FOR IMMEDIATE RELEASE

East Central Human Rights Authority
Report of Findings
Case 12-060-9015
Neighborhood Opportunities

The East Central Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegations concerning residential health services at Neighborhood Opportunities located in Kankakee, IL:

1. There are issues surrounding abuse and neglect of an individual with a disability.
2. An individual with a disability was unable to access adequate and humane care.
3. An individual with a disability was given medication which had been discontinued by his physician.

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/1 et seq.), and the Division of Mental Health and Developmental Disabilities Administrative Code (59 Ill. Admin. Code 115 and 116). Neighborhood Opportunities is licensed by the Illinois Department of Human Services to provide Community Integrated Living Arrangements (CILA) and Day Training.

COMPLAINT STATEMENT

The complaint alleges that an individual's medication from 12/2011 to 1/2012 was not administered in the CILA per the physician's orders. Another consumer allegedly punched this consumer in the left eye; this was at least the 4th conflict with this consumer. The consumer who was punched reportedly walked out of the facility at 3:00 am and went to the gas station to call the police. Staff were unaware the individual left the home as per the complaint. The police found the consumer and took him to the emergency room (ER). When the staff were called to pick up the consumer they received written instructions that this individual needed follow up with his physician in 1-2 days. He was reportedly not taken by staff to see a physician until 2 weeks later. The consumer may need eye surgery as a result of being punched.

INVESTIGATIVE INFORMATION

The HRA proceeded with the investigation having received written authorization to review a consumer's record. To pursue the matter the HRA visited the facility and met with the Administrator. The HRA was provided a tour of the home and met with direct care staff and individuals. Relevant practices and policies were also reviewed.

Interviews

The HRA asked about what types of services were provided. The staff explained that CILA and day training would be provided. They have 4 CILA homes that are licensed. There are 2 homes with 6 beds. The others are a 4-bed and a 5-bed home. They have just reopened 2 of the 4 homes. The geographic area served has been Will, Grundy, Iroquois, and Kankakee Counties. They have provided services to individuals from as far away as Danville, Springfield, and Rockville. There are approximately 17 employees that provide services for the two homes that are open. Employees include a qualified service professional (QSP), 2 nurses, and 14 direct service personnel (DSP). Nurses must be trained as a nurse trainer to oversee the DSP Staff.

Staff shared with the HRA that the facility had just been reviewed by the Department of Human Services (DHS), Bureau of Accreditation, Licensure, and Certification (BALC) in April. (They achieved a score of 45% out of 100% per BALC standards.) Admissions of new individuals were not allowed; corrective action to bring the agency back into good standing was completed. If corrective actions had not been taken, the agency would have been subject to having their license revoked. Per the administrator, what caused the incident was that the agency had just lost both of the nurses who would oversee medication which caused the review. DSP staff could no longer assist in passing out medications without being overseen. They have since hired two nursing staff and have had major improvements in providing services per staff. The agency has reopened two of the homes and now may take new admissions.

The HRA asked about the admission process. The administrator explained that a new admission would be discussed with the administrator, the QSP, and the nurse. Sometimes the administrator makes the decision.

The HRA asked what training is in place to assist staff in providing adequate and humane care. At hire staff are provided the 5 modules of DSP Training. The HRA asked how staff are trained in recognizing and reporting incidences of abuse. Staff stated that they have quarterly in-service training on abuse and neglect prevention. Recently they had training on autism, dealing with difficult clients, and managing threatening clients. The provider has a policy of no restraints. They do use open handed redirection. Refresher training on abuse/neglect and consumer rights is provided to staff quarterly. OIG contact information for consumers and staff phone numbers are posted. Rights information would be provided at admission and annually to the consumer and the guardian. Confidential reporting does occur as per staff. The HRA advised that rights information should be posted along with OIG and third party advocacy group information. The administrator advised that rights information would be posted by the end of the day at all homes and at the workshop.

The HRA asked if the home has an active, internal human rights committee and an active behavioral management committee. Staff responded that there are two community representatives, a family member, an individual, QSP, nursing and staff who serve on each committee. They have a behavior specialist from a state facility that participates. They meet quarterly. Regarding this case, the committees have not discussed the issues in this case because the individual was discharged prior to August 2012.

