FOR IMMEDIATE RELEASE

Egyptian Regional Human Rights Authority
Report of Findings
09-110-9032
Hidden Valley Shelter Care
January 26, 2010

The Egyptian Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation concerning Hidden Valley Shelter Care. The shelter care facility, which is located in Jonesboro, provides services for 29 male residents. The specific allegations are as follows:

1. Residents at Hidden Valley Shelter Care are not receiving medications as prescribed.
2. The facility does not have an adequate system for dispensing medications.

If substantiated, the allegations would be violations of the Illinois Administrative Code (Admin. Code) (77 Ill. Admin. Code 330) and the Nursing Home Care Act (210 ILCS 45)

Statutes

Part 330 of the Admin. Code provides mandates for sheltered care facilities and is known as the Sheltered Care Facilities Code. Section 330.1110 of the Admin. Code states, "The facility shall have a written program of medical services approved in writing by the advisory physician that reflects the philosophy of care provided, the policies relating to this and the procedures for implementation of the services. The program shall include the entire complex of services provided by the facility and the arrangements to effect transfer to other facilities as promptly as needed. The written program of medical services shall be followed in the operation of the facility."

Section 333.1510 of the Admin. Code states, "Every facility shall adopt written policies and procedures for assisting residents in obtaining individually prescribed medication for self - administration and for disposing of medication prescribed by the attending physicians. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility."

Section 330.1520 provides mandates for the administration of medication and states, "a) All medications taken by residents shall be self-administered, unless administered by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Licensed practical nurses shall have successfully completed a course of pharmacology or have a least one year's full-time supervised experience in administering

medications in a health care setting if their duties include administering medications to residents. b) No person shall be admitted to the facility who is not capable of take his or her own medications, as approved in writing by the resident's personal physician. Facility staff may remind residents when to take medications and watch to ensure that they follow the directions on the container. c) Assistance in Self-Administration of Medications 1) Facility staff may assist a resident in the self-administration of medications by taking the medication from the locked area where it is stored and handing it to the resident. If the resident is physically unable to open the container, a staff member may open the container for the resident. 2) Facility staff may also assist physically impaired residents, such as those who have arthritis, cerebral palsy or Parkinson's disease, in the removal of the medication from the container and in assisting the resident in consuming or applying the medication when requested to do so by the resident. (For example, a staff member may place a single dose of medication in a container and place the container to the mouth of a resident who would not be able to do so himself without spilling it).

Section 2-104b of the Act and Section 330.4220f of the Admin. Code require that all medical treatments be administered as ordered by a physician and that all new orders are to be reviewed by a nurse or charge nurse designee for compliance with the orders.

Investigation Information for Allegation 1:

Allegation 1: Residents at Hidden Valley Shelter Care are not receiving medications as prescribed. To investigate the allegation, the HRA Investigation Team (Team), consisting of one member and the HRA Coordinator (Coordinator), conducted a site visit at the facility. During the visit the Team spoke with the facility Administrator, toured the facility, and observed the medication storage cabinet. The Team requested masked records of residents whose last names begin with K and S and a copy of any policy pertinent to medication administration.

I...Interview:

According to the Administrator, twenty-nine males reside at the facility that is surveyed and licensed by the Illinois Department of Public Health. She stated that an individual who is not capable of administering his own medication can not be admitted to the sheltered care facility. An individual is considered capable of self administration of his own medication if he is able to identify his medication by size, shape, color, etc. and know the amount that is to be taken at each time of administration. The Administrator stated that facility staff may assist a resident by taking the medication from the locked storage cart and handing it to the resident. If the resident is not able to open the medication, staff may assist.

The Administrator informed the Team that Hidden Valley has a contracted physician who comes to the facility once monthly to review residents' laboratory reports, medications, and any medical issues that have occurred since the previous visit. Additionally, a Registered Nurse (RN) reviews all residents' records once monthly and matches Physician's Orders with the Medication Administration Records (MARs). She stated that the facility has two RNs that are employed on a contracted basis to complete the reviews. The Administrator stated that when a resident's medication is changed the RN will check the order, make the changes in the MARS, speak with the resident about the changes and inform other staff of those changes.

