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HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS
Case # 11-090-9019
Bridgeway, Inc.

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving a complaint of possible rights violations at Bridgeway, Inc. Complaints alleged the following regarding a Community Integrated Living Arrangement (CILA):

1. Inadequate care, including not providing food purchased for individuals, food running out at houses, inadequate catheter care, unclean clothing and inadequate hygiene care, MRSA precautions not followed, inadequate food portions.

2. Lack of supervision and monitoring of CILA staff.

3. Behavioral needs not met for staff at CILA homes.

4. Mismanagement of public benefits.

5. Lack of guardian notice for medication changes.

6. Inadequate protection against retaliation for filing grievances.

If found substantiated, the allegations would violate Community Integrated Living Arrangement (CILA) Regulations (59 Illinois Administrative Code 115), and the Mental Health and Developmental Disabilities Code (405 ILCS 5/1-100).

Bridgeway, Inc provides services to 10 Illinois counties and 3 Iowa counties. They provide programs such as: behavioral health counseling, vocational training, substance abuse, family services, community employment, services to individuals with developmental disabilities and community living. The complaints concern the Bridgeway, Inc. office in Macomb which serves 12 CILA clients.

To investigate the allegations, HRA team members met and interviewed Bridgeway staff in the Macomb office, and examined pertinent documents regarding the case. All documents were reviewed with the guardian's written consent.

COMPLAINT STATEMENT

The complaint states the facility does not adequately care for consumers. One part of the complaint states that pineapple is bought on a Monday for a consumer and it would still be in the kitchen on Friday surrounded by fruit flies and stuck to the counter. The complaint states that in reviewing the receipts, new pineapples were not purchased and it was the pineapple that was purchased on Monday. The complaint states that according to physician orders, the consumer was supposed to be given 2 servings of pineapple per day but the untouched pineapple indicates that the consumer is not getting the pineapple as ordered. The complaint states that a consumer was left alone when he was not to be unsupervised. The complaint also states that 3rd shift staff at the houses were sleeping when they were supposed to be working. Also, staff were to be receiving training but did not actually use the training they received. The complaint states that one person works at the houses when it should be two individuals working. The complaint also states that if one consumer wants to go somewhere, the other consumers have to go because no one is there to supervise them. The complaint also states that many staff members will not take the consumers places because there is too much negotiation about who wants to go where between staff and consumers. The complaint reports that individuals are not taken to events except going to get pizza or sometimes to the carnival, and when the consumers are taken; it is a quick, in-and-out trip. The complaint alleges that the supervisor is supposed to visit CILA houses but does not go to the houses except on Mondays to pick up time sheets. The complaint indicates that the supervisor is not available to staff and will not answer phone calls and text messages. The complaint alleges that mail gets piled up at the CILA houses and a staff member is to open the mail and put it away but this does not occur. The complaint asserts that a consumer had $80 dollars missing from his/her link card. The complaint also states that a consumer had Methicillin-Resistant Staphylococcus Aureus, or MRSA, and was touching objects and staff members in the house. The complaint reports that a consumer is very violent, and pulled the glasses off one staff member kicked another staff member in the groin and knee, hit another staff member and hit a consumer. The complaint states that the same consumer was taken to a fast food restaurant where he hit a little boy and the boy's mother. All the facility did was restrict the consumer's visits to the fast food restaurant. The complaint states that the consumer is very aggressive and is too violent to live with some of the other consumers. The complaint alleges that the Office of Inspector General was not called with these incidents.

According to the complaint, the consumers are dressed in dirty clothes with dirty faces. The complaint states that the consumers would come back from lunch without their faces being washed. The complaint alleges that the paperwork at the Washington Street house is bad and staff members do not keep good records of the money; checks and receipts are not being organized at the house. The complaint also states that staff purchase food that they already have because they do not know what food is in the house. Also the house has to call other houses for food because they run out, even though the house should have enough money to purchase food. The complaint states that the consumers get fed small portions of food that are not enough for them, and when this is questioned, the staff state that they are trying to keep the consumers healthy and that a specific consumer would steal food anyway so he got smaller portions (even though all the consumers get the same portions as that consumer). The complaint indicates that a staff member would get a consumer, who has stomach problems, to go to the bathroom and be

regular, then by the time that staff member was at for their next shift, the consumer would be constipated again. The complaint states that Bridgeway does not treat the staff well if you report things and a lot of the staff are afraid to speak because they do not want to lose their jobs.

The complaint alleges that an older consumer was taking medication about which his guardian new nothing. The medication was discontinued, but then the consumer was put back on the medication at a later date. Bridgeway staff was told not to tell the guardian because they did not have time to get her permission, and since she did not know about it before it was considered as not hurting the situation if the guardian was not informed. The complaint also states that staff were reusing a consumer's catheter without cleaning it. The complaint alleges that the staff were told to clean the catheter with hot, soapy water but they were not doing it. The complaint states that the individual was getting urinary tract infections (UTIs) and had to have surgery because of the infection.

FINDINGS

Staff Interviews (1/24/2011)

The Bridgeway staff began the interview by explaining the Link card process. The staff explained that when Link cards are utilized, the store has to ship the number back to the state. If someone loses the receipt, you can still get the receipt through public aid. Bridgeway still has to balance the link card, so they will call public aid if there was an error. The Bridgeway staff acknowledged that they do have a physician's order for pineapple and referenced a receipt where 3 pineapples were purchased which the HRA reviewed at the interview.

In regards to food and menus, the staff explained that the residential counselor asks the consumers what they want. The menu plan is made based on the food that the consumers want to eat. The menu plan is then sent to a nurse for approval so that the diet orders are followed when setting up the food plan. Each house creates their menu this way. Also the consumers can go shopping with the house staff.

The staff told the HRA that they do not have a policy on catheter care. They stated that there is a consumer who uses a catheter but they have never gotten a complaint about the care. The staff explained that consumers with catheters have gotten UTIs, but that is common with catheters. They also stated that staff do not change catheters, only nurses will change them. The staff explained that the catheter does not get reused, but the catheter bag will get reused and they have a day bag and a night bag. The catheter is changed once a month. They have never had a consumer need surgery from a catheter.

In regard to the complaint that the consumers are unclean and do not have proper hygiene, the staff said that daily care records are kept for consumers. That is not to say that someone does not get food on them because that happens occasionally. They stated that the staff can get the consumer looking nice and then the consumer will change their clothes into something dirty.

The staff explained that they do not plan a menu for someone sneaking food and they would not calculate that into the food. The only food restrictions they give to the consumers is when someone is supposed to lose weight or has a doctor's orders. Also, the staff member that works for the CILA house also shops for the same house, so they know the individuals for whom they are shopping. There is no log kept for how much food is left at the end of the week.

In regard to the complaint about MRSA, the staff explained that the nurse was there for a medication training, went to put lotion on a consumer, saw what could be MRSA, and took the consumer to the hospital. The staff explained that as long as the wounds are covered, the individual could go back to the house.

In regard to the complaint that a guardian was not being made aware of medication changes, the staff explained they cannot make medication changes without guardian approval and they cannot fax a medication to a pharmacist without the approval. The staff explained that with certain drugs, if public aid stops covering, the medication will be discontinued. Staff make no medication decisions; they will take medication issues to the doctor, then they call the guardian for approval. They send a fax to the guardian and have it signed. They will also get a verbal consent. The staff explained there has never been a situation where the guardian was not notified. In fact, there were times they could not start a medication because they could not reach the guardian. The supervisor calls the guardian regarding any medical consents or medical issues.

