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East Central HRA Report of Findings
Macon Resources
Case 09-060-9007

The East Central Regional Human Rights Authority, a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegations concerning developmental disabilities services at Macon Resources located in Decatur, Illinois:

1. Care is inadequate in that a resident is found to have frequent injuries.
2. The agency conducts inadequate investigations of resident injuries.
3. There is a lack of guardian notification of resident injuries.
4. Injury and incident reporting is inadequate in that the person completing the reporting is not always directly involved in the incident and the reports are not timely.
5. A resident does not receive sufficient grooming care.
6. Medication errors occurred on multiple days for a resident.
7. The agency grievance process is ineffective.

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/1-100 et seq.) and the Administrative Codes for Community Integrated Living Arrangements (CILAs) (59 Ill. Admin. Code 115) and Medication Administration in Community Settings (59 Ill. Admin. Code 116).

Macon Resources, Inc. is a not for profit organization in Decatur, Illinois that provides comprehensive services and supports, for children and adults with disabilities. There are approximately 270 individuals in day programs and about 200 more that receive support services from Macon Resources. They have five eight-bed CILAs, one six-bed CILA, and 1 four-bed CILA, and about 30 people in private homes for whom that they provide services.

To investigate the allegations, the Authority interviewed the director of community living services, the case manager for a recipient, the human rights officer, an Office of Inspector General (OIG) contact for the agency and the CILA home supervisor of the home where the resident lives. The Authority examined the record of a resident, with consent, and reviewed pertinent policies and related facility mandates.

COMPLAINT

According to the complaint the guardian was not notified for three days that the resident had a black and swollen eye, at which point the guardian requested that the resident be taken to the doctor. The Guardian did not receive an accident report until several weeks later. Also, staff

let the guardian know about the incident instead of the supervisor contacting guardian. Staff have stated they do not know how resident was injured. The complaint states that a particular staff always seems to be with the resident when he gets hurt and does not know how it happens. The complaint states that the resident will not "tell" on someone else if he thinks this will get someone in trouble. These issues were brought to the social worker and the director; however answers did not seem satisfactory. Issues of the resident receiving adequate and humane care were questioned. A complaint was made to the OIG but they would not take case since a nurse had seen the resident.

On 6/28/08 the guardian received a message that medication (Coumadin) was not given on 6/26/08 and 06/27/08. The error was discovered on Saturday evening. The resident was taken to the hospital and was admitted due to protime being 1.6. The hospital was told he had not missed his medication inadvertently by staff, but he had missed two doses of Coumadin. The guardian thought that staff failed to give the medications but the nurse failed to order them.

FINDINGS

Interviews

An HRA investigation team met with and interviewed the director of community living services, who reported that they have five eight-bed CILA, one six-bed home CILA, and one four-bed CILA, and about 30 people in private homes for whom they provide services. The CILA where the recipient resides is an eight-bed CILA that serves individuals with developmental disabilities. Family and friends can call at any time.

The recipient has been diagnosed with mental retardation, Down Syndrome, has poor circulation, has battled MRSA (methicillin- resistant staphylococcus aureus), sleep issues, has issues with his urethra, has a pacemaker and two prosthetic heart valves, and also has rare skin reactions called syringoma. This also created some issues with staff about how much hair gel to use on the resident's hair. This resident also bruises easily due to his prescription medication (Coumadin).

Macon Resources explained to the HRA that training had been provided to direct service personnel. This included basic health and safety training, human sexuality training, blood borne pathogens/ infection control training, cardiopulmonary resuscitation (CPR) and AED (Automatic External Defibrillator) steps training, and medication administration training. Illinois Department of Human Services (DHS) training on medication administering hazard communication training, human rights, reporting abuse and neglect, advocacy, Direct Service Personnel (DSP) communication and interaction, self assessment and Individual Service Plan (ISP), fire safety training, first aid training, and corporate conduct and compliance training. Mandt is the behavioral management training provided for handling behaviors. Copies of all training manuals were provided to the HRA. The agency explained that staff receive training on rights at hire and also annually.