The HRA asked what happens if there is an emergency. The response was that they would call the QSP and/or the administrator. The QSP works an 8:00 am to 8:00 pm schedule. If the QSP is not available the administrator would be. They would assist staff in handling the emergency.

The HRA asked if staff adhered to the physician's orders regarding medication for the consumer. The response was that this individual was an emergency placement with the agency. He had been living in a nursing home for persons with mental health disabilities. He had become eligible to receive CILA funding. He had been on quite a few psychotropic medications when he arrived at the CILA. His parent who has been the power of attorney agent (POA) had initiated a medication wash on a home visit. Then she brought the individual back to the CILA. The consumer exhibited dangerous and aggressive behaviors. The parent/POA agent had promised to be available to assist if the individual had issues, but made it clear that she was unavailable when the provider asked for help. As a provider when they do a medication wash it is usually done in a safe environment at the hospital. This left the provider with a dangerous and aggressive individual who was acting out as a result of the medication wash. Both the provider's staff and other individuals were injured as a result of individual's behaviors from the medication wash. The provider stated that the individual came to the provider with these medications; it should have been done in a safer manner because he had violent behaviors. The parent/POA agent knew of his history, but did not prepare or protect the individuals or the staff at the CILA by her actions as per staff.

The HRA asked if the individual have to leave the home to call the police. The response was there are two phones available for staff and consumers in the house. We questioned that if care was needed because of an altercation between the consumers why was the individual not taken to the ER by staff. Per the administrator the staff could have called the QSP or herself to assist. She did not know how the individual got by the staff to leave the home at 3:00 am.

The HRA explained that the police report stated the individual had been gone for 3 hours. When asked about the consumer's safety, the administrator did not know it had happened that way. The report also stated that staff could not contact a supervisor in this situation to obtain help. She had no answer for that. She stated the QSP was notified. When asked about contacting the guardian or substitute decision makers, the policy for notifying the guardian requires notice at the time of the incident itself. Staff call them immediately. Consumers can make unimpeded confidential phone calls and may call at any time.

As far as follow-up after the resident left the emergency room, the QSP would be notified. The administrator would be involved. The nurse would read the discharge notes and she would do the follow-up. The DSPs do take consumers to physician's appointments. The QSP would go to all psychiatric appointments.

The HRA was provided a tour of the home where the consumer had lived. It was an older home, but appeared to be clean. The downstairs bathroom did have a strong odor. There were 2 phones in the home as per the previous discussion. Staff interaction with consumers appeared to be very positive. Several consumers stated they liked living in the home and they liked the staff.

Information regarding how to contact OIG was posted. There was no posting of rights information, but the HRA was advised that a rights statement was posted after the site visit.

Records Reviews

The HRA reviewed the progress notes written by the registered nurses regarding care provided to the consumer, the QSP's Monthly Summary/Program Progress Notes, the police report and the hospital record. The following documentation applies to the complaints:

12/15/12 - The QSP documented that the consumer saw a psychiatrist who provided psychotherapy; the plan was to continue current behavior medications, behavior program and continue psychiatric supports and services as needed.

12/23/11 - The QSP documented that the consumer had been taken to see a psychiatrist at a hospital psychiatric department on 12/19/11. Brain scans of the consumer were reviewed. The psychiatrist there recommended the elimination of Lithium from the consumer's drug regimen. An order for the discontinuation of Lithium was received 12/23/11. The previous psychiatrist may dismiss the consumer due to dueling psychiatrists. No further acute medical concerns.

The nurse documented the consumer saw a new psychiatrist, and Lithium Carbonate was discontinued.

Physician's orders received document Lithium was to be discontinued.

1/2/12 - The nurse documented she went to see the consumer. His great toe nail had fallen off. She noted fungus on the toe nails.

1/3/12 - The nurse documented the consumer went to see the podiatrist.

1/25/12 - The nurse documented the consumer saw the neuro-psychiatrist today; the parent/POA agent explained the plan of care was to wean the consumer off of all psychotropic medication.

Physician orders included having the 100 mg Trazadone discontinued, and 50 mg Trazadone to be given for 30 days and then discontinued.