In regard to the complaint about the consumer with violent behaviors, the staff stated they met about the fast food restaurant incident as soon as it happened. The staff stated they have a behavior plan and if the consumer has 5 days without behaviors, he is rewarded. The staff also said they pursued a medication change and the consumer has been less aggressive. They stated the consumer's behaviors have improved as compared to his previous behaviors, and he hits lightly like play hitting. The consumer will pull glasses off the staff but that means they are physically too close. The staff explained that there is an increase in his behaviors when a new staff member starts but, at this time, there are no new people in the house. When there are changes, the facility tries to have experienced staff with him one-on-one during the changes. The staff explained that some individuals have restrictions, for example, there is one male consumer that can only live with other males. The facility tries to identify what people need and then they try to meet their needs. The staff stated that the consumer occasionally acts out towards other consumers but, when he hits them, he mostly taps them. The consumer also has a habit of saying people hit him. When he states a staff member hit him, the OIG gets called, but if it is a consumer, then they do a regular investigation. The staff explained that when the consumer gets frustrated, he acts differently, but his actions are definitely not life threatening. If any of the situations came close to life threatening, then they would address the individual. They stated that their admitting policies are very cautious. They stated that in CILAs, they are careful as to who they accept because it is difficult to terminate them from the program. They examine the individual's packet, and then meet the person before admitting them into the Bridgeway program. The consumer with the violent behaviors has a behavior plan that informs the staff what to do when he acts up and other consumers know to walk away when he acts up. The consumer with behaviors has also been with the facility for a long time.

The Bridgeway staff explained that when an employee has a complaint, the supervisor gets a form, and they take it to Human Resources (HR). If they want to bypass the supervisor, they can go directly to HR or to the Vice President. Staff often tell the first person that they see. If staff have a problem, then they are supposed to try to solve it, rather than not bring it up to someone. The management has had people put notes in mailboxes before if they want to be anonymous. The administration allows staff members with problems to come and speak with them. Within their direct care staff, one member has 15 years with the program, a couple have 5 years, and one has 10 years. Employees have classes and training and during those classes the agency will ask them to identify any needed changes. The Illinois Department of Human Services' Office of Inspector General (OIG) training does the same and says to go to the next step of supervision if the one you speak with does not respond. The facility has staff meetings and so do the house staff. The staff texts the house supervisor frequently. The staff declared that staff scheduling issues and other people working the shift is the number one complaint. They have never documented a formal staff grievance process. They always encourage staff to take issues to whoever they are most comfortable.

The Bridgeway staff explained that their employees receive Direct Support Personnel training, which is 40 hours of classroom and on the job training. In the 4 bed CILA, there is only one staff member because residents are higher functioning. Also, one of the consumers can be left alone. There are times when staff may not go somewhere because consumers did not want to go somewhere, but that usually does not happen. The ratio depends on the level of consumers in the house. Supervisors go through personal mail and give the mail to consumers. If the mail is from DHS the Department of Human Services, the supervisor reads through to make sure that it does not need immediate attention and then gives it to the consumer. This action also goes for other items that may need attention. The staff stated that sometimes mail needs immediate attention and personal mail would never just sit.

The staff assured the HRA that 3rd shift sleeping by the direct care staff is not allowed. If it would happen, Human Resources would issue. Third shift will clean, help with toileting, and do other random tasks around the house. The 3rd shift for the house is 11pm - 9am.

The staff stated that consumers can do whatever they want when they go on a trip. During the summer, when there are community events, the staff will take the consumers to the events. One such event is a day trip for Christmas shopping to Moline. The consumer will pick out activities that they want to be a part of, such as carnivals, boating, fishing, swimming.

In regard to the complaint concerning supervision at the CILA houses, the staff stated that the House Manager works regularly at the houses. They stated that the House Manager stops by at least once a week. The staff also explained that all consumers and staff come to the main Bridgeway building and they can go to administrative staff offices for complaints. The House Manager is to be there when the consumers return home. The House Manager also has two phones and can be called at all times. The staff assured the HRA that the House Manager is very available and is always around the office or the homes.

Regarding the consumer who was left alone when he should not have been, the staff stated that the consumer was never left alone. The Bridgeway staff would bring in a special staff

in the morning to watch him when it was the busiest time for staff members. They also stated that the supervision level is on the consumer's service plan.

The staff also explained that the Washington Street House's resident records are at the main Bridgeway office. The house also has a transaction log for petty cash. They have receipts from petty cash for the Washington house but no checkbooks.

In a later conversation, the HRA spoke to Bridgeway regarding staffing. The staff stated that they have no staffing policy for the Bridgeway CILAs, but their staffing model is as follows; 1 waking overnight staff member, 2 individuals during medication passes, and in the evening, they try to have 3 staff on duty. The staff member stated that, for a time, they were understaffed because of hiring new staff members who had to complete training, so they did not always have 3 people in the evening. The staff member also stated that the amount of staff is dictated by the needs of the consumers. The staff member stated that if there are 5 people in the house, they are usually not going to have 3 staff members but rather 1 or 2 staff.

RECORD REVIEW

The HRA reviewed pertinent documents related to the complaints in this report. In regards to the complaint that consumers received inadequate care, the HRA reviewed the first issue in the complaint which alleges that pineapple was not given to a consumer and also the fourth issue in the complaint regarding mismanagement of public benefits when consumer Link cards were not being used properly. The HRA reviewed food stamp records and receipts for food purchased for the house. In one request there were 3 pineapples purchased and this receipt coincides with a food stamp record for the date of 10/6/10 ($22.71 was spent on the receipt and that amount was deducted from the food stamp form). The HRA reviewed another receipt where 2 pineapples were purchased which coincides with the 10/11/10 food stamp record. This receipt indicates that pineapples were being purchased 5 days apart. The HRA also reviewed another receipt in which $16.64 was spent and this coincided with the food stamp record (No pineapples were purchased on this receipt). The HRA also reviewed other receipts with pineapples being purchased (although there were no dates on the these receipts) as well as other foods being purchased for consumers such as meat, fruit, milk, candy, etc. The amount of food being purchased does indicate that an appropriate amount of food is being bought to sustain consumers in the house which is also one of the cited complaints. In reviewing house logs, the HRA saw that there are multiple communications regarding the purchase of food, going to the store, making dinner, etc. that indicate that the houses are stocked with food for the consumers. The HRA saw no evidence in the house log that a house had to call another house because they were out of food. The HRA reviewed further receipts for food stamp records and saw 11 occurrences of the records being documented correctly.

The HRA reviewed a previous report that had been written for case #10-090-9030 where, in regards to the consumer who was to receive daily pineapples, the report did not substantiate the complaint that Bridgeway did not follow the consumer's special diet or that the consumer did not receive adequate nutritional oversight. Because of the similarities of the complaint, the HRA feels as though this aspect of the complaint has been addressed.

The HRA reviewed the food stamp procedures. The procedures state that all food stamp (LINK card) usage should be recorded on the record month. The record should show the balance forward, which is the amount remaining from the previous month, as well as the allotments received in the current month. The procedure asks that each time food stamps are used, an entry should be made on the record that indicates the person using the food stamps, location of purchase, amount spent and remaining balance. Also, the receipt should be attached to the record. The procedure explains that at the end of the month, the record should be balanced and signed by the managers. In reviewing the food stamp form, the procedure seems to have been followed for the month of October 2010 and November 2011, which were the two samples given.