According to the Administrator, a Licensed Practical Nurse (LPN) gives injections, monitors residents' blood sugar levels, and reviews discharge summaries. Direct care staff members, known as house aides, assist residents with activities of daily living. The house aides also assist residents with their medications by taking the medications from the medication cart, handing the medications to the residents and observing the residents taking the medication(s).

The Administrator stated that staff members have monthly in-service training. Newly employed house aides are required to shadow a seasoned employee for a period of at least three days. This training includes observation of the procedure involved in medication passes.

II...Record Review:

During the site visit, the Team requested masked records to include Physician's Orders, MARs, and Progress Notes for all residents whose last names begin with K and S. After the site visit, the facility sent by mail the requested records for four individuals.

Resident A

Documentation indicated that the 37-year-old resident has the following diagnoses: Borderline Intellectual Functioning, Chronic Schizophrenia, Hypothyroidism and Hypertension. The record indicates his need for continued sheltered care level of services. The physician documented that the resident was capable of administering his own medication with supervision.

The November 2008 Physician's Orders included the following: 1) Felodipine ER (10 mg tablet once daily); 2) Levothyroxine (50 MCH once daily); 3) Clozapine (100 mg 2 tablets twice daily); 4) Metroprolol (25 mg 1 tablet every AM and PM); Teargen Drops (1 drop in each eye three times daily); and Acetaminophen (2 tablets twice daily, as needed). Documentation indicated that there were no changes in Physician's Orders for December 2008.

Documentation in the MARs for Recipient A is as follows:

Medications	Number of days Administered	Number of days Not Administered	Month Year
1) Felopdipine ER……	16 (7AM)	14	11/08
	29 (7 AM)	2	12/08
2) Levothroxine……	18 (7AM)	12	11/08
	29 (7AM)	2	12/08
3) Clozapine……	19 (7AM)	13 (AM)	11/08
	28 (8 PM)	2 (PM)	11/08

	29 (7 AM)	2 (PM)	12/08
	31 (8 PM)	0 (PM)	12/08
4) Metroprolol……	18 (7AM)	12 (AM)	11/08
	28 (8 PM)	2 (PM)	11/08
	29 (7 AM)	2 (PM)	12/08
5) Teargen Drops ……17 (7 AM)		13 (7 AM)	11/08
	3 (12 PM)	28 (12 PM)	11/08
	28 (8 PM)	2 (8 PM)	11/08
	27 (8 AM)	4 (8 AM)	12/08
	2 (12 PM)	29 (12 PM)	12/08
	31 (8 PM)	0 (8 PM)	12/08
6) Acetaminophen (as needed)…….....		None given during the month	11/08
		None given during the month	12/08

The Authority did not observe any documentation in the MARs or in Progress Notes regarding the resident's refusal to take the prescribed medications or that the resident was absent from the facility when the medications were scheduled to be administered.

Resident B

According to documentation, Resident B is a 67 year-old male with the following diagnoses: Diabetes Mellitus, Developmental Disability, Glaucoma, Schizophrenia, Coronary Artery Disease, Recurrent Cellulites, Peripheral Vascular Disease, and Hypertension. The resident's record indicated that he was evaluated monthly by a physician and determined to be appropriate for the sheltered care level of service. The physician also determined that the resident was capable of administering his own medication with staff supervision. He was examined and his medications were reviewed monthly.