2/18/12 - The nurse documented that she went to the CILA. It was explained to her by staff that the consumer's behavior was escalating. The DSP reported "He is running out of the home." "He scratched his arm." There was a superficial abrasion to the consumer's arm. Neosporin was applied. One-to-one therapeutic intervention was provided to the consumer. He made good eye contact. He verbalized understanding. He was offered alternatives to running down the street. Per DSP staff behavior was more labile since he was off medication.

2/19/12 - The consumer had been taken to the hospital as a result of behavioral issues at his home. He was treated and released. No changes in medications and procedures due to his psychiatrist not working out of this hospital. An X-ray showed that he had a non-displaced fracture of his nose; follow up with a specialist was recommended.

2/20/12 - The nurse documented the administrator spoke to the consumer's psychiatrist. The consumer had to be taken to the hospital yesterday evening for fighting with others in the home. He had punched a wall. He hit his own face on the wall. He was discharged from the hospital when his parent/POA agent refused medication and hospitalization.

3/2/12 - The QSP documented that the consumer went to the hospital as a result of a behavioral issue in the home. He was transferred to the psychiatric unit of the teaching hospital for evaluation.

The nurse documented that she spoke to the parent/POA agent and would get copies of the office visits. She explained that the consumer's behavior had escalated during medication reduction. His parent promised to provide extra family support during this time of medication adjustment. The POA agent explained in detail the reason and the outcome of the consumer's plan of care.

Since the POA agent lived so far away an aunt would be more involved to provide additional support. The administrator observed behavior problems and contacted family to make arrangements to have the consumer transported to the hospital of his psychiatrist for inpatient stabilization.
3/13/12 - The nurse documented that she had contacted the hospital social worker and left a message about the consumer being discharged.
3/15/12 - The nurse contacted the social worker. All prescriptions would be faxed to the pharmacy so medications would be available on discharge.
3/16/12 - The QSP documented that the consumer returned to the CILA with new medication orders of Ativan three times daily, Sertraline 12.5 mg daily AM, and Clindamycin Sol apply twice a day to his face; Geodon was discontinued.
The nurse spoke to the POA agent regarding the consumer's plan of care, prognosis and medication regimen. Medications were kept in a lock box at CILA. At the CILA the consumer hugged others and said "I am glad to be back. I was gone a long time."
Physician's orders received were to discontinue Geodon, and start Ativan (Lorazepam)1 mg three times daily, Zoloft (Sertraline) 12.5 mg daily at breakfast Clindamycin Sol apply twice a day face.
3/19/12 at 3:51 a.m. Police Report - The HRA reviewed the police report which documented the incident. In the narrative portion of the report it states: "The caretaker, states that the consumer walked away from the group home for people with disabilities, after starting a fight with another consumer. The staff did not report the incident right away because the consumer had done this before and had returned on his own. The police were called initially by a gas station attendant when the consumer showed up there. He had a black eye and some scratches to his right arm. The consumer was brought to the home by the police officer. The staff stated that the consumer was always hitting the other individual and that individual defended himself by hitting the consumer back.

The consumer stated in front of the police officer that he wanted to fight that same person again. He then stated he wanted to hit people. The officer transported the consumer to the hospital for a mental evaluation. The staff estimated the consumer had been gone from the home about 3 hours. Due to the mental state of both of the subjects, no complaints were filed and the staff will report to her immediate supervisor, who she said was unreachable at this time. The staff was advised that anytime one of the group home residents leave the house to call the police and not just wait to see if they return."

Hospital Record for 3/19/12 5:00 a.m.: The chief complaint was battery. Per the exam it documented: "Battery-multiple contusions. Patient feels fine." It was also documented in the record: "The patient needed closer observation at the group home. He should not be allowed to wander off. Home supervisor will pick up patient." His diagnosis was ecchymosis (bruise) of the left periorbital area and bi-lateral arms. The discharge instructions stated: "Follow up with your physician in 1-2 days. Return to the ER for any concerning symptoms."

The QSP documented that the consumer went to the hospital after being in an argument and fight. He eloped from CILA 1 at 3:00 a.m. Later that morning he went to the day training program. A transfer to CILA 4 was done on the same day to change his environment. Hopefully

this would result in the consumer being more comfortable in his living arrangement. There were no further acute medical concerns.

