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East Central Human Rights Authority
Report of Findings
Case 14-060-9008
Shelby County Community Services, Inc.

The East Central Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegation concerning Shelby County Community Services, Inc.:

An individual with a disability was not given his medication which had been prescribed by his physician.

If found substantiated, the allegation represents a violation of the Mental Health and Developmental Disabilities Code (405 ILCS 5) and the Department of Human Services' Medicaid Community Mental Health Services program regulations (59 Ill. Admin. Code Section 132.150). The agency indicated that it also applies Community Integrated Living Arrangement (CILA) regulations (59 Ill. Admin. Code 116) as they pertain to medication errors for residents who reside in supervised apartments.

Shelby County Community Services, Inc. provides a range of services to persons with both developmental disabilities and mental health needs, including residential, vocational and counseling services. The complaint concerns a residential site, called Cornerstone that provides supervised apartments for 12 individuals.

The complaint alleges that on January 3, 2014 an individual's medication was found by his guardian, on the floor of his apartment. The individual is visually impaired (legally blind). He has other disabilities which include mental impairment and mental illness. The pill was green in color and it had the marking of the number 47. It was shown to a staff person at the apartment. The staff put it in an envelope. It was then placed on the medication cart. The medication at the apartment had been passed out by registered nurses hired by Shelby County Community Services. The residential manager was contacted. The guardian attempted to discuss what was found and allegedly was told it may be a pill that the individual did not need. The guardian was advised that it would be discussed with the nurses who dispensed the medication. It was determined that the medication was a Losartan 100 mg pill, the individual's high blood pressure medication. There were no return phone calls from the manager to the guardian per the complaint.

According to the complaint, the medication protocol was for the nurse to dispense medication into a black bowl on the individual's table. The individual could reach in the bowl to retrieve the pills. This would be supervised by the nurse. The individual takes 12 ½ pills in the morning.

To investigate the allegation, HRA team interviewed agency representatives, examined pertinent documents and toured the vocational and residential programs.

FINDINGS

The HRA was provided a tour of the supervised apartments. Information regarding resident rights and Office of the Inspector General (OIG) were posted.

In a meeting with agency representatives, the HRA team learned about the agency's services. The agency sponsors a developmental training program for individuals with both developmental disability and mental health diagnoses. Approximately 55 individuals participate in developmental training and an additional 27 individuals do contract work. The agency sponsors a mental health clinic for children and adults along with an activity/drop-in center for persons with mental health needs. There is also a crisis team. They have an outpatient substance abuse clinic. The agency sponsors 2 group homes and a supported apartment program. The apartment program serves 12 individuals. There is an agency staff person always available to the apartment residents, if not in person, by phone. In addition, an on-call nurse is available 24-hours per day. Apartment residents receive case management, medication management, counseling, and transportation services. They serve approximately 400 people. There are approximately 70 employees providing client services.

Per the leadership of the agency, staff are trained to provide adequate and humane care. Before anyone is allowed to work with a client they are provided the DSP (Direct Service Personnel) training module and the OIG training. They provide OIG training annually and to new hires. There is regular in-service training with staff refresher training on abuse/neglect and consumer rights.

The HRA shared that we had asked a staff person what could have caused the medication error. The staff shared that nurses are required to carry the on-call phone, which can be distracting when passing out medications. The leadership staff stated they would create a policy that would stop nursing staff from carrying the phone while they pass out medications as a result of the HRA investigation.

The HRA asked about the alleged statement that maybe this was not a pill the individual needed. The residential manager denied making this statement. She stated she had asked if the individual was safe and did he need to go to the emergency room or see a physician. Per her statement, she was told by the guardian that the individual was safe.

The HRA inquired if anyone considered that another individual could have found and taken the dropped medication. Staff responded, "no," because consumers are provided education on taking medication as part of their regular programming. Side effects of medication are part of

the education process for individuals served. The incident was documented on a medication error report since there were no adverse effects.

The HRA asked when nursing staff were notified of the medication error, because per the complaint, one of the nurses did not know for over a week. The nursing manager was aware and shared with other nurses right away. She could not reach one specific nurse because she was off work during that week.