Physician's Orders for November 2008 indicated the following medications were prescribed: 1) Cyanocobalamin (injection 1 m each month); 2) Actos (45 mg tablet once daily); 3) Lisinopril (5 mg 1 tablet daily); 4) Nitroglycerin (0.2 mg. Apply patch to skin every AM and remove at bedtime); 5) Brimonidine (0.2% Dr 1 drop every 12 hours); 6) Glyburide (2 5mg tablets twice daily); 7) Metformun HCL (1000 mg tablet twice daily); 8) Acular (0.5% eye drops

in right eye 3 times daily); 9) Penicillin VK (1 tablet daily..no stop date); 10) Cosopt Drops (10 ml instill 1 drop in both eyes twice daily); 11) Pentoxifylline (400 mg tablet, 1 tablet 3 times daily); 12) Vigamox (0.5% Opt. Sol 3 ml, instill 1 drop in both eyes 4 times a day 2 days prior to surgery; 13) Acetaminophen 325 mg tablet ..2 tablets by mouth every 6 hours as needed); 14) Albuterol (Proair) HFA 8.5 gm Inhale 2 puffs every 6 hours as needed for cough); 15) Lantus Insulin (100 U/ML 10 ML RX. Inject 22 units sub-Q every morning as directed by MD) and 16) blood pressure to be taken daily and reported to the physician weekly.

Documentation in the MARS for Resident B is listed below:

Mediations	Number of Days Administered	Number of Days Not Administered	Month Year
Cyanocobalamin	0	1	11/08
	0	1	12/08
Actos	27	3	11/08
	29	1	12/08
Lisinopril	26	4	11/08
	29	1	12/08
Nitroglycerin Patch	22	8 (Placed on)	11/08
	28	2 (Taken off)	11/08
	27	4 (Placed on)	12/08
	31	0 (Taken off)	12/08
Brimonidine	22	8 (7AM)	11/08
	28	2 (8 PM)	11/08
	28	2 (7 AM)	12/08
	31	0 (8 PM)	12/08
Glyburide	22	8 (7AM)	11/08
	28	2 (8 PM)	11/08
	30	1 (7 AM)	12/08
	31	0 (8 PM)	12/08
Metformin HCL	22	8 (7 AM)	1/08
	28	2 (8 PM)	11/08
	30	1 (7 AM)	12/08
	31	0 (8 PM)	12/08
Acular	16	14 (7 AM)	11/08
	4	26 (12 PM)	11/08

	25	5 (5 PM)	11/08
	29	2 (7AM)	12/08
	0	31 (12 PM)	12/08
	31	0 (7 PM)	12/08
Penicillin	25	5 (7AM)	11/08
	29	1 (7AM)	12/08
Cosopt Drops	22	8 (7 AM)	11/08
	29	2 (8PM)	11/08
	30	1 (7AM)	12/08
	31	0 (8 PM)	12/08
Pentoxifylline	17	13 (7 AM)	11/08
	28	2 (12 PM)	11/08
	27	3 (8 PM)	11/08
	29	2 (7 AM)	12/08
	31	0 (12 PM)	12/08
	31	0 (8 PM)	12/08
Vigamox	2	0 (7 AM)	11/08
	2	0 (12 PM)	11/08
	2	0 (4 PM)	11/08
	2	0 (8 PM)	11/08
Acetaminophen (PRN)	0	0	11/08
	0		12/08
Albuteral (PRN)	6	0	11/08
	0	0	12/08
Lantus Insulin (every morning as directed by physician)	23		11/08
	29		12/08
Blood pressure daily	22	8	11/08
	25	6	12/08

Documentation in the Progress Notes indicated that the resident had cataract surgery on 11/5/08 and a follow-up examination after the surgery on 11/06/08. On 11/12/08, the record indicated that the resident's physician was notified when the resident's blood sugar level was elevated. Documentation indicated that the resident's physician came to the facility on 11/25/08

to examine the resident and to review his medications and laboratory results; however, the physician did not issue any new orders.

The HRA did not observe any documentation in the MARs or Progress Notes that indicated that the resident had refused medication or that he was absent from the facility when medications were not administered as prescribed in the Physician's Orders.