In regard to the complaint that a consumer had stomach problems related to the presence of a particular staff member, the HRA reviewed a complaint regarding that consumer in report #10-090-930 which substantiated allegations regarding the consumer's constipation problems. The complaint was addressed in that report, complete with a response from the facility, and will not be covered within the context of this report.

In regard to the complaint that Bridgeway is not adequately caring for individuals who use catheters, the HRA reviewed masked medication administration records (MAR) for an individual who has a catheter and lives in one of the CILA houses. The HRA reviewed MARs from June 2010 through December 2010 which indicate that the catheter was changed by an RN monthly (with the exception of one occasion when the catheter was changed by a doctor). The MAR has the date the catheter needed to be changed and the exact date that it was changed. The catheter was changed on the exact date indicated on the MAR with the exception of when it was done by the doctor (the catheter was done a day later) and the dates of 11/1/10 when it was done a day late, 8/18/10 when it was done 6 days late, and 12/1/10 when the catheter was changed 12 days early per a physician's request. No reason was given for the late dates on 11/1/10 and 8/18/10. The HRA saw no records regarding the DSPs changing the consumer's catheter bag.

In reviewing a house log from a previous case the HRA reviewed masked records of reminders for the staff to clean out a consumer's catheter bag. One entry on 4/7 reads "[RN] called this AM. She wants to remind everyone to make sure that all bags are getting rinsed for [Consumers] cath. [sic] Also she said to prompt him to empty out leg bag every 2hrs. Rinse bags w/antibacterial soap." An entry on 4/11/10 reads "On Friday [RN] told us to start cleaning [Consumers] pee bags with antibacterial soap. I've been filling a cup with soap and water and pouring it in the bags and then draining it out. I don't know any better way to do it." An earlier entry into the house log, dated 3/10/10 reads "Staff- to prevent further infections [RN] has asked that we start washing out [Consumers] bags w/ daily [sic] hot and soapy water. I will walk him through the process tonight but he'll prob need assistance for the first few times. His overnight bag should be done first thing in the AM and daytime bag right before bed."

In regard to the complaint that consumers are unclean and dressed in unclean clothes, the HRA reviewed case #10-090-9030 in which the HRA did not substantiate a claim that the consumer's grooming needs were not met. Because of the similarities of the complaint, the HRA feels as though this aspect of the complaint has been addressed.

In regard to the complaint that a consumer who has MRSA was touching objects and staff members in the house, the HRA reviewed documentation regarding the situation. According to an unusual incidents report, dated 12/1, the staff lifted the consumer's pant leg to apply cream and saw a sore. The nurse happened to be at the house at the time and they took the consumer to the local hospital. There is also a supervisor investigation that reiterates the account. The supervisor's comments and conclusions state "[Consumer] was reminded about his constant scratching. Staff followed proper procedures and are doing everything they can to ensure universal precautions are taken to prevent spread of possible MRSA." The physician documentation provided showed that the consumer was taken to the ER, where he was prescribed Bactroban Ointment and a Doxycycline Cap on 12/1. The HRA reviewed the consumer's MAR and saw that the medication was given. According to the Bridgeway Daily Log Sheet, on 12/9 the consumer had a follow-up appointment with his primary physician who referred the consumer to another doctor which he visited on 12/10. The doctor discontinued one medication but prescribed a different medication. The physician also suggested the consumer get a Hibis Cleanser to use during a bath, which in accordance with a receipt from a local pharmacy, was purchased for the consumer on the same day. The consumer's MAR reflects the change in medication. On the daily log sheet, it states on 12/1 that "Staff talked to [Consumer] about his wound. Staff told [Consumer] that it was very important to leave gauze alone. [Consumer] asked a couple of questions about his wound. Staff answered his questions. [Consumer] seemed to understand." On 12/3, it is documented that staff checked the gauze and it was in place. It was stated that the consumer was messing with the gauze on the first day but has been leaving it alone since. The log states "Staff stated that they have been spraying the entire house down with En-Bac and have even been having [Consumer] wear gloves when he starts itching or bathing to prevent possible MRSA spread. "According to the log, on 12/3 the staff received a call stating that the wound was in fact MRSA. A case management document from 12/3/10 states that the Bridgeway RN discovered that the wound culture had MRSA and called the house manager to inform her of the culture results and to inform her that the staff need to keep the area covered and the consumer's hands away. The RN states in the log that if the consumer keeps picking at the gauze then he would have to be isolated. The RN also indicated that all staff will "Still need to continue with Universal Precautions and to always have gloves on when touching all wounds."

In regard to the complaint that the supervisor is supposed to visit houses but does not and is unavailable to staff, the HRA reviewed the job description for Residential Coordinator. The job description states that part of the responsibilities are to "Provide administrative and clinical oversight and supervision of the residential staff and facilities ensuring that policies and procedures are implemented in order to meet the standards set forth by Bridgeway and other stakeholders." In reviewing the job description, there is no standard set forth for the amount of times a supervisor is to visit the houses and there is also no standard for how the supervisor is to be contacted. In reviewing the house log on 3/25, there is an announcement introducing a new house manager. Along with the announcement, there are two phone numbers and an e-mail address where manager could be reached. There are comments throughout the house log indicating that the supervisor has been communicating with the staff, such as one stating the supervisor was contacted regarding a strange voicemail that was left and the supervisor stated she would look into it, and a comment that the supervisor would like the staff to start checking their emails daily. There are also some notes in the log written directly by the supervisor. The HRA reviewed other documents signed by the house supervisor such as food stamp records,

supervisor follow-up actions on incident reports, physician's orders, and daily log sheets indicating that the supervisor is overseeing aspects of the facility.

Concerning the complaint that mail is not properly being taken care of by the staff, the HRA reviewed the CILA resident's rights agreement. Within the agreement, it states "I have the right to unrestricted mailing privileges." An entry from the house log on 2/13 states "Poor [Consumer] has been checking the mail religiously for something from his Mom and he has gotten nothing. I remind him it could just be late but he's pretty upset." This entry indicates that the mail is being reviewed. Another masked consumer Interdisciplinary (IDT) plan that was reviewed by the HRA states "Bridgeway staff will assist me in sending and receiving mail."

For to the complaint that many residents are not taken to substantial events, and when they are taken, it's a quick trip; the Bridgeway CILA handbook states "You [Consumer] will be out in the community a lot of the time. You will go shopping at the grocery store, go to the park, go out to eat, etc. If you want, you can also choose to go to church. There are lots of things to do." In reviewing the house log, the HRA saw instances of consumer outings. One entry on 1/15 states that a staff member borrowed the van to take the consumers to dinner. Another entry on 1/12 stated that a consumer was brought back from "MO" today and he seemed to have had "a nice time." On 1/9, the consumers were taken to Walmart. On 1/1 an entry in the log states that a guardian "invited Washington [CILA] and Grant [CILA] to the party. They [Washington House] don't have extra staff so I'm pickup up at least one guy and supervising him as well and getting some of the mobile Washington St. guys. We got it sorted out and had a nice time." This also accounts for the complaint that staff members will not take individuals places because there is too much negotiation about who wants to go where. Another example of an entry states on 11/29 "[Three Consumers] and I went to church. [Two Consumers from the church trip minus one] went to the YMCA to work on exercise goals. [Citizen] took [Consumer] shopping for toiletries and batteries. I took [Consumer] to Dollar Store for body wash and batteries. [Consumer] went with us." In another entry, on 3/12, it states that a bowling alley has agreed to let the consumers bowl for a reduced rate. The majority of the trips reviewed are to locations such as the store and eating out. There is no indication on how long the trips last.

