FOR IMMEDIATE RELEASE

Peoria Regional Human Rights Authority
Report of Findings
Case #10-090-9002
Davies Square

The Peoria Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegations concerning Davies Square:

1. **A resident's needs are not being met.**
2. **Treatment plans are not being followed.**
3. **There are inadequate staffing levels.**
4. **Resident personal belongings are mishandled.**
5. **There is an inadequate response to grievances.**
6. **A guardian was denied the right to access and copy a resident's file until an enforcement agency was consulted.**

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.), the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110), the Illinois Probate Act (755 ILCS 5/11a) and mandates and regulations that govern intermediate care facilities for persons with developmental disabilities (210 ILCS 45/2; 77 Ill. Admin. Code 350).

Davies Square is a 16-bed intermediate care facility for persons with developmental disabilities located in Pekin and operated by Community Living Options, Inc., a DD Homes Network affiliate. The home is licensed by the Illinois Department of Public Health.

To investigate the allegations, the HRA met with the guardian of a resident, interviewed agency staff, toured the facility, reviewed a resident record, with guardian consent, and examined pertinent policies, forms and mandates. The HRA also examined Public Health records on the facility.

COMPLAINT STATEMENT

The complaint states that a 20-year resident of the facility has seen a reduction in service provision. A guardian has repeatedly lodged complaints with little response. The complaint states that the resident does not received adequate care with regard to menstrual care resulting in stained clothing. The facility reportedly does not notify the guardian when personal items are needed and the resident has been found without a toothbrush, toothpaste and a special brand of shampoo that works particularly well for the resident. The complaint indicates that the resident's

personal items are used on other residents. When the resident began refusing food, the guardian allegedly requested that a food diary be kept to monitor food consumption. Subsequently, the guardian requested that substitutes be provided for food that the resident refused to eat; however, this request was not followed and the resident continued to receive food that she did not like and would not eat. The complaint further stated that staffing levels have been reduced from approximately 2 ½ staff when residents are at home to 1 staff person on duty when residents are home. The decreased staffing level has reportedly resulted in lapses in hygiene and personal care. According to the complaint, the guardian has picked the resident up for a scheduled outing to find the resident in need of personal care even when the guardian requested that personal care be provided prior to the outing. The complaint also states that the facility does not follow the resident's treatment plan; an example of this is the lack of follow-through on the use of the specified shampoo. Another example is that the resident is to receive an antibiotic prior to dental and podiatry care due to her history of a heart condition; however, the guardian must remind staff of this and has requested that the antibiotic be noted on the resident's chart and plan.

FINDINGS

Staff Interviews

An HRA team met with and interviewed Davies Square staff regarding the allegations. The interviews began with questions regarding the administration of the home and its services. Staff explained that although the home is licensed for 16 beds, the current census is 15. Residents have varied diagnoses, including mild to profound cognitive impairments, cerebral palsy, seizure disorders and other medical issues. The home completed its most recent licensure survey in November 2008 at which time it was issued a 2-year license. A licensed administrator oversees this and 3 other residential facilities; the assistant administrator oversees this facility and 5 community integrated living arrangements (CILAs). A Qualified Mental Retardation Professional (QMRP) is assigned to the home. A registered dietician visits the home monthly and a nurse spends 6 to 8 hours, minimum, at the home. The nurse provides nursing care to 8 different residential sites.

To evaluate the needs of residents, staff reported the use of various assessments that are completed on an annual basis. Assessments include reviews of functioning levels, psychological exams, reviews of sexual functioning and issues, dietary assessments, nursing reviews, and programming evaluations. A physician completes a physical exam on an annual basis and when needed. Monthly medication checks are also completed.

With regard to treatment planning, staff reported that they are required to complete annual and six-month reviews. Assessments are completed and reviewed approximately 30 days before the annual treatment review meeting. The team reviews all assessments and the guardian is invited to attend the meeting. If the guardian is unable to attend, contact is made with the guardian by telephone and the guardian receives a copy of the treatment plan. The resident, vocational programming staff and family members also attend.