Resident C:

According to Documentation, Resident C is a 48-year-old male with the following diagnoses: Schizo-Affective Disorder; Gastro-Esophageal Reflux Disease (GERD), Polydipsia, Bipolar Disorder, Seizure Disorder, and Hypokalemia.

Documentation indicated that a physician assessed the resident on a monthly basis and determined at each assessment that the resident needed continued care at the sheltered care level. Additional evaluations by the physician indicated that the resident was capable of administering his own medication with supervision.

Physician Orders for November and December 2008 indicated that the resident's physician had prescribed the following medications: 1) Amiloride (5 mg. 1 tablet daily); 2) Flunisolide Nasal Solution 0.025% (1 spray in nostril daily); 3) Haloperidol 5 mg (1 tablet daily); 4) Lithium 450 mg (1 tablet every AM and 2 tablet every PM; 5) Ranitidine 150 mg (1 tablet in AM and 1 Tablet in PM); 6) Tegretol XR 400 mg (1 tablet in Am and 1 tablet in PM); 7) Potassium (1 tablet three times daily; 9) Seroquel 25 mg. (1 tablet at bedtime) and Guiatuss DM Syrup for cough (5 ml every 4 to 6 hrs PRN for cough).

Documentation in the Resident C's MARS for November and December 2008 is as follows:

Medications	Number of Days Administered	Number of Days Not Administered	Month Year
Amiloride	30	0	11/08
	30	1	12/08
Flunisolude	30	0	11/08
	30	1	12/08
Haloperidol	30	0 (7 AM)	11/08
	30	0 (8 PM)	11/08
	30	1 (7AM)	12/08
	30	1 (8 PM)	12/08
Lithium	30	0 (7 AM)	11/08
	30	0 (7 PM)	11/08
	30	1 (7 AM)	12/08

	30	1 (7 PM	12/08
Ranitidine	30	0 (7 AM)	11/08
	30	0 (8 PM)	11/08
	30	1 (7AM)	12/08
	31	0 (8 PM)	12/08
Tegretol	25	5 (7 AM)	11/08
	30	0 (8 PM)	11/08
	30	1 (7 AM)	12/08
	31	0 (8 PM)	12/08
Potassium	21	9 (7 AM)	11/08
	30	0 (5 PM)	11/08
	30	0 (8 PM)	11/08
	21	10 (7 AM)	12/08
	31	0 (5 PM)	12/08
	31	0 (8 PM)	12/08
Seroquel	30	0 (Bedtime)	11/08
	29	0 (Discontinue pr Physician's orders on 12/29/08.)	12/08
Guiatuss (PRN)	0	0	11/08
	0	0	12/08

Documentation in Progress Notes indicated that the resident was taken to an area hospital emergency room on 11/03/08 after he complained of numbness in his head and left arms. The record indicated that his labs and scans were normal and no new medication orders were issued. The resident's record indicated that he was seen by a physician at the facility on 12/26/08. At that time the physician reviewed the resident's medications and his labs and did not issue any new orders. Documentation indicated that the resident was seen by a psychiatrist at a community mental health facility on 12/29/08. At the time of that visit, the psychiatrist wrote an order to immediately discontinue Seroquel.

The Authority did not observe any documentation in the MARS of the Progress Notes to indicate that the resident had refused to take the prescribed medications when the record indicated that the medications were not administered as prescribed. Nor was there any record of the resident being absent from the facility at medication administration times.

Resident D:

Documentation indicated that Resident D is a 64-year-old male with the following diagnoses: Constipation; Chronic Schizophrenia; Hypercholesterolemia; Non-verbal; Diabetes

and Syncope. The record indicated that the resident's physician assessed his status on a monthly basis and determined that he was in need of continued sheltered care level services. Additionally, the physician documented that Resident D was capable of administering his own medication with supervision.