4/5/12 - The nurse documented the consumer denied complaints, but would be seen by the physician for his eye.
The QSP documented that per the physician the consumer may need possible eye surgery. There would be follow-up in May.
4/12/12 - Notes documented a conversation with the consumer's parent/POA agent regarding a cataract that could have come from the trauma to the eye on 3/19/12. Surgical intervention would be discussed on 5/8/12. (There is no further documentation until 5/16/12.)
5/8/12 - The QSP documented that the consumer saw the physician for his eye. Eye surgery would be needed.
5/16/12 - The nurse documented the consumer's parent/POA agent took the consumer to see a psychiatrist. Ativan was decreased and Zoloft increased. He was very social with staff. He attended the workshop Monday through Friday.
The QSP documented that the consumer went to the psychiatric unit at the teaching hospital for a medication management review. Ativan was decreased to .5 mg, 3 times a day and Zoloft was increased to 25 mg. He returned to see the physician for an eye evaluation. Surgery on the eye was to be completed in June.
6/5/12 - The nurse documented that the consumer was talkative, socialized with peers and staff. He has no medical concerns. He was in a good mood. He attends the workshop Monday through Friday.
6/12/12 - The QSP documented that the consumer had eye surgery at the teaching hospital. Follow-up appointments were scheduled.
6/19/12 - The QSP documented that the consumer had a medication review at the psychiatric unit at the teaching hospital. Ativan was increased back to 1.0 mg, 3 times daily.
7/2/12 - The nurse documented last p.m. the consumer became very violent and tore up the home. He attacked a DSP and bit her, causing the DSP to go to the ER. The consumer went by ambulance to the hospital. He has been admitted to the psychiatric unit. His mother was called at 9:05 to be sure she knew. She stated she already knew that they had called her at 1:30 a.m. and she had talked to the hospital staff this a.m.
7/6/12 - The nurse documented the consumer returned to the CILA with a prescription for Zoloft.
7/7/12 - The nurse documented the consumer was up and about. He was alert and oriented. He stated he was glad to be home. He had a calm demeanor. He was talkative and denied any discomfort. It was observed that he apologized to the DSP he assaulted.

The HRA reviewed the Individual Support Plan (ISP) and Behavior Management Plan (BMP) dated 9/14/11. It was not completed with the consumer's POA agent/parent. It did list the name of a third party, but it did not list providers of services to the consumer from outside the agency. The ISP was not signed by anyone including the QSP, the individual or his agent.

The BMP was completed by a physician who was a behavior specialist and QSP. It was not completed with an interdisciplinary team which should include the individual, his parent/POA agent and other staff who have worked directly with the individual both at the program and the individual's residence. In the third page of the BMP plan there was a directive that if the consumer exhibited physical aggression that placed others at risk or injury, to call 911

and request assistance. There were no notes regarding the consumer from human rights committee or the behavior management committee.

The HRA requested the medical administration record's from 12/2011 through 6/2012. The agency could not locate the MARs for 12/2011, 1/2012 and 2/2012. The HRA followed up with the pharmacy to see if medication would have been returned and if there would have been a count of the returned medication. The HRA was advised that it would have been destroyed because it was not a controlled substance. They did not deliver the discontinued medications in question.

Bureau of Accreditation, Licensure, and Certification (BALC) Survey 1/7/13-1/9/13

In the survey there were reviews that were completed after the incidents in this case. They are included in the report to show the strides that the agency has made. They do not address missing MARs, or the individual's specific issues.

" 59 IL ADC 115.220 c) 2 – The agency did not link individuals to resource and services to meet their needs because the behavior intervention plan was not developed by behavior specialist/psychiatrist and team input.

59 IL ADC 115.240 m) – There was no documentation in the record that the individual/Guardian has been apprised of medication benefits, risk, and side effects with the signed statement that they were provided.

59 IL ADC 115.320 c) 3 – Due to the behavior plan not being valid there's no way to determine if the plan contains objectives and methods for use of positive intervention for exhibiting behavior actively and ultimately eliminating behavior, reviews from both the behavior management committee and human rights committee to determine if plan restrictions outweigh the individual rights. There was no documentation that the current plan was explained to the individual/Guardian.