OIG contact information for residents and staff was easily displayed, but rights were poorly displayed and hard to locate at the corporate headquarters which serves and trains

individuals with disabilities. When it was located it was highlighted in pink which made reading it difficult. However at the CILA, rights were posted numerous times with OIG phone numbers located by an accessible cordless phone which residents could remove and take to their rooms. Also noteworthy and commendable was that rights were also displayed in a picture form at the CILA which most residents could easily understand.

It was explained to the HRA that staff are trained in recognizing and reporting incidences of abuse. The HRA was shown training manuals which provided training on reporting abuse by DHS policies and procedures. It appears that confidential reporting could occur. There is an in-house OIG person who is responsible for OIG investigations. The HRA was provided a copy of the OIG report on the incident as well with masked names. Macon Resources stated its policy of notifying the guardian of any incident is usually within 24 hours. They also stated that a report should be written by staff who observed the incident.

When Macon Resources was questioned about what procedures are in place to insure resident safety and protection, and for documenting, reporting and reviewing behavioral incidents or resident injuries, the response by the agency was that DSP staff are fully trained on safety and supervisors are in the homes daily. The HRA was provided numerous training manuals which had agency policy and procedures regarding safety training, as well as accident reporting. The HRA was informed that since the recipient was taking Coumadin that he bruised very easily and that even the director of the agency tried to figure out how he would get hurt. They looked at how the recipient's room was set up and moved furniture and items to prevent the recipient from accidentally bumping himself and getting bruised. They could not identify a specific staff member that was always present when the resident would develop a bruise.

In regards to grooming, Macon Resources explained that is about the choice of the resident. This resident does require some physical assistance. He is able to dress himself. He knows colors and is able to make some clothing choices. Staff are fully trained in regards to assisting residents with personal grooming, but also wanted the guardian to provide instruction on how the guardian would prefer to have the resident's hair to be groomed. At the time of the interview the guardian had not provided the training. At the completion of the report the guardian had provided the training to the staff.

Regarding medication issues, Macon Resources explained that staff are trained on the administration of daily medications and what to do if a resident is running low on medications. There is a nurse on call 24 hours a day. It was the agency that found the medication error and the nurse who failed to order meds for the recipient is no longer employed by Macon Resources. Staff have quality assurance training by the DHS. It was the director of community living services who notified the guardian of the medication error when it was discovered.

In regards to the grievance process there is a problem resolution process in which both the guardian and/or the resident can appeal a decision made by an employee. Macon Resources has a hierarchical process of problem resolution which utilizes a step-by-step procedure.

Macon Resources has a human rights committee and an active behavioral management committee. Macon Resources has a staff member specifically assigned to human rights, and a

human rights committee. There was also an advocacy group consisting of residents called Voices. Any grievance made by an individual/guardian that is a suspected violation of human rights shall be reported to the human rights committee. Any advocate for the individual may be requested by the individual, parent or guardian at any step in the problem resolution process. This committee meets monthly to discuss rights issues and a resident sits on the committee. The committees have discussed the issues in this case. They go over every new behavior specific to each individual.

The HRA was provided with a tour of the home; the posting of the OIG number and rights were clearly documented in writing and in picture form. These were located by an accessible and cordless phone. Residents stated they liked living there and are happy there. This also included the resident whom this complaint is about. From what was observed programs appear to be followed. Also training of staff in this home about human rights was documented and scheduled. There appeared to be a staffing ratio of about three staff members to eight residents during the time that the HRA toured the home.

Policy Reviews

DSP Abuse and Neglect: Recognition, Reporting & Prevention September 2003

The HRA reviewed the policy regarding recognizing and reporting abuse. In this manual, staff are taught the definitions of abuse and neglect as defined by the Office of Inspector General. It also trains on staff responsibility to report abuse to the OIG and their supervisor. It shows staff their legal obligation to report and what is reportable such as abuse, neglect, serious injury, death, inappropriate interactions and employee misconduct. There are practice exercises of what or what not to report, false reporting, and creating and maintaining a trust-producing, healthy, and engaging environment. There is also a role perception, attitude, emotions, and overcoming your vulnerabilities exercise. There is training in supporting the emotions of individuals, and strategies to diffuse a situation. There are also lessons on teamwork and role play.