According to Physician's Orders for November and December 2008, Resident D received the following medications: 1) Actos (30 mg 1 tablet once daily); 2) Fluoxamine MAL (100 mg 2 tablets every morning); 3) Lactulose (15 ml once daily by mouth); 4) Ranitidine (150 mg 1 tablet in AM and 1 tablet in PM); 5) Crestor (10 mg 1 tablet at bedtime); 6) Docusate Sodium (100 mg 1 capsule at bedtime) ; 7) Haloperidol (2 mg at bedtime); 8) Diphenhydramine (25 mg capsule as needed in AM) and Milk of Magnesia (45 ml every 4 to 6 hours as needed).

Documentation in the MARS for Resident D is listed below:

Medications	Number of Days Administered	Number of Days Not Administered	Month Year
Actos	21	9	11/08
	30	1	12/08
Fluvoxamine MAL	20	10	11/08
	30	1	12/08
Lactulose	20	10	11/08
	30	1	12/08
Ranitidine	20	10 (7 AM)	11/08
	28	2 (8 PM)	11/08
	30	0 (7 AM)	12/08
	31	0 (8 PM)	12/08
Crestor	28	2	11/08
	31	0	12/08
Docusate Sodium	28	2	11/08
	31	0	12/08
Haloperidol	28	2	11/08
	31	0	12/08
Dipenhydramine	0	0	11/08
	0	0	12/08
Milk of Magnesia	0	0	11/08
	0	0	12/08

According to a 10/01/08 Progress Note in Resident D's clinical chart, the resident was found unresponsive and when staff could not find a pulse CPR was administered and emergency services were contacted. The Documentation indicated that Resident D began to breathe after he placed in the ambulance for the transport to an area emergency room. The record indicated that the resident was released from the hospital on 10/02/08 and seen by a cardiologist on 10/16/08. A 10/22/08 Progress Note indicated that the heart monitor that was ordered on 10/16/08 was placed on Resident D during a visit to an area heart institute. The record indicated that the resident was examined by a physician at the facility on 10/28/08 and returned to a cardiologist on 11/12/08. During the visit to the cardiologist, the resident was informed that all of the tests administered in response to the 10/01/08 incident were within the normal range. According to documentation in a 11/26/08 Progress Note, the resident was examined and his medications and labs reviewed by a physician who came to the facility.

During a review of the resident's MARS and Progress Notes, the HRA did not observe any documentation to indicate that the resident had refused medications or was out of the facility at the time of medication administration during the target time of HRA's review.

The Authority's review of the residents' records indicated that none of the residents were recently admitted to the facility and had been living at the sheltered care facility for a considerable amount of time.

III: Facility Policy

The Authority reviewed the facility's Administration of Medication Policy. The Policy states the following: "All medications taken by residents in this facility must be self-administered, unless administered by a nurse or physician properly licensed to practice in Illinois. Facility staff shall NOT administer medication to residents unless the staff person is a properly licensed nurse or physician. "

"No person shall be admitted to this facility who is not capable of self-administering his/her own medications and/or biologicals, as approved in writing by the resident's personal physician, and who is not willing to do so; except that facility staff, as they exercise program oversight, may guide new residents in the self-administration of medication for a period not to exceed thirty (30) days following a change in the resident's medication regimen by the attending physician."

"Facility staff may assist a resident in the self-administration of medications by taking the medications from the locked area where it is stored and handing it to the resident. If the resident is physically unable to open the container, a staff member may open the container for the resident."

"Facility staff may also assist physically impaired residents, such as those who have arthritis, cerebral palsy, Parkinson's disease, etc., in the removal of the medication from the container and in assisting the resident in consuming and applying the medication when requested to do so by the resident. (For example: a staff member may place a dose of medicine in a

container and place the container to the mouth of a resident who would not be able to do so him/herself without spilling it.)"

"To be considered 'capable of self-administering his/her own medications and/or biologicals,' a resident must, at a minimum, be able to identify his/her medication by size, shape, color, etc., and know when he/she is to take it, and the amount to be taken each time."