According to staff, resident personal care is provided by the residential staff. Any special request for personal care related to an outing should be accommodated. Program sheets are used to document activities related to treatment plan goals which are then placed in a resident's case

file. The QMRP reviews and monitors program activities and the administrator monitors the QMRPs. Records are kept at the facility. If, after three months, a program step is met or not met, a program revision is made. If there are significant problems related to treatment planning goals or the resident is refusing to participate in treatment goals, the guardian is notified and guardian feedback is secured. Guardians can also add information or suggestions to a treatment plan.

The HRA team inquired about staffing levels. An administrator reported the following staffing levels: 1 staff person during the day from 6 a.m. to 2:30 p.m. when most residents are at work; 1 staff person is on duty from 2:30 p.m. to 10:30 p.m. and another one from 3:30 p.m. to 11:30 p.m.; a part-time staff person is on duty from 4 p.m. to 9 p.m.; and one staff person is on duty at night from 11:30 p.m. to 9:30 a.m. A part-time cook is also on staff. Staff stated that typically, one staff person is assigned to each wing to provide personal care after work. Program activities are completed after work. Staff verified that there are occasional staff absences and that there has been recent turnover due to retirement. The agency is currently rebuilding its core staff for the facility. When staff are absent, back-up staff, including the QMRP, administrators or other staff are assigned to provide coverage. To be considered for hire, an applicant must be age 18, have a GED, have 8th grade equivalent literacy and pass background checks. New staff must complete 120 hours of direct service personnel training. In addition, new staff receive orientation with an administrator and the QMRP. On the job, competency-based training is also provided. Staff are required to have annual training on certain topics such as cardio-vascular resuscitation, aggression management, dietary/nutrition and blood borne pathogens. Quarterly training is provided on issues related to abuse/neglect, hot water temperature gauging, evacuation procedures and van safety.

Staff reported that resident personal belongings are inventoried twice per year. New purchases are labeled and added to the inventory. Resident money is kept in lock boxes. Other items could be locked up if requested.

With regard to grievances, the grievance process is discussed during the resident's rights review completed each year. Residents/guardians can take complaints to staff or an administrator. A list of phone numbers is posted that includes the Public Health hotline and a corporate concern hotline. For complaints of abuse of neglect, staff typically contact an administrator who then files a report with Public Health although staff stated that calls can be made directly to Public Health.

A resident and the guardian can request record access per staff. Staff stated that the record access occurs within 24 hours of a request and a staff person is present during the review. If copies are requested, there might be a delay in getting the copies made. Delays occur depending on the time of the request and the availability of staff to assist with the request. Record access is listed on the Resident Rights statement and staff inform individuals of the 24 hour turnaround time frame to respond to requests.

Concerning the situation under HRA review, staff reported that the resident is non-verbal, has a profound cognitive impairment and has a visual impairment. Staff reported that the facility does provide shampoo for all residents; each resident receives his/her own bottle which is

marked with the resident's name and placed in a shower caddy. For the resident in this case, a special shampoo is purchased by the resident; the shampoo is labeled with the resident's name and kept in locked storage in the resident's shower caddy along with the resident's toothbrush and toothpaste. Staff indicated that a food preference list has been developed for the resident; staff recently met with the guardian to review and update the list. Staff utilize a checklist during lunch preparation to ensure that preferences and special diets are followed. Staff indicated that the pre-appointment antibiotic should be listed in the resident's treatment plan, but the nurse must still pursue an order prior to the actual appointment. Staff stated that there was a communication problem that resulted in the resident not receiving personal care prior to an outing; the missed care was discussed with the guardian. Also, the QMRP's number has been given to the guardian for when problems arise. Staff stated that the facility did not have an issue with the guardian accessing the record; the time of the request may have been an issue. Staff acknowledged that the resident's menses care has been a problem in the past and measures have been taken to improve the situation; the resident's medication has been changed that allows staff to better determine the time of the resident's menses and staff have been retrained. Staff also acknowledged an incident in which the resident's pre-dental antibiotic was missed; the error was caught and the dental appointment was rescheduled. Also, the pre-appointment antibiotic was added to the resident's treatment plan in June 2009. Staff stated that they believe that they have addressed the guardian's concerns.