In regard to the complaint that consumers are receiving inadequate food portions, the HRA reviewed two consumer ISPs, both of which indicate that the consumers are on specific diet plans. One ISP, dated 4/8/10, states that "[Consumer] is on a low fat/cholesterol diet." The ISP also states that "Staff thicken his [Consumer] liquids and puree his foods." Another ISP, dated 8/20/10, states that the individual is on a "low fat, bland diet." The ISP states, in the diet recommendation section that the individual is on a "Reduced calorie" diet and may only have seconds on fruit and vegetables.

The HRA reviewed house logs and viewed entries regarding food portions such as 12/2 "got pork loin cut up in 4 packs of 6-chops each - 2 are downstairs/2 upstairs - I think one pack should be enough for one meal … or whatever you want to do." Another entry on 3/21 states "Now that we're making [Consumer] take healthy stuff in his lunch, can we get some ind. Raisin boxes, and other semi-healthy snacks." Another log states "For most meals we typically only need 1 lb or hamburger or sausage unless noted differently. For spag [sic] the guys usually like

sausage if we have it - but hamb. [sic] is always fine too." Notes indicate that the staff is consciously determining food portions for the consumers.

In regard to the complaint that a consumer was left alone when he was to be continuously supervised, the HRA reviewed the consumer's IDT meeting dated 4/17/2008 which states that the IDT team agreed that "[The Consumer's Name] will no longer have 2 hours of alone time at home or in the community. [The Consumer's Name] is to have staff supervision at all times due to safety and behavioral issues. [The Consumer's Name] may ride the bus to and from work alone."

The HRA saw no evidence in the documentation of staff sleeping during third shift. In the house log, there are indications of staff not sleeping, such as comments that a consumer is sneaking food in the middle of the night and the staff member indicated that they have to be in the kitchen now when he wakes up to drink his milk. There are also comments such as "All is fine on third shift" and "Pretty quiet tonight." The HRA also saw a comment in the log stating that they filled out a unusual incident report because a consumer fell down at 12:45am, indicating that the staff member was awake. Another entry stated that a consumer had a bowel movement at 2am one morning.

The HRA reviewed a duty list for the overnight staff that was provided by the facility for a previous case. There are items like checking all medication and goals for errors, examining the menu and laying out meat to thaw for the next day, making sure the kitchen is clean and neat, etc. There are also tasks that are divided out into separate days, such as cleaning the bathrooms on Wednesday.

In regard to the complaint that Washington Street has poor documentation of money and checks and receipts are not organized, the HRA reviewed documents from a previous case (#10-090-9030) regarding a similar complaint. The HRA reviewed a document titled "Management of Consumer Funds." The document states that receipts are kept for all purchases. The document goes on to say "For consumers' personal funds, the Residential Coordinator will maintain a Consumer Expenditure Book and secured for the their [sic] personal use. These funds will be maintained in the Residential Coordinators' office. No more than $40 will be maintained for each consumer at the residence. The personal consumer funds will be kept secured in the Coordinator's office and cash will be given to the consumer or to a designated staff as approved by the Coordinator. A 'Cash Transaction Log' is kept by the Residential Coordinator to document use of funds and to maintain receipts."

The HRA also reviewed a masked money tracker form and corresponding receipts. The money tracker form did not specifically indicate which house the consumer resides in but the HRA had requested the documentation to be from the Washington Street house. The money tracker follows the consumer's money spent between the dates of 12/10/10 and 4/21/11. The form indicates the beginning balance, amount spent, amount deposited back, where the money was spent, and the ending amount. The staff who documented the money transaction also documents their names. The receipts provided for review were not consecutive (days were skipped in-between the receipts) but each receipt was accounted for on the money tracker and the account was balanced by 4/21/11 in accordance with the calculations.

The HRA examined training for direct care staff members in regard to the complaint that staff are not using their training. The direct service providers (DSP) are to take 40 hours of training required by the state which include classes such as "Human Rights," "Abuse & Neglect," "First Aid," and "Activities of Daily Living" to name a few. The classes are taught by Bridgeway staff. The HRA reviewed a document discussing on the job training activities. The DSPs are to complete certain on the job training tasks under the tutelage of a qualified individual and these tasks are to coordinate with the classes; for example, once the DSP takes first aid class, they can complete the first aid on the job training. The document also indicates that the staff have to pass a health and safety class, as well as complete the classroom and on the job training.

In regard to the complaint that safety needs are not met for staff at CILA homes. the HRA reviewed IDT team meeting notes on the consumer who was named in the complaint as being too aggressive to live with others. The IDT team met on 8/6/2010 to discuss a situation in which the consumer hit a young girl and her mother while at a fast food restaurant. The consumer also hit a staff member who tried to intervene in the situation. As stated in the document, the IDT team discussed the fact that the consumer has had an increase in behaviors at the day program over the last month and a half and an increase at home over the last month and a half. The team discussed the possibilities of what could be causing the problem and decided that it was more behavioral than psychiatric. The team also discussed that the consumer was anxious prior to leaving the day of the incident. The team decided that if the consumer "… shows signs of any agitation during the day then he needs to stay at home/work and will not be permitted to go on any outing, especially outings where the event/place could be crowded. The team also decided that [Consumer] should avoid going on outings where the situation could increase agitation, anxiety or paranoia." The notes go on to say "Team also decided that they will monitor [Consumers] behaviors and agitation over the next few weeks. If there is not an increase in behaviors then a consult with [Consumer's Physician], about increased anxiety, would be needed."

In staffing notes, dated 12/3/10, the IDT met to discuss an increase in behaviors by the consumer. During that meeting, it was agreed by the team that if the consumer uses his "hobbies" (which is not defined in the IDT) as weapons, then staff will take them away until safety can be assured. The team also discussed a reward program which dictates that if the consumer has no behaviors for 3 days, he will earn a "treat." If the consumer has no behaviors for 5 days, then he will earn an outing into the community. The team also stated that while at a specified location, the consumer will earn a treat of his choice for everyday that he does not have a behavior. The IDT team discussed that they should consult with the consumer's psychiatrist because the behavioral interventions that they have been trying have been ineffective. They talked about moving the time that the consumer is taking his anxiety medication to help him deal with some of his behaviors.

The HRA reviewed the consumer's current behavior support plan dated 12/3/10. The plan illustrates a frequent behavior by the consumer, such as hitting people, along with the cause of the behavior and then an approach of different options to try and deal with the behavior. An example of something that may be done as an option to deal with hitting would be reminding the consumer that he should not do the behavior and suggest alternatives to the behavior. Some of the approaches for the behavior list what to do if the behaviors happen in the community. In

regard to the complaint that the Office of Inspector General (OIG) was not contacted in these situations, the HRA did not see any evidence that the OIG was contacted regarding the behaviors at the fast food restaurant or other incidents discussed in the IDT meeting. On the behavioral plan, it does state that if the consumer reports that a staff member hit him, staff are not to ask him if he has told the truth but immediately notify a supervisor so that OIG guidelines can be followed. Also, on the ISP, there is documentation that hitting people occurred 3 times in the month of May, 19 times in the month of April and 7 times in the month of March. The documentation does not state that the hitting is directed toward staff or of other consumers.