Problem Resolution Process (Undated)

The HRA reviewed policy on the problem resolution process. The policy states that no one involved in the action or decision being aggrieved or appealed shall be part of the review of that action or decision. It lists numerous tiers of authority where the resident/guardian may appeal a decision with the Primary Case Manager, if there is no resolution the program director will refer to the Deputy Director. If there is no resolution at this stage the appeal will go to the Executive Director. The Executive Director's decision shall constitute a final administrative decision. Grievances will be referred to the Human Rights Committee if there is a suspected violation of human rights. There is also a mandate for employees to assist all individuals, guardians and families in contacting advocating agencies such as the agency's Human Rights committee, Guardianship and Advocacy Commission, Prairieland Service Coordination, Equip for Equality, the office of Public Aid, and/or Department of Human Services.

DSP Basic Health and Safety Trainee's Notebook January 2003,
(Section 3, Health Conditions and Symptoms, pg.44, Reporting Guidelines for Signs & Symptoms.)

The HRA reviewed the trainee's notebook, and on this page, on the second dot point, it states "Describe how the individual appears physically." Further in the text, it states "Describe any visible bleeding or swelling, how much and how fast. If injury, describe how it happened. Describe the size of wound or injury. "

DSP Basic Health and Safety Trainee's Notebook January 2003,
(Section 5, Assisting individuals with Activities of Daily Living), pg.110, #19Assisting an Individual with Shampooing Step 12.

On this page under step 12, it states: "Prompt or assist individual to blow dry/set hair or use curling iron if it is individual's choice to do so. Style hair in age-appropriate style per individual's choice. Use gel/moose, etc., per individual's choice."

Do's and Don'ts Completing Accident/Incident, Behavior Incident, Vehicle Accident Reports.

This policy showed a copy of the blank report and listed the following:

"DO:

- Complete the report entirely.
- Write legibly.
- Paint a picture of what happened.
- Complete the report as soon as possible after incident.
- Record the specific location of the incident.
- Remember to sign and date the report after completing it.
- Complete additional reports if necessary
- Correct errors by putting one line through the error: write the "error" and initial it.

DON'T:

- Put your emotions into the report. Document only facts.
- Put more than one individual's name on a report. Complete additional reports for a an additional person.
- Complete a Behavior Incident Report in front of the individual about whom you are writing.
- Use white-out.
- Document the specific profanity used the individuals. Just state that the individual used profanity or cursed."

It listed scenarios to practice with and an example of a properly completed report.

GENERAL AGENCY ADMINISTRATION, 1.5 Health & Safe ty, 1.
5.2. Safety Committee, F, Special Health & Procedures. March 2006

The HRA reviewed this policy regarding report routing. A copy of the report goes to the Master Case Record, the residential facility, Registered Nurse/CLS Adult Outreach, and the Human Rights Committee. If a there is a possibility of abuse, neglect, violation of rights, or the injury required treatment by a physician, a copy of the report goes to the to the safety committee and to the Executive Director. If the accident/ incident involved a safety issue, the injury required treatment by a physician or has an external impact on the agency. The report goes to Human Resources (HR) for inclusion in an employee's personal file within 24 hours of the occurrence. The HR Coordinator will log the report in accordance with worker's compensation

guidelines and as outlined by OSHA (Occupational Safety and Health Administration). In regards to routing a copy of the report to the guardian, this policy states in part 1.b.2 that "Individual/Guardian - a copy of the report, or a verbal report, will be provided based on the wishes of the individual/guardian."

*Medication Administration OJT (*on-the-job training*)*

The HRA reviewed the OJT training manual regarding dispensing medications. There was training on keeping records of drugs dispensed for PRN (as needed) and controlled substance inventory. There is training on medication classifications and implications which included anticoagulants.

Under the heading Anticoagulants it was explained that these were used to decrease the ability of the blood to clot and help prevent harmful clots from forming in blood vessels. Examples are: Coumadin, Warfarin. (Coumadin is the drug that resident was taking when the medication error was made.) Under this heading the following was explained:

- "Protime blood test needs to be done to see how fast blood is clotting - monthly.
- Give drug same time every day, preferably 4pm.
- Do not stop giving drug unless instructed by doctor
- Taking too much of the drug can cause bleeding. Contact the doctor if any signs of bleeding occur.
- Signs of excessive bleeding.
- Prolonged nosebleeds.
- Bleeding from gums.
- Prolonged oozing from cut: more than 5-10 minutes.
- Blackish stools or bright red blood present in stools."