Facility Tour

The HRA team toured the facility. An activity calendar is posted in the facility and the calendar references the facility resident council meeting where residents can voice concerns or preferences. All resident rooms are semi-private. In reviewing resident rooms, the HRA team saw evidence of resident personal belongings being labeled. The facility supply room was viewed; the supply room was locked with a deadbolt lock and contained personal supplies such as shampoo, menses supplies, etc. The team also visited the room of the resident in this case which was neat and clean. The resident's clothing was marked and clothing in the hamper did not appear stained. The resident's shower caddy contained the special shampoo, toothbrush and tooth paste, all of which were marked. The resident's dislike list was posted on the refrigerator in the kitchen. A file box also contained file cards on each resident listing any allergies, likes and dislikes.

Record Review

With guardian consent, the HRA examined the record of a resident. The record showed some weight change for the resident. Also documented were guardian contacts with the resident; the guardian met with the resident at least monthly. The record included a notice of the resident's treatment planning meeting which the guardian signed as having received.

The resident's treatment plan, dated 06-19-09, documented the resident's level of functioning as profound cognitive impairment, Down Syndrome, Chronic Rhinitis, Dysfunctional Uterine Bleeding, Urinary Tract Infections, Hyperthyroidism and Gerd (Gastroesophageal reflux disease). The resident takes medication, including medication for the uterine bleeding. The plan documented a medical history that included excessive bleeding since the resident's teenage years; medication adjustments have been made as a means to address the bleeding. Also noted were additional medical issues, including a corneal ulcer, thyroid problems

and a history of a mitral valve regurgitation. The resident's need for a pre-dental antibiotic is documented in the medical history and exam sections of the plan. The plan noted a change in physicians at the request of the guardian. In the dietary section of the plan, the resident's normal weight range is listed as 113 to 137 pounds; her current weight is listed as 123 pounds and the plan stated the resident weight has been maintained between 120 and 130 pounds in the past year. The resident's dietary likes and dislikes were included in addition to eating patterns. The plan indicated that substitutes are offered when her dislikes are on the menu. A dietary tracking form was discussed as part of the treatment plan review but was declined. Guardianship arrangements and notification requirements are documented in the plan. With regard to personal care, the plan indicated that the resident needs assistance with dressing, using the restroom, disposing of soiled clothing, bathing, and grooming. One statement indicated that the resident demonstrated inconsistencies in programming although the plan also noted some improvement with toothbrushing as a result of programming. In terms of the recipient's behavior, the plan indicated that the recipient becomes agitated during most exams, thus, Ativan and Chloral Hydrate were to be given prior to each exam. The plan's primary priorities for treatment planning included money identification, showering, self medication, hygiene/wiping, dressing, menstrual care and water temperature gauging.

The HRA team examined a sample of program documentation for the month of September 2009. According to the data sheet, it appeared that the program for showering occurred daily and the resident either completed the task with verbal prompts, physical prompts or hand-over-hand assistance. Programming for coin identification appeared to occur 13 times during the month and required verbal or physical prompts. There was no documentation related to menstrual care for the month of September 2009. Programming for dressing appeared to occur on a daily basis with the exception of weekends and programming for hygiene/wiping appeared to occur three times during the month. Finally, for the self-medication goal, programming appeared to occur daily except for the weekends.

Sample QMRP progress notes dated 08-10-09 and 09-17-09 were examined by the HRA team. The notes dated 08-10-09 documented the resident's weight at 123 pounds and indicated that there had not been a weight change from the prior month. The notes stated that the resident struggled with programming, and revisions would occur in August. According to the notes, there were 31 sessions of showering and 9 sessions of coin identification; the number of sessions for menstrual care and dressing were not listed. The QMRP notes dated 09-17-09 indicated that the resident's weight dropped one pound to 122 pounds. Also the notes stated that the program goals had been revised. For the showering goal, the notes stated that the resident had 20 sessions and met objectives 75 % of the time (the goal was 80%). For coin identification, the notes stated that the resident had 12 sessions and met objectives 42% of the time (the goal was 80%). With regard to menstrual care, the notes stated that the resident had 4 sessions and completed objectives 100% of the time and for dressing, the notes stated that the resident had 21 sessions and completed objectives 66% of the time (goal for dressing was 80%).