Concerning the complaint that there is a lack of guardian notice for medication changes, the HRA reviewed 3 masked medication change form/informed consent forms that were from the same individual (all three forms were linked by the birthdate). One form, dated 9/3/10, indicated that the consumer was receiving Amoxil and Gentamicin. The form indicated that the consumer's guardian was informed on the medication change on 9/3/10 at 4:01pm and that the consumer was also made aware of the change on the same date. Another form, dated 6/14/10, indicates that the consumer received Nitrofurantoin as a new medication, and both the consumer and the guardian were informed of the change on 6/14/10. On the third form, dated 7/20/10, the consumer was also to receive Nitrofurantoin as a new medication. On this form, the consumer was informed of the change but the guardian was marked as "Not Applicable" and there was no indication that the guardian had been informed of the change on the form.

For the complaint that the staff have inadequate protection against retaliation for filing grievances, the HRA did not review any policy or procedure because Bridgeway does not have a staff grievance procedure. This writer has taken the Rule 50 training, which as indicated in the QSP/Residential Assistant job description and the Residential Coordinator job description, is a mandatory course for the position. In reviewing notes from the course, the Office of Inspector General states that any employee who suspects, witnesses, or is informed of an abuse allegation is a required reporter and proceeds to explain, when discussing retaliation, that "It is a violation of the Act for any employee or administrator of an agency or facility to take retaliatory action against an employee who acts in good faith in conformance with his or her duties as a required reporter." The Rule 50 training proceeds to explain that there are consequences if a mandated reporter does not report which entail possibly being disciplined, discharged, or even criminally charged among other consequences.

MANDATES

The HRA reviewed mandates pertinent to the complaints within this case. In regard to the complaint that there is inadequate care for the consumers, the CILA regulations state that "5) Every individual receiving CILA services has the right to be free from abuse and neglect" (59 Admin. Code 115.250). The CILA regulations also state "d) Based on their needs, individuals shall receive supervision and supportive services which may range from continuous to intermittent. CILAs shall be designed to promote optimal independence in daily living, economic self-sufficiency and integration into the community through the interdisciplinary process" (59 Admin. Code 115.200).

Concerning the complaint that there is a lack of supervision and monitoring of the CILA staff, the CILA regulations state that "2) When paraprofessional or untrained employees are used

in direct services, they shall be supervised in the provision of services by professional employees" and "B) All services shall be provided by appropriately trained employees, operating under the supervision of qualified clinical professionals" (59 Il Admin Code 115.320).

For the complaint that behavioral needs are not addressed by staff at a CILA home, the CILA regulations state "a) The community support team shall consider recommending termination of services to an individual only if: . . . 2) The behavior of an individual places the individual or others in serious danger;" (59 Il Admin Code 115.215). The regulations also require the following: " b) Licensed CILA agencies technically agree to a no-decline option; however, the agency may decline services to an individual because it does not have the capacity to accommodate the particular type or level of disability (e.g., an agency that serves only individuals with autism) and cannot, after documented efforts, locate a service provider which has the capacity to accommodate the particular type or level of disability. No otherwise qualified persons shall be denied placement in a CILA solely on the basis of his or her physical disability. The CILA agency or service provider associated with such agency must provide a reasonable accommodation for such persons, unless the accommodation can be documented to cause the agency or other service provider an undue hardship or overly burdensome expense" (59 Il Admin Code 115.200).

In regard to the complaint that there is a lack of guardian notice for medication changes, the CILA regulations state that "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" (59 Il Admn Code115.250). Chapter 2 of the Mental Health and Developmental Disabilities Code states "(a) An adult recipient of services or the recipient's guardian, if the recipient is under guardianship, and the recipient's substitute decision maker, if any, must be informed of the recipient's right to refuse medication or electroconvulsive therapy. The recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication or electroconvulsive therapy" (405 ILCS 5/2-107). The Probate Act of 1975 "(b) 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" (755 ILCS 5/11a-23).

The CILA regulations state that ”a) The purpose of the Community-Integrated Living Arrangements Licensure and Certification Act [210 ILCS 135] is to license agencies to certify living arrangements integrated in the community in which individuals with a mental disability are supervised and provided with an array of needed services. b) The objective of a community-integrated living arrangement is to promote optimal independence in daily living and economic self-sufficiency of individuals with a mental disability" (59 Il Admn Code 115.100). The CILA regulations also define community integration as "On-going participation in community life including at least the following: The amount of time spent out of the living arrangement in generic (non-disability) related activities such as church, Y.M.C.A., Y.W.C.A., education, library, clubs, shopping and amusements. Participation in family activities and celebrations such as holidays, birthdays, reunions, communication (telephone and mail) and vacations" (59 Il Admn Code 115.120).

The Mental Health and Developmental Disabilities Code states that "… a recipient who resides in a mental health or developmental disabilities facility shall be permitted unimpeded, private, and uncensored communication with persons of his choice by mail, telephone and visitation… [and] "(a) The facility director shall ensure that correspondence can be conveniently received and mailed, that telephones are reasonably accessible, and that space for visits is available" (405 ILCS 5/2-103).

CONCLUSION

Complaint #1 - Inadequate care, including not providing food purchased for individuals, food running out at houses, inadequate catheter care, unclean clothing and inadequate hygiene care, MRSA precautions not followed, and inadequate food portions.

The complaint states that Bridgeway is providing inadequate care for the consumers at the CILA houses. The first complaint of inadequate care states that an individual was not receiving 2 servings of pineapple per physician's orders. The complaint states that a pineapple was bought for the consumer on Monday and the same pineapple would still be on the counter on Friday. The Bridgeway staff referenced a receipt showing that 3 pineapples were purchased and did state that they had a physician's order for the pineapple. The HRA reviewed receipts that showed 3 pineapples were purchased and then, 5 days later, 2 more pineapples were purchased. The HRA also saw other receipts where pineapple was purchased.

The complaint states that a consumer was left alone when he was to be supervised. The staff stated that the consumer was never left alone and, in fact the facility would bring in special staff to watch the consumer in the morning. In reviewing documentation from a previous report, it was stated in the consumer's IDT meeting in 2008 that the consumer was to no longer get alone time and was to always be supervised due to safety and behavioral problems. The consumer was still allowed to ride the bus to and from work by himself.

The care complaint states that 3rd shift staff was sleeping when they were supposed to be working. The Bridgeway staff members stated that sleeping during third shift is not allowed and, if that happened, someone would receive a remediation from Human Resources. The staff did say that it has occurred but it was some time ago. The staff stated that 3rd shift has tasks that they must complete while on 3rd shift. In reviewing documentation, the HRA saw that 3rd shift had written in the house log regarding incidents that happened during 3rd shift that they would have to be awake to have discovered. The HRA also reviewed a task list provided by the facility for 3rd shift employees.