Records Reviews

The programs and behavioral plans that were in place for the resident involved in the incident were reviewed by the HRA. The documentation of treatment plan and medication administered by staff were reviewed as well.

The HRA reviewed medication orders for Coumadin. Per the physician orders, the recipient was to take 1 tablet (1mg) at 4:00 pm. per day. The resident has two prosthetic heart valves and a pacemaker and the Coumadin prevented the danger of a blood clot.

The HRA reviewed the OIG report regarding the medication error. From review of the report the registered nurse in charge of reordering the medication failed to reorder the medicine timely. The staff responsible for giving the needed medication failed to give this medication or alert anyone there was no medication available to give. When the error was discovered the RN contacted the recipient's physician, who had the resident hospitalized so he would not coagulate and hospital staff could regulate the Coumadin. After this incident the registered nurse was no longer employed at Macon Resources.

The HRA reviewed an accident/incident report and chronological notes regarding the report the recipient was hospitalized after missing two doses of his medication and the physician requested that he receive a heparin drip. The resident pulled out his intravenous drip three

different times. The hospital staff on the following day chose to give him his medications by injection into his abdomen. Per chronological notes he returned back to the CILA after being hospitalized for two days. The notes show staff documenting the recipient's condition every hour for five days after the hospitalization.

The HRA reviewed an accident/incident report and chronological notes, regarding the report about the bruise over the eye. It appears that staff did refer the resident to the nurse. It also appears there was follow-up with the medical doctor as well. There was no evidence that showed any abuse or neglect by staff. There was no indication of how it occurred except that the resident bruises easily from his prescription medication.

The HRA reviewed documentation from the meeting held with the guardian and a family member of the resident voicing their concerns. The concerns and/or questions expressed by them were:

- There is a lack of compassion demonstrated by the staff at the CILA.
- There is more concern about the paycheck staff receive then giving quality care.
- Concerns that when an accident occurs it is not being addressed in a timely manner.
- Examples include incidents/accidents reports not filled out correctly or within agency policy.
- That it is assumption of staff that the incidents are the recipients' faults and not looked at that others could be responsible.
- They named a specific staff member who always seems to be working when the recipient has an accident and this staff member never fills out a report.
- It was requested by these two parties that Macon resources would deal with staff and contact the guardian of any accident or incident.

Macon Resources responded with having the executive director, the CILA director, house supervisor, case manager meet with all the staff of that CILA and monitor staff performance and address accordingly. The guardian would be notified of any accident/incident between the hours of 7:00 am to 10:00 pm, which would also vary depending on if any need of the resident was considered an emergency.

The HRA reviewed notes of the meeting held on behalf of the individual 10 days later with the executive director, the CILA director, house supervisor, case manager and house staff. This also included the particular staff member that the guardian and sister were concerned about. The concerns were expressed to staff and what could be done to eliminate those concerns. Accident and incident report completion was reviewed as well as the timeliness of the report was reviewed. Guardian notification was discussed with staff reiterating that notification would take place of any accident/incident between the hours of 7:00 am to 10:00 pm. This would also vary depending on if any need of the recipient was considered an emergency. The recipient's hair care was discussed. There was also a review of agency expectations. It was also discussed what could be done to make the guardian and resident 's family feel comfortable about the recipient's care as well as providing effective communication.

CONCLUSIONS

Complaint 1. Care is inadequate in that a resident is found to have frequent injuries.

Pursuant to the Mental Health and Developmental Disabilities Code (5/1-101.2),"'Adequate and humane care and services' means services reasonably calculated to…prevent further decline in the clinical condition of a recipient of services so that he or she does not present an imminent danger to self or others." It adds that all recipients shall be provided with adequate and humane care and that they be free from abuse and neglect (5/2-102 and 5/2-112).