A review of physician's orders for August and September 2009 indicated that the resident was to be weighed monthly, that she was to be given Ativan and Chloral Hydrate prior to examinations, that she was to take birth control pills for a diagnosis of abnormal uterine bleeding, that she received a special shampoo (different from the one requested by the guardian)

as needed for a dry scalp condition, and that she was on a general diet with no concentrated sweets. There was no order for pre-appointment antibiotics on either order sheet. There was no directive related to the guardian requested shampoo. A sample medication administration record for May 2009 was examined. The record documented a weight of 123 for May and referenced an April weight of 125. Medication appeared to be given as ordered; the "as needed" special shampoo listed on the order sheet was not used.

The HRA team reviewed a nutritional assessment completed by a registered dietician on 04-24-09. The assessment documented the resident's weight at 125 pounds and an ideal body weight of 125 pounds and an ideal body weight range of "103 - 127 - 137" pounds. The assessment documented that the resident lost 6 ½ pounds since last April or a weight loss of approximately 5% in a year's time. The resident's diet was listed as General with No Concentrated Sweets; the resident's appetite was listed as good; and, the resident's likes and dislikes were listed as being on file. The assessment concluded with a note that the resident's "Wt. is essentially holding over the years - IBWR 123 - 133 #....Appetite - good!...Needs met [with] diet."

Additional documents were also reviewed. The resident's rights statement included the right to present grievances, the right to recommend policy changes, the right to retain/use personal property and the right to adequate care. The rights statement did not address the right to access records. The rights statement was signed by the guardian. A letter to the guardian, dated 07-20-09, indicated discussion of dental services with the guardian, the State's limited coverage of dental services, and a dental provider that will provide care within financial means. An "Acknowledgement of Responsibility for Leave from the Facility and/or Leave from the Facility against Professional/Medical Advice with the knowledge of the resident's decision maker" form was found in the file which releases the facility from any responsibility should the resident exercise her unrestricted right to leave the facility; the guardian refused to sign the form as per notes on the form.

The HRA found no record documentation related to a guardian's record request, no documentation related to guardian problems in securing pre-dental antibiotics, no documentation related to the guardian's dissatisfaction with lack of personal care prior to a scheduled outing and only the one letter in response to a guardian concern.

Policy Review

The policy on Individual Service Plan (ISP) Development states that "The agency will develop a coordinated service plan for each Individual served. The plan shall be based on the Individual's goals and desired outcomes, as well as significant identified needs. The plan and all activities resulting from that plan shall be coordinated and periodically monitored by the assigned Qualified Mental Retardation Professional (QMRP)…The written ISP serves as a primary source document for coordinating identified services within the agency, community and the Individual's support group. Programs providing services to the Individual must provide consistent feedback to the agency QMRP in order to keep the plan current, meaningful and appropriate to the individual." Under QMRP Actions, the policy states that the QMRP is to obtain signed approval of the plan from the Individual and other team members, implement the program immediately following the meeting, inform staff of the plan and provide a copy of the

plan to the legal guardian. The plan is to include a list all current medications, a review of all assessments, including any nutritional assessments, and the identification of primary program priorities. The policy also details the required content of the monthly QMRP Summary which is to list program progress, behavioral issues, medical issues, social contacts, activity participation, day training information and dietary reviews, including weight changes. An accompanying form entitled, "Receipt of Individual Service Plan" allows the agency to document, by recipient signature, the individual's receipt of and agreement with the service plan.

The agency also utilizes a diet history form which documents weight, food likes/dislikes, food allergies, and eating issues. The form also indicates the source of the dietary information received on a resident.

The resident rights policy states that the agency supports the exercising of resident rights and then lists some and explains some of the rights including, the right of each individual is to participate in treatment planning, the right of each individual "…to submit complaints or recommendations concerning the policies and services of the facility....", and the right of each individual to secure services to meet individual needs. "The organization believes that successful service provision occurs when problems or complaints are communicated directly to the immediate supervisor and resolution is quickly achieved. The supervisor will work collectively with the individual, family or staff to achieve a positive outcome for the individual. Situations that cannot be resolved in this manner may be referred to the Administrator…" If still dissatisfied, an individual, guardian or family member can communicate with the agency executive director who has the final say in the resolution. The policy also includes a statement concerning the resident's right to retain personal property although the policy does not include any procedure related to labeling or inventorying personal property. There is nothing in the rights statement related to a resident's or guardian's right to access the resident's record. The HRA also noted that there is nothing in the rights statement regarding a service recipient's right to refuse treatment.