Summary for Allegation 1

When the HRA requested and received masked records for individuals whose last names began with K and S. When the HRA received the records, the months of November and December 2008 were targeted for review. According to documentation, a physician reviewed each of the residents on a monthly basis and had determined that they were capable of administering their own medications with supervision. Additional evaluations by the physician determined that each of the residents' level of care in a sheltered-care facility was appropriate. When the Physician Orders were compared to the MARS, the medications listed on the MARS corresponded to the Physician's Orders. However, there was consistent evidence that the medications were not being administered as prescribed. The facility's Policy entitled "Administration of Medication" is in accordance with the Admin. Code mandates.

Conclusion for Allegation 1

Due to the physician's assessment that the residents are capable to administering their own medication with supervision and evidence in the MARs for residents did not receive medications as prescribed in Physician's Orders the allegation that residents are not receiving medications as prescribed is substantiated. The Authority recognizes a resident's independence with medication and acknowledges that a resident has the right to refuse medication per Code mandates. However, there was no supportive documentation that some medications were even provided/offered as prescribed.

Recommendations:

The following recommendations are issued:

1. Whenever a resident refuses medication or is absent from the facility at administration time, the refusal or absence should be documented in the resident's clinical chart and the MARS.

2. Staff should receive training regarding the Admin. Code requirements pertinent to administration of medications, Physician's Orders, and consistent documentation in the MARs when medications are administered.

3. Staff should be made aware of the definition of administration of medication versus assistance with self-administration of medication and ensure that the definitions are in accordance with the Admin. Code's requirements.

Suggestions

1. Staff should document in the resident's clinical chart that the resident has been provided information about their medications, including the name of the medication, time of administration, and the side effects.

Allegation 2: The facility does not have an adequate system for dispensing medications. To investigate the allegation, the Team conducted a site visit at the facility. During the visit the Team spoke with the Administrator and observed the medication storage cabinet. The Authority reviewed the information obtained in the investigation of allegation 1 and an additional facility policy pertinent to the allegation.

I...Interview:

According to the Administrator, the facility had recently made some changes in the system for administering medications. She stated that presently medications which residents take on a daily basis are obtained in individual sealed packets from one pharmacy provider. The Administrator informed the Team that each medication prescribed by a resident's physician is enclosed in the sealed packet with the label on the packet listing the resident's name, name and dosage of medication, physician, etc. If the medication is to be administered more than one time daily, there is a packet for each administration time. When the packets arrive, they are placed in the appropriate administration time slot in a medication cart that is locked. Other medications, such as antibiotics, that are prescribed for non-chronic conditions may be obtained from local pharmacies and are stored in the same manner. According to the Administrator, the key to the medication cart is the responsibility of and in the possession of the staff persons responsible for overseeing the self-administration of the medications, and is only used at scheduled medication times or when necessary to obtain medications that are prescribed to be used as needed.

The Administrator informed the Team that the medications that are prescribed to be used as needed and topical medications are stored in separate areas of the medication cart. Each medication is labeled with the resident's name, medication, dosage, etc. Medications that require refrigeration are kept in a separate, locked container and stored in the refrigerator.

According to the Administrator, the locked medication cart is kept in a locked storage area when not in use.

The Administrator stated that prior to obtaining medication in the sealed "blister/bubble" packets, residents were receiving medications from various pharmacies and those medications were stored in individual medication containers in a locked cart. She stated the current system has simplified the procedure of medications passes. The Administrator stated that the new procedure was implemented in April 2008.

According to the Administrator, staff members in charge of assisting the residents in self-administration of their medications, are also responsible for documenting in the MARS that the medication has been taken at each scheduled medication pass.

During the visit, the Team observed the medication cart and noted that the medications were stored as reported by the Administrator.

Policies:

The Authority reviewed the facility's "Administration of Medication Policy" outlined in investigation information for allegation 1, as well as, the "Labeling and Storage of Medications Policy".