The complaint indicates that one person works at the house when there should actually be two individuals working and consumers are not be able to go places when they want to due to lack of supervision. In speaking with the Bridgeway staff, they stated that they try to staff at least 3 individuals when the house is full, but they did have run a situation when they were hiring and they were short staffed. The HRA reviewed regulations related to staffing and saw that there was no regulation/statute for a specific staffing ratio for a CILA house as long as consumer needs are met. The HRA also, through reviewing house logs, saw that the staff makes an effort to

arrange rides and also takes some consumers with them on errands while they do not take others, therefore the others are being supervised by someone else.

The complaint states that individuals are not taken to events too often and, when they are taken, it is a quick trip. The HRA reviewed the CILA handbook, which states that the consumer will be taken on outings such as out to eat or to the park. The staff state that there are many opportunities to take consumers on trips and they do activities such as a day trip for Christmas shopping, carnivals, boating, fishing, and swimming. The HRA reviewed house logs in which the consumers are being taken out to eat, to the store, etc. The HRA does acknowledge that the consumers are being taken to the same activities often, but there is some variance involved in their community visits. The CILA regulations define community integration as on-going participation in community life (59 Il Admin Code 115.120) and also that the focus of the consumer's community support team is to assist the individual in developing community supports and developing relationships with people in the community who are not paid to assist the individual (59 Il Admin Code 115.220). The HRA found no indication in the CILA regulations on what type of community experience the consumers should get or a duration of time for the experiences, only that the individuals should be integrated into the community which the HRA saw evidence of happening in the documentation.

The complaint that states consumers are dressed in dirty clothes, their faces are dirty, and they come back from lunch without their faces being washed was reviewed in case #10-090-9030 (minus the complaint that consumers come back from lunch with dirty faces) and was not substantiated. In regard to the complaint that consumers come back from lunch with dirty faces, the staff stated that it does happen occasionally that an individual will get food on them. Other than the staff statement, the HRA saw no evidence in the documentation that this is or is not occurring.

Concerning the food complaints, the staff explained that the residential counselor sits down with the consumers and asks them what they want as far as food. In reviewing the documentation, the HRA saw no evidence that one house called another because it was out of food and also saw that the staff shopped often and purchased an abundance of food. The HRA reviewed the house logs where the staff wrote back and forth often regarding meals and food items that needed purchased.

The complaint also states that consumers get fed small portions of food that are not enough for them, and when questioned, the staff states that they are trying to keep consumers healthy and referenced a consumer who would steal food anyway. The staff stated that they do not plan meals based on the possibility that an individual might steal food; this is not calculated into their food. The staff stated that the only limit that they give consumers is when someone is supposed to lose weight or has doctor's orders. The staff also stated that the staff member who works at the house takes the same house shopping, so they know consumer preferences. The HRA also reviewed two consumer's ISPs which have documentation regarding diets and one individual had a restriction on seconds to only being allowed fruit and vegetables.

In regard to the complaint about the consumer's stomach problem, this complaint was dealt with in a report for case #10-090-9030 and will not be duplicated within this report.

For the complaints regarding catheter care, the staff states that they have never gotten a complaint regarding the consumer who has a catheter and that individuals who have catheters in general are more susceptible to UTIs. The staff reported–that the staff does not change the catheters but rather the nurses change them. The staff stated that the catheter bag gets reused and it has a day and night bag. The staff also stated that they have no policy regarding catheter care. In reviewing masked medication administration records, the HRA saw an occasion on the consumer's MAR where the catheter was changed a day late with no explanation and then 6 days late with no explanation. The HRA reviewed house logs from a prior investigation documenting that the staff were asked on 3/10/10 to clean the consumer's catheter bag with soap and water and then was reminded on 4/7/10 the catheter needs cleaned with soap and water.

The complaint states that one person works at the houses when it should actually be two individuals working and also, because of this, when a consumer wants to go somewhere, the other consumers have to go because no one is there to watch them. The staff stated that they try to have 3 individuals staffing the CILA but there has been times, because of hiring new staff, in which there was only one staff member. In the 4 bed CILA, there is only one staff member because they are higher functioning. Also, one of the consumers can be left alone. The staff explained that if someone has alone time, then they can be left alone by staff members. There are times when staff may not go somewhere because consumers did not want to go somewhere, but that usually does not happen. The ratio depends on the functioning level of consumers in the house. In reviewing the house log, there is documentation that the staff try to work other staff and the consumers on scheduling outings and staff take some consumers places while others do not have to go. Also, there are no regulations that specifically dictate travel and transportation within the CILA regulations.

Another section of the complaint states that mail gets piled up and a staff member is to open the mail and put it away but this does not occur. The Bridgeway staff stated that Supervisors go through the personal mail and give it to the consumers. If the mail is from DHS, the supervisor reads though and then gives it to the consumer and this also goes for other items that may need attention. The staff stated that personal mail would never sit. The CILA's rights documentation also states that consumers have a right to their mail and the HRA also reviewed a house log where it is described that a consumer is waiting for mail and looking through it daily.

The HRA reviewed receipts and a money tracker, which indicated that there is a system in place for calculating the amount of money consumers spend and bring into the house and that, to the extent of the samples provided, are being followed.

The final part of the complaint states that a consumer had MRSA and was touching objects and staff members in the house. The Bridgeway staff explained that a consumer did have MRSA but the individual was put on antibiotics and the staff used precautions. The staff also stated that as long as the wounds are covered, the individual could go back into the house. The HRA reviewed the facility's documentation on the situation and what was done and feels as though the facility took precautions and tried to keep everyone safe while in the situation.

In reviewing the various aspects of the complaint, the HRA finds a **substantiated** violation but only in regard to the complaint about catheter care, due to the fact that the catheter was not changed on the correct date on two occasions, one being a week late, which is a violation of the Mental Health and Developmental Disabilities Code (405 ILCS 5/1-102) which states "(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 HRA finds no violations on the other aspects of the complaint.

The HRA gives the following **recommendations** regarding the catheter care:

- Assure that the catheter is being changed by the RN on the dates for changing as per physician orders and as listed in the medication administration form.
- Audit the MAR for patients with catheters to assure that the catheters are being changed as prescribed and as indicated on the MAR.

The HRA also offers the following **suggestions**:

- Although the HRA cannot substantiate that the catheter bags were not being cleaned by the staff, the house logs indicate that the RN mentioned on two separate occasions that the staff should clean out the catheter bags. Because of this, the HRA suggests that a MAR type checklist is created for changing and cleaning the catheter bag that is completed by the staff.
- The facility stated in their interview that they did not have a policy regarding catheter care. The HRA recommends that a policy regarding catheter care is created and the staff is educated on the policy.
- The HRA is concerned with the statements made during the site visit regarding the staff reading the consumer's mail if it is something from DHS or something that may be considered important. The Mental Health and Development Disability Code states that consumers should have private and uncensored access to mail (405 ILCS 5/2-103) and the HRA feels that, although reading the mail for consumers is being done with good intentions, it could also be a violation of the consumers right to privacy if not done carefully. The HRA did review a masked IDT that states that the individual needs assistance with sending and receiving mail but the HRA would encourage Bridgeway to be careful to not violate the Code with this assistance and allow the consumers to have as much privacy as possible with their communications. The HRA suggests ensuring that the facility has consent before opening consumer's mail.

Complaint #2 - Lack of supervision and monitoring of CILA staff.