After the site visit, the HRA inquired about a policy on record access and guardian involvement.

Guardian Correspondence

The HRA received and reviewed copies of correspondence sent from the guardian to the facility. A letter dated 06-04-08 documented that the antibiotic pharmacy label incorrectly stated that the antibiotic is to be given the night before a dental appointment when it should be given an hour before the appointment as per the guardian. The letter also references a food diary and questions the workshop's involvement in documenting food intake. The guardian also enclosed a check to cover costs for copying part of the resident's record. A note to the HRA indicated that the guardian had been refused a copy of a record document, but the facility complied after guardian had contact with the Illinois Department of Public Health.

A letter dated 08-21-08 documented the guardian's request not to provide the resident with candy as a snack and the guardian's provision of alternative snack items such as pudding, apple sauce, etc.

A letter to the facility dated 09-06-08 voiced the guardian's dissatisfaction with the home sending food in the resident's lunch (as per the guardian's contact with a vocational program) that she is known not to like. Additional notes to the HRA stated that the resident was refusing foods; therefore, the guardian requested that a food diary be kept and the guardian scheduled a dental exam. Upon picking the resident up for the dental exam, the guardian reportedly inquired about the pre-dental antibiotic which had not been arranged.

Finally, a letter dated 04-30-09 indicated that the guardian would be picking the resident up on a particular day for an event and requested that she have a bath and her hair washed prior to the event.

Illinois Department of Public Health Information

Information secured from the Illinois Department of Public Health website lists the facility's state licensure recertification date as 11-13-2008 at which time the facility was found to be in compliance with licensure requirements for the provision of intermediate care for persons with developmental disabilities. A complaint investigation dated 10-16-08 documents compliance as well. Information indicates that the facility is licensed for 16 beds but only 15 beds are in use and all residents have a primary disability of developmental disability.

MANDATES

The Mental Health and Developmental Disabilities Code, in Section 5/2-102, requires the provision of "…adequate and humane care and services in the least restrictive environment, pursuant to and 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….In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided."

The Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/4) identifies the individuals who are entitled to copy and inspect a service recipient's record, including "…the guardian of a recipient who is 18 years or older….d) Whenever access or modification is requested, the request and any action taken thereon shall be noted in the recipient's record."

The Illinois 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…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."

Regulations that apply to intermediate care facilities (77 Ill. Admin. Code 350) that serve persons with developmental disabilities provide more specific direction regarding service provision in such settings. Section 35.810 states the following:

> *Sufficient staff in numbers and qualifications shall be on duty all hours of each day to provide services that meet the total needs of the residents. At a minimum there shall be at*

least one staff member awake dressed and on duty at all times…Regardless of the organization or design of resident living units, the minimum direct care staff to resident ratios are as follows:…For units which include any of the following types of residents, the staff to resident ratio shall be two and one-half hours of care per day per resident…B) severely and profoundly retarded.…The number and categories of personnel to be provided shall be based on the following: 1) Number of residents. 2) Amount and kind of program content, supervision, and personal care needed to meet the particular needs of the residents at all times. 3) Size, physical condition, and the layout of the building including proximity of service areas to the resident's rooms. 4) Medical orders.…The facility shall provide a Resident Services Director who is a Qualified Mental Retardation Professional…who is assigned responsibility for the coordination and monitoring of the residents' overall plan of care.…The Resident Services Director shall be responsible for ensuring that all recommendations in the individual plan or care are carried out as stated in the plan.

With regard to dietary services, the regulations require in Section 350.3770 that a certified individual oversee food service in facilities and if the individual is not a dietitian he/she must consult with a dietician at least 2 hours per month. Section 350.1880 also addresses food and states the following:

Menus, including menus for 'sack' lunches or between meal or bedtime snacks, shall be planned at least one week in advance. Food sufficient to meet the nutritional needs of all the residents shall be prepared for each meal. When changes in the menu are necessary, substitutions shall provide equal nutritive value and shall be recorded on the original menu, or in a notebook marked 'Substitutions', that is kept in the kitchen.

Section 350.1060 requires that each resident have evaluations that will serve as the basis for treatment planning and treatment objectives, that there be a treatment record documenting activities related to objectives, and that there be sufficient staff to carry out objectives.