The resident lived in a CILA where it had been documented to have adequate support staff that appeared to interact appropriately with residents. Chronological notes and the individual support plan show a supportive plan to address the injuries and the care the resident received. It appears that he is closely monitored. Macon Resources recognized a need to address a pattern of injures which is supported by a service plan to meet his needs. From the documentation it appears that Macon Resources does follow up and review each injury. Injury reports were provided to the HRA showing the injuries documented but without evidence of physical abuse. The director of the agency as well as all support staff looked for any item that would cause the resident to be bumped or bruised and removed them. Based on documentation and personnel statements, it appears that the resident was receiving adequate and humane care. The HRA found no evidence to support that care was inadequate. **Complaint 1.Care is inadequate in that a resident is found to have frequent injuries is not substantiated.**

Complaint 2. The agency conducts inadequate investigations of resident injuries and Complaint 7. The agency grievance process is ineffective.

The Mental Health and Developmental Disabilities Code (5/2-200) states, "(a) Upon commencement of services, or as soon thereafter as the condition of the recipient permits, every adult recipient, as well as the recipient's guardian or substitute decision maker, and every recipient who is 12 years of age or older and the parent or guardian of a minor or person under guardianship shall be informed orally and in writing of the rights guaranteed by this Chapter which are relevant to the nature of the recipient's services program. Every facility shall also post conspicuously in public areas a summary of the rights which are relevant to the services delivered by that facility."

The CILA Rules (59 Ill. Admin. Code 115.250) state under individual rights and confidentiality, "To ensure that individuals' rights are protected and that all services provided to individuals comply with the law, agencies licensed to certify CILAs shall assure that a written statement, in a language the individual understands, is given to each individual and guardian specifying the individual's rights.

a) Employees shall inform individuals entering a CILA program of the following:

1) The rights of individuals shall be protected in accordance with Chapter II of the Code except that the use of seclusion will not be permitted.

4) Their right to contact the Guardianship and Advocacy Commission, Equip for Equality, Inc., the Department's Office of Inspector General, the agency's human rights committee and the Department. Employees shall offer assistance to individuals in contacting these groups giving each individual the address and telephone number of the Guardianship and Advocacy Commission, the Department's Office of Inspector General, the Department, and Equip for Equality, Inc.

5) Every individual receiving CILA services has the right to be free from abuse and neglect. ….

c) Individuals or guardians shall be permitted to present grievances and to appeal adverse decisions of the agency and other service providers up to and including the authorized agency representative.

d) Individuals shall not be denied, suspended or terminated from services or have services reduced for exercising any of their rights."

The executive director, the CILA director, house supervisor, case manager all completed investigations into what was causing the resident to incur injuries, per interview and documentation of accident reports. The guardian was referred to other agencies outside of the CILA to investigate, including the OIG and the HRA. The agency met with the guardian and family member and with all managerial staff to resolve any issue and formed a plan to cooperate with the guardian in meeting expectations as well as taking extra steps to allow for training for that specific individual's hair care. There is policy in place for grievances and they educate recipients and guardians on how to engage the grievance process. This was documented in the *Problem Resolution Process (Undated) and* Rights statements in the CILA were displayed in their entirety in writing as well as in picture form.

On the issue of the resident not receiving his Coumadin, it was the agency that discovered that the recipient had not received the Coumadin. Per the incident report the agency CILA director notified the guardian and made immediate arrangements for the recipient to see his physician and to be hospitalized per the physician's orders. Per the interview and the reports related to this incident, the agency completed a very exhaustive investigation which resulted in at least two employees being separated from employment with the agency. **Based on the actions of the agency that effectively completed the investigation and responded appropriately to the grievance of the guardian and family the two complaints, the agency conducts inadequate investigations of resident injuries and the agency grievance process is ineffective are not substantiated.**

Complaint 3. There is a lack of guardian notification of resident injuries and Complaint 4. Injury and incident reporting is inadequate in that the person completing the reporting is not always directly involved in the incident and the reports are not timely.