The complaint states that that there is a lack of supervision and monitoring for the CILA staff; the supervisor is supposed to visit the CILA houses but the supervisor only goes once a week to pick up time sheets. The complaint also states that the supervisor is not available and will not answer phone or text messages. The Bridgeway staff states that the staff member stops by the house at least once a week and explained that all consumers and staff come to the main Bridgeway building and can go to the administrator offices if they have complaints. Also, the house manager is to be at the buses when the consumers get off the bus. The staff also stated

that the supervisor has two phones and that she can be contacted by at all times. In reviewing the records concerning the complaint, the HRA saw that there is no set amount of time that the supervisor is supposed to spend at the house. The HRA also reviewed documents indicating that the supervisor's phone numbers and e-mail address were made available to the staff. There was also documentation through the house logs that the supervisor had been communicating with the staff through the house logs. CILA regulations also do not have statements indicating a certain amount of time that a supervisor should spend in the houses or communicating with staff. Due to the fact that the HRA found no evidence that there is a lack of supervision and monitoring of the Bridgeway CILA staff, the HRA finds this complaint **unsubstantiated** but offers the following suggestions:

- The HRA saw no indication of house meetings between the staff and the supervisor. To alleviate any possible future complaints that the supervisor is not available to the staff, the HRA suggests periodic meetings between direct care staff and the supervisor that are documented and kept on file.
- The HRA only viewed one instance of the supervisors phone numbers being made available to the staff, the HRA suggests that the supervisor make her phone numbers available on multiple occasions so that it is assured that the staff know how to contact the supervisor.
- When resident records are kept at administrative offices, ensure that direct care staff have adequate access to consumer information (e.g. treatment plans, behavioral approaches, consumer preferences, etc.).

Complaint #3 - Behavioral needs not met for staff at CILA homes.

The complaint states that the behavioral needs are not met for staff at the CILA homes with a consumer that is too violent to live in at the CILA. The complaint states that the consumer has been violent towards staff and towards citizens when on a trip to a local fast food restaurant. The complaint also states that the consumer is on medication but is too violent to live in the CILA with some of the other consumers. The complaint reports that the Office of Inspector General was not called with these incidents. The Bridgeway staff state that that the consumer's behaviors have actually improved and when the incident occurred at the fast food restaurant, it was immediately addressed. The staff also stated that they have addressed the consumer's behaviors in other ways such as having staff members with whom he is familiar around during any changes at the house so that the consumer does not get aggravated. In reviewing documentation regarding the individual, the HRA sees that the staff have taken steps to help the consumer's behaviors. As far as the OIG not being contacted regarding the incident at the fast food restaurant, the HRA saw no evidence that they were contacted by the facility, but the incident was not staff abuse towards a consumer. In reviewing the consumer's service plan, it does state that if the consumer says staff hit him, the staff is not to ask questions but only contact the OIG; therefore, the staff does have plans in place to contact the OIG if there is staff abuse allegations. Due to the fact that the facility has taken measures to address consumer behaviors by the consumer, the HRA finds this complaint **unsubstantiated** but offers the following suggestions:

- Although there are indications that measures are being taken to address the consumer's behaviors, the HRA suggests that more measures be taken to keep other consumers safe

from the individual's behaviors and that these measures be documented in the consumer's ISP and behavior plan.

- The HRA did not see evidence of any incident report or documentation regarding the behaviors at the fast food restaurant. The HRA suggests that all behaviors such as this be documented much like the documentation regarding the possible MRSA that the HRA reviewed in this report.
- In reviewing the consumer's service plan, the HRA noticed areas where the document could be more specific, such as what the consumer's "hobbies" are in one IDT reviewed for this report, and also what are the "treats" that the same consumer gets to pick from. The HRA suggests adding more incident details and specific rewards into the IDT so that if a new staff member was to read the IDT, it would be clearly understood.

Complaint #4 - Mismanagement of public benefits.

The complaint states that a consumer had $80 missing from their Link card (food stamps). The staff stated that when Link cards are utilized, the store has to ship the number back to the state. If someone loses the receipt, the receipt can be obtained through public aid. The facility still needs to balance the Link card at the end of the month and will call public aid to see if numbers do not correspond to the balance. The HRA reviewed purchases with Link cards on receipts in relation to the balance sheet for the consumer and saw 11 occurrences of the balance being correct. The HRA also reviewed the Link card usage policy and it seemed as though the policy was being followed on reviewed balance sheets. Although the HRA does see how an incorrect balance could show if a mistake was made or if a receipt was lost, due to the fact that the review of the documentation showed correct bookkeeping for the consumers, the complaint is **unsubstantiated.**

Complaint #5 - Lack of guardian notice for medication changes.

The complaint states that an older consumer was taking medication that his guardian did not know about, and the medication was discontinued. The consumer was put back on the discontinued medication at a later date and the Bridgeway staff was told not to tell the guardian because there was no time to get permission. The Bridgeway staff stated that they cannot make medication changes without guardian approval and they cannot fax medication to a pharmacist without the guardian's consent. The staff explained that certain drugs are discontinued and this may create confusion. The staff also stated that they have never had a situation where the guardian has not been notified for medication. In reviewing 3 medication forms from the same consumer, the HRA discovered that one of the forms was filled out differently and indicated that the guardian was not made aware of the new medication. Due to the fact that the document indicates that the guardian was not made aware of the medication change, the HRA **substantiates** the complaint and strongly **recommendations** the following**:**

- Secure consumer/guardian informed consent for medication**.**
- Educate staff to follow requirements for gaining informed consent for medication from consumers/guardians.
- Assure that the consumer's guardian is aware that the consumer is taking the medication that was specifically reviewed by the HRA

Complaint #6 - Inadequate protection against retaliation for filing grievances.

The complaint states that Bridgeway staff has inadequate protection against retaliation for filing grievances. The complaint states that staff are not treated well if they report incidents and they are in fear of losing their jobs if they do report incidents. The staff explained that there is a process that the staff can go through if they have a complaint. They also stated that the staff has attended OIG training where they are told to report incidents. The staff indicated that they have never documented a formal grievance process for the staff. The OIG training does mandate that if staff see an incident that could be considered abuse/neglect, they must report the incident or there are consequences for that staff member. , the HRA found no regulations that a grievance policy must be created for staff, therefore, the HRA finds the complaint **unsubstantiated** but offers the following **suggestion:**

- To ensure that staff are aware of a grievance mechanism; the HRA suggests documenting the process that the facility already has in place and educating the staff on the process, including staff's ability to file grievances without retaliation.

RESPONSE

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

BRIDGEWAY

August 12, 2011

Meri Tucker, Chairperson
Regional Human Rights Authority
5407 North University, Suite 7
Peoria, IL 61614

Re: Human Rights Authority Case #11-090-9019

Dear Ms. Tucker:

Bridgeway is responding to the Human Rights Authority Report of Findings in the above referenced case involving a complaint of possible rights violations. Bridgeway has reviewed the extensive report and is responding to the one substantiated finding that had two recommendations. We have also reviewed the "suggestions" contained within the report and we will take them under advisement but we will not formally respond to them.

We appreciate the diligent work of the Human Rights Authority and we share your goal of ensuring that the rights of persons with disabilities are preserved. Bridgeway does, however, have concern that the work of the Human Rights Authority is often duplicative of the Office of the Inspector General. The HRA and OIG have had two common Bridgeway cases this past year resulting in a significant amount of staff time devoted to these investigations.