Documentation in the "Labeling and Storage of Medications Policy" is as follows, "All medications shall be stored in a locked area at all times. Areas shall be lighted and of sufficient size to permit storage without crowding. This area may be a drawer, cabinet, closet or room."

"The key to the medicine area shall be the responsibility of, and in the possession of the staff persons responsible for overseeing the self-administration of medications by residents."

"The medicine area shall not be used for any other purpose. It shall not be located in residents' rooms, bathrooms, or the kitchen. However, for those persons whom the attending physician has given written permission to handle their own medication, medications may be stored in a locked drawer or cabinet in the resident's room along with other possessions of that resident."

"Residents for whom the attending physician has given permission to be totally responsible for their own medication shall maintain possession of the key, or combination of the lock, to their own medication storage area. A duplicate key, or a copy of the combination shall be kept by the facility in its safe, or some other secure place, for emergency use, such as if the resident should lose or misplace his/her key, or forget the combination.'

"Medications for external use shall be kept in a separate location in that medicine area or in a separate locked area."

"All poisonous substances and other hazardous compounds shall be kept in a separate locked area away from medications."

"Biologicals or medications requiring refrigeration shall be kept in a separate, securely fastened locked container in a refrigerator, or in a locked refrigerator."

"The label of each individual medication container filled by a pharmacist shall clearly indicate the resident's full name, physician's name, prescription number, name and strength of drug, amount of drug, date of issue, expiration date of all time-dated drugs, name, address, and telephone number of pharmacy issuing the drug, and the initials of the pharmacist filling the prescription. If the individual medication container is filled by a physician from his/her own supply, the label shall clearly indicate all the preceding information except that pertaining to the identification of the pharmacy, pharmacist, and prescription number."

"Medication in containers having soiled, damaged, incomplete, illegible or makeshift labels shall be returned to the issuing pharmacist, pharmacy, or dispensing physician for relabeling or disposal. Medications in containers having no labels shall be destroyed in accordance with Federal and State Laws."

"The medications of each resident shall be kept and stored in their originally received containers. Medications shall be transferred between containers."

Additional Information:

The Authority did not observe any documentation or facility policy/procedure pertinent to staff assisting residents in the self administration of their medications. Additionally, the Authority did not obtain any record to indicate that the facility had a policy or had provided training regarding documentation relevant to assisting residents with medication administration, the recipient's refusal to take the prescribed medications, and relevant procedures to take when there was consistent refusal.

Summary for Allegation 2:

According to the Administrator, a new system had been implemented prior to HRA's site visit at the facility. She stated that Physician's Orders for residents' medications are sent to a single pharmacy provider. When the medications arrive at the sheltered care facility, they are enclosed in blister/bubble packets, with a packet provided for each administration time. The resident's name, name of medication, dosage, and other identifying information is listed on the labeled packets. Each packet is placed in the medication cart in the appropriate time designated for its administration. Medications that are prescribed for non-chronic conditions may be obtained from local providers and are stored in the same manner. Medications prescribed to be administered as needed are stored in an area designated in the cart for that purpose, and topical medications are stored in an area in the cart that is separated from the oral medications. The medication cart is locked at all times other than during medication passes, and the locked cart is stored in a locked storage area. Medications that require refrigeration are stored in a locked container in the refrigerator. The Administrator stated that prior to implementation of the new system, the residents received their medications from various pharmacies and those medications were stored in individual containers that were received from the each pharmacy.

The facility has a policy pertinent to the storage of medication; however, it appears that the policy has not been updated to include the changes made in the manner in which the medications are labeled and stored. The Policy did not contain an implementation date or a date that the policy was reviewed and revised. The Authority did not observe any documentation or policy pertinent to training staff in assisting residents in self-medication.

Review of information obtained relevant to Allegation 1 indicated that a physician had accessed each resident on a monthly basis and had determined the need for continued level of sheltered care and the ability for each resident to self-medicate with supervision.