59 IL ADC 115.240 – the registered nurse (RN) did not train the direct service personnel in medication programs for clients. There was no PRN [as needed] and maximum dosage… There was no documentation of follow-up. There was no policy that medication would be given by RN, license practical nurse, physician, license practical registered nurse. There was a lack of privacy during the medication pass. During the medication pass, expired medications were in the medication box. The medication label did not match the MAR….

59 IL ADC 115.300 c – the following clean and life/safety issues were noted in the home where the consumer lived. In the bathroom on the main floor the baseboards by the toilet were coming off the wall. Facing on the cabinets were coming off and needed to be reattached the medicine cabinet mirror was broken. There was a large discolored mirror. The water temperature for the hot water heater was at hundred and 120°. The stove area needed to be cleaned. The dryer exhaust pipe needed to be cleaned.

59 IL ADC 119.240 g) 4 – in 1 of the 2 records BMC and HRC reviewed and approved the behavior program to manage with medications that was invalid.

59 IL ADC 119. 245) a – the HRC did not meet and supply minutes consistently every 90 days.

59 IL ADC 119.255) a – the building used by the agency was not safe and clean. The water temperature was 120° (corrected)."

All violations were to be corrected. A written plan of correction compliant with the criteria for submission of a plan of correction must be submitted to the Department of Human

Service on or before 2/11/2013 and for the CILA 1/21/2013. The survey was signed by the administrator on 1/9/2013.

The agency responded by 1/8/13 and documented that they had completed all repairs.

On 1/9/2013 DHS/BALC documented an on-site review. In a letter to the agency on 2/15/2013 it stated: "The department considers the home (where the consumer had lived) to be in compliance with section 115. 300 of the civil rule and capacity appropriate for 8 individuals, 0 non-ambulatory."

It continued by stating: "Although the sites have been found to be in compliance, your agency's current status with the Department is 'suspended'. Due to the status, your agencies still a program cannot receive referrals or accept any individuals for placement until further notice from the Department."

On 3/7/2013 DHS announced via email "The Department of Human Services' Division of Developmental Disabilities has completed a re-review of Neighborhood Opportunities' Community Integrated Living Arrangement (CILA) program. As a result of that re-review, the previous prohibition of enrollments in its CILA program has ended effective immediately."

Policy Reviews

The HRA reviewed the following policies:

Department of Human Services Rights of Individuals (R-6-11)
Policy #625 A Human Rights Committee (No Date)
Policy #W629Behavior Development and Management (No Date)

The HRA had requested, but was not provided any grievance procedures, any policy on family involvement and any policy regarding medication.

CONCLUSIONS

Regarding **Complaints 1. and 2. There are issues surrounding abuse and neglect of an individual with a disability and an individual with a disability was unable to access adequate and humane care**. Per the Mental Health Code in 405 ILCS 5/2-112: "Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect." Per the documentation on 3/19/12 the consumer hit another individual and that individual had hit him back. This happened during a period of time when the consumer's psychotropic medication was being adjusted. Maybe no one could have anticipated the consumer's specific behavior that evening, but this consumer had a history of violent and aggressive behavior. The individual service plan or behavior management plan included the QSP and the QSP for day training, but failed to include the participation of staff who worked directly with the consumer at the individual's residence. Per section 115.220 a) "…The Community support team (CST) shall consist of the QMRP or QMHP, as indicated by the individual's primary disability, the individual, the individual's guardian or parent (unless the individual is his

or her own guardian and chooses not to have his or her parent involved, or if the individual has a guardian and the guardian chooses not to involve the individual's parent), providers of services to the individual from outside the licensed CILA provider agency, and persons providing direct services in the community."

Per some of the notes, the parent/POA agent may not have been always available, however there was no evidence in the record that the parent was invited to participate. **Section 115.230 Interdisciplinary process** f) states: "Within 30 days after an individual's entry into the CILA program, a services plan shall be developed that: 1) Is based on the assessment results; 2) Reflects the individual's or guardian's preference as indicated by a signature on the plan or staff notes indicating why there is no signature and why the individual's or guardian's preference is not reflected;" The ISP was not signed by anyone. Per section Section 115.230 Interdisciplinary process for CILA rules j) "The services plan shall be signed by the QMRP and the QMHP and the individual or guardian."