We will continue our mission of serving the "sickest and the poorest" always striving for excellence and always endeavoring to create solutions in partnership with the people we serve.

Sincerely,

Sandra L. Wood
Senior Vice President

☐ 2323 Windish Drive, Galesburg, IL 61401 • (309) 344-2323 • FAX (309) 344-2200 ☐ 900 S. Deer Road, Macomb, IL 61455 • (309) 837-4876 • 1-800-475-4226 • FAX (309) 833-1531
☐ 137 E. College, Kewanee, IL 61443 • (309) 852-4331 ☐ 301 Industrial Park Road, Monmouth, IL 61462 • (309) 734-9461 • FAX (309) 734-3909
☐ 2079 Edgewater Drive, N. Pekin, IL 61554 • (309) 382-2006 • FAX (309) 382-2007 ☐ 1007 Frontage Road, Oquawka, IL 61469 • (309) 867-2626 • (309) 867-2025 • FAX (309) 867-2216
☐ 825 N. 6th St., Burlington, IA 52601 • (319) 208-0894 • FAX (319) 758-9425 ☐ 208 Bank St., Keokuk, IA 52632 • (319) 524-3873 • FAX (319) 524-3876
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BRIDGEWAY

September 8, 2011

Gene Seaman
HRA Coordinator
Regional Human Rights Authority
5407 North University, Suite 7
Peoria, IL 61614

Re: Human Rights Authority Case #11-090-9019; Revised Response

Dear Gene:

Bridgeway is providing a revised response to the Human Rights Authority Report of Findings in the above referenced case involving a complaint of possible rights violations. Bridgeway is responding to the second substantiated finding that had three recommendations.

Please feel free to contact me at my office phone: 309-344-4231 if you have any questions.

Sincerely,

Sandra L. Wood
Senior Vice President

☐ 2323 Windish Drive, Galesburg, IL 61401 • (309) 344-2323 • FAX (309) 344-2200 ☐ 900 S. Deer Road, Macomb, IL 61455 • (309) 837-4876 • 1-800-475-4226 • FAX (309) 833-1531
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☐ 3913 15th St. D, Moline, IL 61265 • (309) 757-1276 • FAX (309) 757-1279

SERVICE PROVIDER'S WRITTEN RESPONSE	RESPONSIBLE PERSON(S)	DATE
Complaint #1 regarding inadequate catheter care • Assure that the catheter is being changed by the RN on the dates for changing as per the physician's order and as listed on the medication administration form (MAR). • Audit the MAR for patients with catheters to assure that the catheters are being changed as prescribed and as indicated on the MAR.		
Bridgeway Response/Plan of Action: 1) The Bridgeway Nurse Trainer staff provides the nursing leadership to ensure that the physician's orders related to the change of catheters is implemented as prescribed. Catheters are generally changed each month. The date of catheter change is established and documented on the monthly MAR and the nurse maintains a personal tickler schedule as a reminder. Either the Nurse Trainer or a licensed registered nurse changes the catheter as ordered by the physician. If the catheter is not changed on the prescribed date, documentation by the nurse indicating the reason is maintained in the consumer's clinical record in a progress note and on the MAR.	Nurse Trainers: Rachelle McCoy, RN; Rich McCoy, RN	August 12, 2011 and ongoing
2) There is now a double check audit system to ensure that the catheter changes occur as prescribed. The MAR is audited each month by the nursing staff and the Director and/or Coordinator will now conduct an audit each month on the date that the catheter change is to occur. The Director/Coordinator will initial and date the MAR demonstrating that the audit was completed.	Nurse Trainers: Rachelle McCoy, RN; Rich McCoy, RN Tonya Beckner, Director of Rehabilitation and Residential Services	August 12, 2011 and ongoing August 12, 2011 and ongoing
Complaint #5 regarding lack of guardian notice for medication changes. • Secure consumer/guardian informed consent for medication. • Educate staff to follow requirements for gaining informed consent for medication from consumers/guardians. • Assure that the consumer's guardian is aware that the consumer is taking the medication that was specifically reviewed by the HRA.		
Bridgeway Response/Plan of Action: 1) It is Bridgeway's practice to obtain informed consent from the consumer/guardian for medication. This includes new medications, medication changes or discontinuation of medication. See attached Procedure and Medication Change Form/Informed Consent.	Wendy Skrypkun, Coordinator of Community Support Services and Quality Assurance for DD Services	September 8, 2011 and ongoing

2) Staff are trained to follow requirements for gaining informed consent for medications from consumers/guardians during their initial medication classes upon hire. Macomb staff will be retrained on this practice during the next month utilizing the attached procedure and form.	Tonya Beckner, Director of Rehabilitation and Residential Services	October 1, 2011
3) The consumer of the case reviewed by the HRA was informed and will continue to be informed of medications that he is taking, changes in medications, and/or discontinuation of medications. The issue in this case was due to the fact that the consumer is his own guardian. Staff are being retrained in properly completing the required forms for such cases. (See attachments)	Tonya Beckner, Director of Rehabilitation and Residential Services	September 8, 2011 and ongoing
Regarding HRA Case No. 11-090-9019 Bridgeway, Inc. James H. Starnes CEO/Executive Director Sandra L. Wood Senior Vice President Authorized Representative September 8, 2011		

Medication Change Form Procedure

PURPOSE: This form was designed to help staff quickly identify medication changes that may have occurred.

Procedure:

1. This form is to be completed any time a consumer is taken to a medical provider and a medication has been changed, added or discontinued. This form will be "orange" to alert staff that changes have occurred.
2. Original form will be kept with other medication documentation.A copy will be sent to the QSP the **next** business day.
3. This form is to be used for one medical provider per appointment.
4. Guardian and consumer are to be informed of all medication changes prior to implementation. At least verbal consent must be received before medications can be changed. Verbal approval may occur on this form, pending written documentation on the "Informed Consent".
5. Written informed consent must also be obtained for all medication changes. Written signed consent will be obtainbed by the QSP.
6. If the consumer is his/her own guardian, then the "Not Applicable" box should be checked under the "Check all that apply line" by the Guardian. The Consumer line needs to be filled out completely.
7. Enter information for all medications that were changed, added or modified.
8. Specify the code related to the medication(s) noted.
9. Specify how the pharmacy was notified of medication change(s)
10. Form is to be signed by the person who completed the documentation and should be filed with MARS at the end of the month.

BRIDGEWAY, INC.
MEDICATION CHANGE FORM/INFORMED CONSENT

Consumer: ______________________ DOB: ______________ Date: ____________________

Staff Completing Form: __________________________

Guardian: ☐ Not Applicable ☐ Present at appointment ☐ Informed of change (verbal) Date: ____________
Consumer: ☐ Present at appointment ☐ Informed of change Date: ____________

Check all that apply:

☐ Medication Dosage Change (C) ☐ New Medication (N) ☐ Medication Discontinued (DC)

Code	***Medication***	***Dose***	***Instructions***	***Med Times***	***Purpose***

☐ Pharmacy notified by Physician's Office ☐ Written order taken/faxed to Pharmacy ☐ RN notified Pharmacy

Informed Consent:

I agree to the above medication change(s) and have reviewed the enclosed medication instructions (if applicable, referencing the most common side effects).

______________________________ ______________
Consumer/Guardian Signature Date