Conclusion

Based on the information obtained during the investigation, the Authority recognizes that there have been some improvements in the medication system. The HRA's review of four residents indicated that each resident was capable of self medicating with staff supervision. However, there was evidence in the MARs of all of the cases reviewed that the residents were not receiving medication as prescribed. The Authority was unable to determine if the residents had refused the medications, were absent at the time of the medication pass, responsible staff failed to adequately document that the resident had taken the medication or there were other extenuating circumstances. Therefore, the allegation that the facility does not have an adequate system for dispensing medication is substantiated.

Recommendations

1. The facility should update their existing policy to reflect the present labeling and storage procedures.

2. The facility should add to existing policies or formulate a policy pertinent to the necessity of residents receiving medication as prescribed by Physician's Orders and obligation to document each time a resident received the medication, as well as a resident's refusal to take the medication or the resident's absence from the facility at medication pass times.

3. The facility policy should be approved in writing by the advisory physician and should reflect the facility's philosophy of care and procedures for implementing services.

4. Facility staff should receive training regarding the policy mandates.

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, some provider responses appear verbatim in retyped format.

UNIVERSAL PROGRESS NOTES

NAME: Hidden Valley Care Center

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DATE/TIME		SIGNATURE
2-23-2010 12:15pm	In regards to the allegations investigated by the Egyptian Regional Human Rights Authority. Case # 09-110-9032, ~~there was error~~ (2) Pertaining to the Conclusion for allegation #1, all residents that reside at Hidden Valley Care Center are capable of administering their own medications per physicians orders. Residents can receive assistance by staff as stated in the Shelter Care regulations. All residents have the right to refuse medications, but it is required by staff to document in the MAR that the resident refused. If the resident is not at the facility during med pass time, the staff must also document that in the MAR. All staff have been trained / in-serviced that there is to never be an open spot in the MAR's. Everything must be documented & the on going Compliance of this will be ensured by this writer.	

Pertaining to the Conclusion of allegation #2, all medications at Hidden Valley are locked in a secure medication cart in a secured place in the recreation room. All medications come from Omnicare pharmacy & are on "bubble packs" with each residents name, time to be given, medication & dosage to be given. All medications have a clear, precise label with exact instructions on how to be given. Each resident has their own slot in the med cart for each med pass time. All ear drops, eye drops, ointments, creams, etc., have separate sections in the med cart away from all oral medications. All insulin, & any other medication that would require refrigeration, are

Continued (2)

UNIVERSAL PROGRESS NOTES

NAME: Hidden Valley Care Center

DATE/TIME		SIGNATURE
2-23-2010 12:15pm (continued)	stored in a seperate locked box for medications in a refrigerator at Hidden Valley. Any discontinued medication or damaged label is destroyed immediately. Facilities medical director, Dr. Steven Beatty, comes to Hidden Valley once a month & Reviews medications, labs, blood sugars & blood pressures. Dr. Beatty is also notified anytime there is any significant changes in a residents condition. Each month, Ed Russell, consulting pharmacist from Omnicare comes to this facility & Reviews each residents chart, labs and medications. He also goes through the entire med cart to look for damaged labels and expired medications. He documents in each residents charts & faxes any recommendations to attending physician, Dr. Beatty. MD. Russell also goes through our MARS to make sure everything is being done appropriately. Added to all the previous stated, facility RN, Allison Tweedy, Reviews & makes any changes to physician orders and MARS. She also comes to facility one time weekly to look over all medical stuff and medications. This letter tells that many necessary changes have been made to Hidden Valley to create a more stable & adequate system for both allegations made. Thank you for your time regarding this matter and I am always available for any questions or concerns that you may have (618) 697-8938. I hope that you feel that we are striving to help our residents reach there full potential in the most stable & correct environment. Again, thank you for your time. Sincerely, Gretchen D. Emrick, Administrator Hidden Valley Care Center	