Under the CILA Rules (59 Ill. Admin. Code 115.320):

"g) Unusual incidents

1) The agency shall have written policies and procedures for handling, investigating, reporting, tracking and analyzing unusual incidents through the agency's management

> structure, up to and including the authorized agency representative. The agency shall ensure that employees demonstrate their knowledge of, and follow, such policies and procedures. Unusual incidents shall include, but are not limited to, the following:…D) Physical injury;"

The Probate Act (755 ILCS 5/11a-23) states that, "Every health care provider and other person (reliant) has the right to rely on any decision or direction made by the guardian, standby guardian, or short-term guardian that is not clearly contrary to the law, to the same extent and with the same effect as though the decision or direction had been made or given by the ward. "

And, according to the Mental Health Code (405 ILCS 5/2-102), "(a) A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient."

The HRA reviewed program policy regarding health and safety report routing. In regards to routing a copy of the report to the guardian this policy states in part 1.b.2 that "Individual/Guardian - a copy of the report, or a verbal report, will be provided based on the wishes of the individual/guardian." The HRA reviewed the meeting held with the guardian and a family member of the recipient voicing their concerns. Macon Resources responded with having the executive director, the CILA director, house supervisor, and case manager meet with all CILA staff, monitor staff performance and address accordingly. It was also determined that the guardian would be notified of any accident/incident between the hours of 7:00 am to 10:00 pm. This would also vary depending on if any need of the recipient was considered an emergency.

The HRA reviewed the accident reports from 06/16/08 to 08/25/08; all reports appeared to be completed by the individual who had witnessed or had knowledge of the accident and injury. They also seemed to follow the agency instructions from the *Do's and Don'ts Completing Accident/Incident, Behavior Incident, Vehicle Accident Reports.* Guardian notification was documented on the reports.

The agency clearly has written policies and procedures for handling, investigating, reporting, tracking and analyzing unusual incidents through the agency's management structure. The agency demonstrated that their staff have knowledge of, and follow, their policies and procedures. The plan for the recipient was formulated and reviewed with the participation of the recipient to the extent feasible and the recipient's guardian in writing. The plan provided adequate and humane care and services in the least restrictive environment. Based on the evidence provided **Complaint 3. That there is a lack of guardian notification of resident injuries and Complaint 4. That injury and incident reporting is inadequate in that the person completing the reporting is not always directly involved in the incident and the reports are not timely are not substantiated.**

Compliant 5. A resident does not receive sufficient grooming care.

As stated previously, according to the Mental Health Code (405 ILCS 5/2-102), "(a) A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient."

The CILA Rules (59 Ill. Admin. Code 115.200) require that "Services shall be oriented to the individual and shall be designed to meet the needs of the individual with input and participation of his or her family as appropriate." Service plans are developed to reflect the individual's and his guardian's preferences (115.230).

Macon's *DSP Basic Health and Safety Trainee's Notebook January 2003, (Section 5, Assisting individuals with Activities of Daily Living), pg.110, #19Assisting an Individual with Shampooing Step 12.* states: "Prompt or assist individual to blow dry/set hair or use curling iron if it is individual's choice to do so. Style hair in age-appropriate style per individual's choice. Use gel/moose, etc., per individual's choice." This policy, in its entirety, is consistent with the statute regarding adequate and humane care.

From the interviews in regards to grooming, this issue was based on the way the resident's hair was groomed. Macon Resources staff explained that it is the choice of the resident how his hair is groomed. This resident does require some physical assistance and he is able to make some choices. Staff are fully trained in regards to assisting residents with personal grooming, but also wanted the guardian to provide instruction on how the guardian would prefer to have the resident's hair to be groomed. At the time of the report the guardian had provided instruction. Staff have been instructed to follow the guardian's instructions on hair grooming, and his grooming preferences are noted in his service plan. Another issue tied to the hair grooming is that medication must be applied to the hair as well and it appears from the record that this is incorporated with the grooming.

Based on Macon Resources policy, procedures, interview, and cooperation with the guardian regarding how the resident would like his hair groomed. **Compliant 5. A resident does not receive sufficient grooming care is not substantiated.**

Complaint 6. Medication errors occurred on multiple days for a resident.