In Section 350.1220, regulations require physicians participate in resident evaluations and review treatment goals and plans. Section 350.1420 requires that "All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber….These medications shall be administered as ordered by the licensed prescriber and at the designated time." Section 350.3220 further addresses medical and personal care and states that "All residents shall be permitted to participate in the planning of their total care and medical treatment to the extent that their condition permits….All medical treatment and procedures shall be administered as ordered by a physician." In addition, this section states that "Every resident, resident's guardian, or parent if the resident is a minor shall be permitted to inspect and copy all the resident's clinical and other records concerning the resident's care and maintenance kept by the facility or by the resident's physician."

Section 350.3210 covers general facility requirements and states that:

A resident shall be permitted to retain and use or wear his personal property in his immediate living quarters, unless deemed medically inappropriate by a physician and so

documented in the resident's clinical resident….The facility shall provide adequate and convenient storage space for the personal property of the resident….The facility shall provide a means of safeguarding small items of value for its residents in their rooms or in any other part of the facility so long as the residents have daily access to such valuables….The facility shall make reasonable efforts to prevent loss and theft of residents' property. Those efforts shall be appropriate to the particular facility and may, for example, include, but are not limited to, staff training and monitoring, labeling property, and frequent property inventories…The facility shall develop procedures for investigating complaints concerning theft of residents/property and shall promptly investigate all such complaints.

Section 350.3310 addresses complaint procedures and states that residents can present grievances without fear of reprisal.

Medication policies are addressed in Section 350.3760. With regard to "as needed" medications, the regulations states that "Each client's medical record shall state what medications may be administered PRN and shall include documentation of administration of PRN medication…."

The Nursing Home Care Act also applies to intermediate care facilities for persons with developmental disabilities. In the rights section of the Nursing Home Care Act (210 ILCS 45/2-104 c and d) the Act requires that, "(c) Every resident shall be permitted to refuse medical treatment and to know the consequences of such action, unless such refusal would be harmful to the health and safety of others and such harm is documented by a physician in the resident's clinical record. The resident's refusal shall free the facility from the obligation to provide the treatment…Every resident, resident's guardian, or parent if the resident is a minor shall be permitted to inspect and copy all his clinical and other records concerning his care and maintenance kept by the facility or by his physician. The facility may charge a reasonable fee for duplication of a record." Section 45/2-211 requires that residents/guardians be given rights information that address the rights enumerated in the rights section of the Act, including Section 45/2-104.

CONCLUSIONS

Complaints #1 and #2: A resident's needs are not being met. Treatment plans are not being followed.

The complaint states that a resident's needs were not always being met and then specifically references menstrual care, food substitutes and the use of PRN antibiotics. The complaint further states that the resident's care plan was not being followed with regard to food substitutes, antibiotics, personal care, menses care and the guardian's specific request regarding the resident's shampoo.

Staff reported that the facility receives monthly dietician and nursing assistance and that personal care is to be provided by facility staff who are trained on treatment plans, dietary issues, etc. Individual records are accessible to staff at the facility as well as food preference lists and checklists. Staff acknowledged some problems related to personal care prior to a planned outing

for a resident, past problems with menses care and a missed pre-exam antibiotic. Staff asserted that retraining has occurred, antibiotics have been added to the resident's June 2009 treatment plan, and medication has been changed to address the resident's menstrual needs. According to staff, treatment planning is driven by annual assessments and reviews are conducted every 6 months with input from the guardian. Program information is then to be tracked on data sheets which are reviewed by the QMRP who completes a monthly summary; revisions occur when needed.

The record contained an updated treatment plan dated June 2009 that documented medication changes to address uterine bleeding, antibiotics for pre-dental care, the resident's food likes/dislikes, and the resident's significant need for personal care assistance. An approximate 5% weight loss in the past year was noted in a dietary assessment and monthly weights were being checked. Programs related to personal care were identified. The HRA noted in its review of two months of program documentation that some programs were not run on weekends; it is unclear why weekend programming did not occur. In September 2009, there was no documentation of the menses program being run and the coin identification program was only run 13 times. Monthly reviews appeared to be completed by the QMRP although the QMRP did not always document the number of program sessions run per objective. The HRA also noted that there was no PRN order for the pre-dental antibiotic although there were PRN orders for lotions, pre-exam sedation, etc. And, the HRA did not find reference to the need for an antibiotic prior to podiatry appointments as discussed in the complaint. The HRA also did not find reference to the guardian preferred shampoo in either the treatment plan or physician order sheet; a PRN medicated shampoo was listed but the medication administration record indicated that it was not used.