The Code in section 405 ILCS 5/2-102(a) states: "A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient. The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the treatment plan. 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." Neighborhood Opportunities failed to protect the consumer's rights by not including his parent/POA agent, the behavior management committee or human rights committee to participate in the development of a safe behavior management plan.

The situation was exasperated by the failure of staff to do anything when this consumer eloped from his home at 3:00 a.m. The consumer's violent behavior showed that he could be a danger to himself or others. Per the police report the consumer stated in front of the police officer, he wanted to fight the other individual again and he wanted to hit people. Per the Code in 405 ILCS 5/1-101.2: "Adequate and humane care and services" means …services reasonably calculated to prevent further decline in the clinical condition of a recipient of services so that he or she does not present an imminent danger to self or others." Section 115.320 d) 1) under Administrative requirements for training, states: "Direct service employees and any other compensated persons with responsibility for direct care of individuals served shall demonstrate competence in training areas listed in subsections…." "…C) Safety, fire, and disaster procedures; D) Abuse, neglect and unusual incident prevention, handling and reporting…."

The record shows that when the consumer was discharged from the ER he was to see his regular physician within 1-2 days. However it was 17 days later before the follow-up occurred. It was the consumer's right to have timely treatment. The agency failed to protect the safety of the individual and others by not following the Code, CILA rules or ER orders. Based on the evidence in the record both **Complaints 1 and 2. There are issues surrounding abuse and**

neglect of an individual with a disability and an individual with a disability was unable to access adequate and humane care are substantiated.

The HRA makes the following recommendations:

1. **Ensure that appropriate individuals and committees are involved with decision-making and treatment planning consistent with the Mental Health Code, and CILA Rules per section 115.220 a). Include them in the development of individual support plans and behavior management plans. Invite guardians, POA agents and other individuals designated by the recipient to treatment plans; document such invitations. Confirm participation via signatures on treatment plans.**
2. **Provide to all staff including management, human rights training regarding consumers' rights to adequate and humane care pursuant to their individual services plans.**
3. **Have safety and emergency plans in place for emergency situations so that adequate and humane care could be provided per the Code and CILA rules 115.320 d) 1).**
4. **Provide timely follow up to ER visits to ensure the provision of adequate care.**

The HRA makes the following suggestion:

1. **Develop procedures that permit individuals, family members, and guardians to present grievances and appeal decisions to deny, modify, reduce or terminate services pursuant to Section 115.250 c) Individual rights and confidentiality CILA Rules which states "Individuals or guardians shall be permitted to present grievances and to appeal adverse decisions of the agency and other service providers up to and including the authorized agency representative."**

Regarding the third complaint, **an individual with a disability was given medication which had been discontinued by his physician.** Neighborhood Opportunities was unable to provide the MAR for 12/2011, 1/2012, and 2/2012. Pursuant to the Administration of Medication in Community Settings, 116.70 b) of the Medication Administration Record and Required Documentation**:** "1) An individual medication administration record shall be kept for each individual for medications administered….2) The medication administration record for the current month shall be kept with the medications or in the individual's clinical record. If logs are kept in the individual's clinical record, the record shall be present when and where the medications are taken so that the appropriate notation can be made in the log….c) In the event of a medication error, authorized direct care staff shall immediately report the error to the registered professional nurse, advanced practice nurse, physician, physician assistant, dentist, podiatrist, or certified optometrist to receive direction on any action to be taken. All medication errors shall be documented in the individual's clinical record and a medication error report shall be completed within eight hours or before the end of the shift in which the error was discovered, whichever is earlier. The medication error report shall be sent to the nurse-trainer for review and further action. A copy of the medication error report shall be maintained as part of the agency's quality assurance program. Medication errors must be reported to the DHS Bureau of Quality Enhancement…."

Because of the agency's failure to keep adequate records as required, there is no evidence of giving services as prescribed per Section 116.50. **The HRA could not determine if this individual was given medication which had been discontinued by his physician, but the failure to keep adequate documentation regarding medication administration is substantiated as a rights violation.**

The HRA makes the following recommendations:

1. **Develop a plan for the safe keeping of medication administration records as required in Rule 116. This not only protects the individual's rights, but confirms Neighborhood Opportunities' provision of services.**
2. **Review 59 IL ADC Part 116 Administration of Medication in Community Settings with all management and with the staff who administer medication.**

The HRA makes the following suggestion:

1. Review individual's rights to confidentiality and the right to inspect one's record pursuant to the Confidentiality Act. The consumer has a right to see his record so you must maintain a full record. The failure of the agency to preserve records does not allow an individual to exercise this right.