The Administrative Code for medication use in community settings (59 Ill. Admin. Code 116) states under Section 116.40, Training and Authorization of Non-Licensed Staff by Nurse-Trainers, "a) Only a nurse-trainer may delegate and supervise the task of medication administration to direct care staff." And in Section 116.50, "c) *A registered professional nurse, advanced practice nurse, physician licensed to practice medicine in all of its branches, or physician assistant shall be on duty or on call at all times in any program covered by this Part* ."

Documentation is addressed in Section 116.70:

"a) All medications, including patent or proprietary medications (e.g., cathartics, headache remedies, or vitamins, but not limited to those) shall be given only upon the written order of a

physician, advanced practice nurse, or physician assistant. Rubber stamp signatures are not acceptable. All orders shall be given as prescribed by the physician and at the designated time. Telephone orders may be taken by a registered professional nurse or licensed practical nurse. All orders shall be immediately written on the individual's clinical record or a “telephone order form” and signed by the nurse taking the order. These orders shall be countersigned or documented by facsimile prescription by the physician within ten working days.

b) Medication Administration Record

3) The medication administration record shall be completed and initialed immediately after the medication is administered by the authorized direct care staff. Each medication administration record shall have a section that contains the full signature and title of each individual who initials the medication administration record.

4) All changes in medication shall be noted on the medication administration record by a licensed practical nurse, registered professional nurse, advanced practice nurse, pharmacist, physician, physician assistant, dentist, podiatrist, or certified optometrist and reported to the registered professional nurse in charge of the program prior to the next dose.

c) 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 medication errors shall be documented in the individual's clinical record and a medication error report 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. Medication errors that meet the reporting criteria pursuant to the Department's rules on Office of Inspector General Investigations of Alleged Abuse or Neglect or Deaths in State-Operated and Community Agency Facilities (59 Ill. Adm. Code 50) shall be reported to the Office of Inspector General."

The HRA reviewed the *Medication Administration OJT Manual for Macon Resources*, the physician's orders and the masked OIG report. The resident went without his medication Coumadin for two days. The registered nurse, who oversees the medication dispensing, did not order enough medication from the pharmacy. The direct service staff did not report that the recipient was out of medicine to the registered nurse or catch the error. Macon Resources has policies and procedures about documenting medication administration that if had been followed by either the RN or the DSP this error would not have occurred. This error resulted in the resident having to be hospitalized and having a heparin drip administered though intravenous therapy. This caused some more suffering for the resident because he repeatedly pulled out the IV and this resulted in him receiving injections into his abdomen.

Regarding the OIG report, there were two recommendations:

1. The Illinois Department of Human Services, Division of Developmental Disabilities, Bureau of Quality Management review this agency's medication administration policies and practices to ensure they are consistent with Rule 116.

2. Macon resources ensure all the client working files are available in the home and updated in case of emergency and system of specifically assigning the duty of medication administration to specific DSP staff on duty.

Per Macon Resources, they responded to these recommendations and have reviewed this policy three times with staff since this report. The policy has been updated as well. There is also a new system of checks and balances in which the following shift double- checks medication administration of the previous shift. Both the supervising registered nurse over medication administration and the house supervisor completes random checks on medication administration at all CILAs. There is a master list of medications that is kept separate from the working file in case of emergency. There is clear documentation that Coumadin causes bleeding and bruising but the resident was not restrained to prevent bruising, but allowed to live and function freely. Both the DSP and the RN are no longer employed at Macon Resources as a result of this investigation.

Based on the evidence of documented medication errors, **Complaint 6. Medication errors occurred on multiple days for a resident is substantiated.**

At this time the HRA makes no recommendations because the Macon Resources has adequately addressed the issue by:

1. Removing staff who failed to follow the policies which lead to the medication error.
2. Updating policy and reviewing the policy and the law behind it.
3. Setting up a system of checks and balances for staff to double check staff and for management to randomly check for errors, as well regular scheduled checks on medication administration.
4. Having a master list of medications to be administered separate from the working file.

A final note: it is commendable that the agency appears to value the rights of all residents of service. When it was difficult to locate rights at the vocational services, the agency followed up with having written rights posted in all classrooms, break rooms, and various areas throughout the building. At the CILA site, rights were displayed by the phone in word and picture form. The HRA wants to thank Macon Resources and staff for their full cooperation with the investigation.