A tour of the facility revealed that on the date of the HRA's visit, the resident's preferred shampoo was available, her list of likes/dislikes was posted in the kitchen and her discarded clothing did not appear to be stained.

The agency maintains a policy related to treatment planning that references adequate care and treatment planning based on assessments, including dietary assessments.

Mandates require adequate care to meet the needs of residents based on assessments, the provider reliance on guardian direction, dietary assessments, the availability of food substitutes and the development of program goals and objectives as well as a means to monitor the achievement of goals and objectives. Mandates ensure guardian and resident involvement in treatment planning. And, mandates specify that medications, including PRN medications, be ordered.

Due to the lack of program documentation related to menses care in September 2009, the infrequent (and without explanation) program documentation for coin identification, the apparent lack of weekend programming with the exception of showering, the lack of a PRN physician orders for pre-dental or pre-podiatry antibiotics, and the lack of reference to the preferred shampoo in either the treatment plan or physician order sheet, the HRA substantiates these complaints. Based on its findings, the HRA recommends the following:

1. **Follow policy and mandates and ensure that resident needs are being addressed. For the resident in this case, ensure that the preferred shampoo is listed on the plan and physician order sheet, and that all antibiotic needs (dental and podiatry) are listed on the treatment plan and physician order sheet.**

2. **Provide programming consistent with residents' treatment plan as required by mandates. If programming is not provided on a given day or month, document the reason. If a program has a certain parameter, such as a coin program being run only during shopping trips, identify the parameter in the program.**

Complaint #3: There are inadequate staffing levels.

The complaint stated that there were lapses in resident personal care due to inadequate staffing levels and that, sometimes, there is only one staff person on duty.

Staff reported that the home has 15 residents with diagnoses ranging from mild to profound cognitive impairments; some residents, including the resident in this case, have medical issues. Staff asserted that there are 2 staff on duty when residents are at home except overnight when there is one staff person on duty. Staff also indicated that absences and turnover occur but the home has back-up staff that can assist and the home is in the process of building its core staff. Staff also acknowledged that a resident did not receive requested personal care prior to an outing as requested by the guardian.

Agency policy and mandated requirements stress that staffing levels are to be adequate to meet resident needs. The mandates further state that if there are residents with profound needs, then there must be 2 ½ hours of care given to each resident in a day which, if multiplied by 15 residents, totals 37.5 hours per day. Recognizing that some hours may be met by QMRP, administrative and dietary staff, the HRA believes that, at a minimum, there should be 2 staff on duty while residents are at home. At the time of the HRA visit, there were several staff in the home.

Although the HRA does not discount the complaint statement that there have been times when only one staff was available to residents when they were at home, the HRA was unable to secure evidence to this effect; the provider concurred that at least 2 staff are to be on duty when residents are at home. Therefore, the HRA does not substantiate the complaint. The HRA does remind the agency of its need to ensure adequate staffing levels to meet resident needs and to comply with mandates.

Complaint #4: Resident personal belongings are mishandled.

The complaint alleges that a resident's personal supplies have ended up missing or have been used on other residents.

Staff reported that the agency completes inventories twice each year and adds newly purchased items to the inventory after labeling these items. A tour of the home revealed that, at the time of the HRA's visit, the resident had a supply of personal items, including her specially purchased shampoo, which was appropriately marked. The HRA found evidence that personal

items appeared to be labeled. And, personal items that the home provides were kept in locked storage and there appeared to be an adequate supply of these items.

Although the HRA was not provided with a policy specific to personal belongings, this topic was covered in the resident rights statement which guarantees the resident's right to maintain and use personal belongings. However, the statement did not contain any description of procedures used to safeguard personal belongings.

Mandates guarantee the right to retain and use personal belongings and require agencies to identify a means of safeguarding those personal belongings as well as a policy to address resident personal belongings.