The HRA would like to thank Neighborhood Opportunities for their cooperation with this investigation.

RESPONSE

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

STATE OF ILLINOIS
Pat Quinn
Governor

GUARDIANSHIP & ADVOCACY COMMISSION
Dr. Mary L. Milano, Director

HUMAN RIGHTS AUTHORITY
LEGAL ADVOCACY SERVICE
OFFICE OF STATE GUARDIAN

REGIONAL HUMAN RIGHTS AUTHORITY

HRA CASE NO. 12-060-9015

SERVICE PROVIDER: Neighborhood Opportunities

Pursuant to Section 23 of the Guardianship and Advocacy Act (20 ILCS 3955/1 *et seq.*), we have received the Human Rights Authority report of findings.

IMPORTANT NOTE

Human Rights Authority reports may be made a part of the public record. Reports voted public, along with any response you have provided and indicated you wish to be included in a public document will be posted on the Illinois Guardianship and Advocacy Commission Web Site. (Due to technical requirements, your response may be in a verbatim retyped format.) Reports are also provided to complainants and may be forwarded to regulatory agencies for their review.

We ask that the following action be taken:

✓ We request that our response to any recommendation/s, plus any comments and/or objections be included as part of the public record.

_____ We do not wish to include our response in the public record.

_____ No response is included.

Erin Kelly
NAME

Adm
TITLE

1/13/14
DATE

Neighborhood Opportunities, Incorporated
160 West Station Street
Kankakee, Illinois 60901
815-936-1566
FAX 815-936-6214

To Whom It May Concern:

In response to the allegation in Case# 12-060-9015, a Doctor's appointment was made at the earliest appointment available. This individual constantly aggravated his peer which resulted in a fight. When an opening was available for the agency to move him away from this peer, it was completed.

We had explained to the individual's mother that a bed that was in another home that appeared to be available, was in fact belonging to another individual who was temporarily at a nursing home, and thus making his bed a bedhold. He unexpectedly passed away. After the paperwork was completed, we transferred her son to the new home hoping to alleviate the problem. This individual's behavior did not change and he continued to be aggressive in his new home.

This individual was his own guardian and everything clinical had been reviewed with him.

All staff members currently are in-serviced to the policy regarding Abuse and Neglect. This is done upon hire and quarterly, thereafter.

Policy 6.04, Individual Service Plan (ISP), includes invitations to guardian in Section 3, #2. He was his own guardian and was notified. Currently all invitations are documented and ISPs are signed within the timeframes designated by DHS. The QIDP writes the ISP with input and approval from the family, individual, and ISSA.

Policy 6.25, Human Rights Committee, includes the makeup of the committee as required by DHS. Its purpose is for the agency to review the behavior plans and interventions with all the behavior plans. Currently we have the proper makeup of committee members and all minutes from the meetings are on file. The committee meets generally the last Wednesday of the month following the end of the quarter. These dates are posted on a wall calendar just inside the main office.

Policy W6.29, Behavior Development and Management, requires the agency to ensure proper implementation. Currently the behavior plans are written by a behavior specialist

with input and approved by family, the physiatrist, and the behavior committee. The Behavior Management committee (along with Quality Assurance) meets generally the second to last Wednesday of the month following the end of the quarter. These dates are posted on a wall calendar just inside the main office.

In-Service training has been completed by the staff regarding safety and emergency situations. This is completed bi-annually.

Resident rights are reviewed with staff upon hire and annually thereafter. Every individual signs and is given an Illinois form 462-1201, Rights of Individuals, upon admission to our CILA program.

All staff has been re-trained regarding medication administration. This retraining was started in Sept 2012 and is a continuing on going practice by the nurse trainer. All medications are locked in a med cabinet and a closet as required by DHS.

Med errors are reviewed by the nurse trainer and are reviewed by the Quality Assurance Committee. All records, to include MARs, are now kept in the main office for safekeeping once the current month is over.

Respectfully submitted,

Rita Kelly

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