the Administrator, activity calendars are mailed monthly to guardians. She reported that a copy of the schedule is kept in the staff's office, but the calendar could not be found during the HRA's visit. The House Manager reported that residents usually play baseball or participate in supervised cook outs on weekdays during the warm weather. Some of them reportedly have cooking goals which are implemented after they return from day programming. They also participate in supervised community outings such as dances or eating at restaurants. According to the Director of Growth and Development, the resident in question participated in many outside activities with his guardian's consent. Documentation indicated that he participated in bowling, basketball and Special Olympics during 2007 and 2008.

We Care Development's policies and procedures (#107A and #107B) state that to guarantee optimal implementation of programmatic duties and responsibilities the direct support staff on the 8:00 a.m. to 4:00 p.m. shift must ensure that residents are properly dressed and groomed. They must check for activities on the schedule. The shift from 3:00 p.m. to 11:00 p.m. must assist residents with individual skills programs as recorded in their ISPs and complete documentation. The staff must aid residents in life skills development and community integration as outlined on the monthly Activity Calendar. They must also provide the necessary level of support to ensure that all personal hygiene tasks have been effectively performed daily.

To provide active treatment, the agency's hygiene policy states that direct support staff must: 1) provide choices to individuals, 2) assist as needed without performing the tasks, 3) reward and reinforce individuals for appropriate participation in group and individual programs and activities, 4) recognize people's strengths and reinforce independence and autonomy, and, 5) use life events as training opportunities even if a formal program has not been written.

The policies further state that staff must ensure that residents are well groomed in order to promote a positive self-image and enhance self esteem. Residents should be promptly provided with assistance to maintain a neat and clean appearance throughout the day including washing face and hands as needed. It also states that hair should be clean and attractively styled.

CONCLUSION

The Medication Rules define a medication error as the administration other than as prescribed resulting in the wrong medication being taken, or medication being taken at the wrong time, or in the wrong dosage, or via the wrong route, or by the wrong person or omitted entirely (59 Ill. Admin. Code 116.20).

> In the event of a medication error, authorized direct care staff shall immediately report the error to the registered professional nurse, advanced practice nurse, physician, physician assistant, dentist, podiatrist, or certified optometrist to receive direction on any action to be taken. All medications errors shall be documented in the individual's clinical record and a medication error shall be completed within eight hours or before the end of the shift in which the error was discovered, whichever is earlier. The medication error report shall be sent to the nurse-trainer for review and further action. A copy of the medication error report shall be maintained as part of the agency's quality assurance program. Medication errors must be reported to the DHS Bureau of Quality Enhancement... in accordance with written instructions from the Department's Bureau of Quality Enhancement. (Section 116.70 c).
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> All medications shall be stored in their original containers. (Section 116.80 d).

According to the CILA Rules,

> Based on their needs, individuals shall receive supervision and supportive services which may range from continuous to intermittent. CILAs shall be designed to promote optimal independence in daily living, economic self-sufficiency and integration into the community through the interdisciplinary process. (59 Ill. Admin. Code 115.200 d).
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> The community support team shall be directly responsible for: … 7) Assisting the individual in developing community supports and fostering relationships with non-paid persons in the community, e.g., neighbors, volunteers and landlords and 8) Providing personal support and assistance to the individual in gaining access to vocational training, educational services, legal services,

employment opportunities, and leisure, recreation, religion and social activities. (Section 115.220 c).

At least monthly, the QMRP shall review the services plan and shall document in the individual's record that: 1) Services plan are being implemented; 2) Services identified in the services plan continue to meet the individual's need or require modification and 3) Actions are recommended when needed. (Section 115.230 m).

Section 5/2-102 (a) of the Mental Health Code guarantees all recipients of services that adequate and humane care and services shall be provided, pursuant to an individual services plan.

Based on the investigation, the Authority substantiates that the agency is not following Community Integrated Living Arrangement requirements for a resident's medication management. The Administrator confirmed that an employee gave the guardian another resident's medications for a home visit. Although the medications were returned without incident, there was no documentation of the incident recorded in the resident's record. This violates Section 116.70 (c). The HRA could not determine how many times the guardian returned the resident to the CILA before his return date and whether unused medications were returned because of poor documentation. However, the agency violates Section 5/2-102 (a) because staff verbally reported that the resident's medications were sometimes reduced to compensate for his early returns.

The complaint that the agency failed to provide the resident with adequate programming in regard to personal grooming and structured activities in the home was not substantiated. The resident's plan indicated that he needed help with dressing and grooming to which the staff said that this was provided whenever the individual was willing. The HRA could not observe the resident because he was discharged prior to our visit. Further, the resident's plan stated that he preferred watching television or listening to music or participating in community activities. Documentation indicated that the resident participated in basketball, bowling and Special Olympics. The HRA finds no violations of Sections 115.200 (d), 115.220 (c) and 115.230 (m).

RECOMMENDATIONS

1. The agency shall follow rules and regulations governing administering medication to residents who resides in Community Integrated Living Arrangements under Section 116.70 (c).

2. Ensure that documentation of medication errors are recorded in resident's records.

3. The agency shall provide adequate medications for home visits and ensure that all physicians' orders and Section 5/2-102 (a) are followed.

SUGGESTIONS

1. Provide residents with choices concerning structured activities in the home and the community outings.

2. Post activity calendars in the homes.

3. Include in resident's records programming for grooming and dressing whenever needs are identified under Section 115.200 (d).

COMMENT

We believe that the facility's efforts in putting medications in plastic bags for the resident's home visits were intended to protect them from loss and were not a violation of his rights. But, we encourage the agency to look at storage and administration regulations in the Medication Rules (59 Ill. Admin. Code 116) whenever medications are taken out of their original package and repackaged for home visits. The HRA understands that the provider is concerned about sending the entire bubble pack home with the resident because the medications may be lost; however, the practice means that staff are dispensing medications without qualification while increasing the risk of poor sanitation and error. We strongly suggest that the agency discontinue repackaging medications.

Additionally, the front door was opened when the HRA arrived at the CILA, and the investigation team noticed a resident sitting on the toilet being supervised by a staff person. The bathroom faces the front door of the home, and the incident was addressed with the staff. An administrative staff member replied that, "he is blind." A member of the investigation team informed the agency's staff that the resident has a right to privacy regardless of his visual impairment.

The Illinois Administrative Code (59 Ill. Admin. Code 115.300 4, (c) states that bathing and toilet facilities shall provide privacy. The provider is also reminded of the right to humane care and services under Section 5/2-102 (a).