Based on the evidence at the time of the site visit, the HRA does not substantiate the complaint. However, the HRA does suggest that, if a policy and procedure is not in place to address the safeguarding of resident personal belongings, that one be developed. The HRA also suggests that staff be reminded that all personal items, including personal care items, be labeled and personal care supplies not be shared amongst residents.

Complaint #5: There is an inadequate response to grievances.

The complaint states that staff do not adequately address complaints. Staff reported that there is a grievance process that is discussed as part of annual rights reviews. For the guardian in this case, staff have provided the guardian with the contact information for the QMRP and staff believe that the guardian's concerns have been addressed.

The HRA found one letter of facility interaction with the guardian over a dental issue. Contact with the guardian indicated that multiple letters of concern have been sent to the agency. The guardian did verify telephone discussions with staff regarding concerns. And, the HRA found evidence that most concerns shared in the HRA case were addressed through the treatment plan which appeared to be one legitimate venue to address concerns and document resolutions. The issue of the personal belongings and the dietary list appeared to be addressed as observed during the site visit. However, the HRA found that documentation specific to the complaints being registered and the formal use of the agency grievance process were not found in the record. It was also unclear from the record how many times the guardian complained, when complaints originated, and the length of time taken to resolve concerns.

Mandates guarantee the right to file complaints without fear of reprisal.

Based on the evidence, it appears that the facility used treatment planning to address guardian concerns; therefore, a rights violation is not substantiated. However, the HRA strongly suggests that the agency more clearly document and complaints filed and agency responses to verify adherence to its grievance process and to ensure compliance with mandates.

Complaint #6: A guardian was denied the right to access and copy a resident's file until an enforcement agency was consulted.

The complaint states that a guardian was unable to access and copy a resident's record until an enforcement agency was notified.

Staff reported that residents/guardians can access and copy records as per its resident rights statement but there is a 24 hour turnaround time for responding to record requests; the 24 hour turnaround is reportedly shared with residents/guardians at the time of a request. Staff indicated that the guardian's request in this case was a matter of timing although there was no record documentation related to a guardian's request to access a resident's record.

The HRA found nothing in the resident rights statement signed by the guardian that the resident/guardian has the right to access/copy a resident's record. The resident's right policy contains no reference to this right or the 24 hour turnaround.

The Mental Health and Developmental Disabilities Confidentiality Act and the Nursing Home Care Act guarantee the right of a resident and guardian to access/copy records. The Nursing Home Care also requires that residents/ guardians be provided with rights statements that include the right to access records.

Due to the staff's report that record access is addressed in the rights statement when it is not and staff acknowledgement that there was a record issue but no documentation, the HRA finds a rights violation related to record access and the admonishment of rights information. There is no written information to guide staff and inform residents or their guardians that they have a right to access records. And, without documenting record access, there is no evidence that the right was granted. Based on its findings, the HRA recommends the following:

1. **Revise the rights statement to include the right to access and copy records.**

2. **Revise the rights policy to incorporate the right to access and copy records.**

3. **Train staff on record access rights.**

4. **To ensure compliance with the Confidentiality Act, document requests to access records and the provision of those records.**

The HRA also suggests that the rights statement include the right to refuse treatment as required by the Nursing Home Care Act.

Comment:

The HRA notes that the guardian refused to sign the "Acknowledgement of Responsibility for Leave from the Facility and/or Leave from the Facility against Professional/Medical Advice with the knowledge of the resident's decision maker." Consistent with past HRA cases involving residential sites operated by DD Homes Network, the HRA finds that this form attempts to relieve the provider from any responsibility related to community outings or visitation which an undefined agency professional has advised against. The form also implies that "…the issue of whether the Resident should have the unrestricted right to leave the Facility has arisen" when there was nothing found in the resident's record in this case to indicate such. The HRA takes this

opportunity to again remind the provider that concerns regarding community access or visitation are best addressed on an individualized basis through treatment planning rather than through the use of a blanket waiver form that all residents/guardians are asked to sign whether or not there is an issue. In discussing this form with an agency manager, the manager claimed that the form was simply a means of documenting the names of individuals who are free to have contact with the resident; however, the form's description implies much more. The HRA again requests that the form be disbanded and visitation/community access be addressed through individualized treatment planning.