When asked what the policy is for notifying the guardian about medication errors, the HRA was told that a guardian would be notified immediately. In this case the guardian was the one who discovered that a medication error had occurred.

The HRA raised two concerns that came up after the investigation. The first was an allegation that staff have been yelling at residents. The HRA was advised by senior management that at no time would it be tolerated for staff to yell at a resident.

The other issue was about assisting the individual with his hearing aid. Supposedly the hearing aid had been found on the medication cart on more than one occasion when the individual should have been wearing it. It was discussed that if the nurses passing medication could focus on the individual during the medication pass, the hearing aid would be provided.

The HRA team made a follow-up impromptu visit and talked to the residents privately. The HRA asked quite a few individuals if they liked living at Shelby County CILA homes and apartments and how they were treated by staff. Most residents stated they liked all of the staff. Some stated they didn't always like a peer, but all seemed to have very positive interaction with staff. When the HRA made the visit, some of the staff were taking their lunch period with the individuals served. Interaction between staff and the individuals seemed very positive. Resident rights and OIG information were dispersed throughout the home and the day training center.

The HRA team observed individuals performing meaningful work. This included weaving rugs, gardening in the greenhouse, working with plastics and at various other full-time, paid jobs.

Records Reviews

The HRA reviewed the documentation of medication administered by staff, the medication error report and the physician's orders. The medical administration record (MAR) did not show that the individual missed a dose of his Losartin 100 mg tablet, even though he clearly did because of the pill being found on the floor. It was documented on a medication error report, provided by Department of Human Services (DHS) and placed in his file. Since there was not an adverse outcome it was not faxed to the DHS Bureau of Quality Management per section 59 Ill. Admin. Code 116.70 c. On the medication error report used by the provider to document the error, under Directions, it stated: "In accord with rule 116, CILA providers must document all medication errors. In addition, all medication errors for which there is an adverse outcome to the person receiving services must be reported to the Division of Developmental Disabilities' Bureau of Quality Management. This form must be completed for each such error. Adverse

outcome errors must be faxed to (217) 782-944 within 7 calendar days of discovery. It is not necessary to notify BQM of errors for which there is on adverse outcome. However, errors for which there is no adverse outcome must be documented and reviewed by the RN-trainer and summarized annually on at least a quarterly basis by the agency."

The HRA reviewed the recipient's Self-Administration of Medication Assessment (SAMA); it documented that he was unable to identify rules for safe self-administration of medication. Safety rules include whether or not an individual indicates that he would not share medication or take someone else's medication. The assessment did indicate he would perform the task of taking the medication. The HRA reviewed one of the individual's goals regarding a specific medication. It included saying the name of the medication, the side effects of the medication and punching out the medication itself. Included was the documentation that nursing assisted the individual with this goal.

The HRA reviewed the side effects of the medication published by PubMed.gov from the US. National Library of Medicine National Institutes of Health. Per the website it states: "Losartan is used alone or together with other medicines to treat high blood pressure (hypertension)…." Regarding side effects "**Call your doctor right away if you notice any of these side effects:**

Allergic reaction: Itching or hives, swelling in your face or hands, swelling or tingling in your mouth or throat, chest tightness, trouble breathing

Change in how much or how often you urinate

Confusion, weakness, uneven heartbeat, trouble breathing, numbness or tingling in your hands, feet, or lips

Fast, slow, or uneven heartbeat

Lightheadedness, dizziness, or fainting

Rapid weight gain, swelling in your hands, ankles, or feet

Unusual bleeding, bruising, or weakness

If you notice these less serious side effects, talk with your doctor:

Back pain

Diarrhea

Cough, stuffy or runny nose, or sore throat

Tiredness."

The HRA reviewed the provider's calendar of in-service training which showed multiple trainings on the Health Insurance Portability and Accountability Act (HIPAA), the prevention of abuse and neglect, various training modules, quality assurance training and Office of Inspector General training.

Policy Reviews

The HRA reviewed the *Medication Pass Policy & Procedure for Cornerstone Residents (1/2014).* It documents that "The nurse is to monitor the individual taking and swallowing his/her medications. The nurse returns bubble cards back into the med cart and locks cart. The nurse signs off on the MAR."

The HRA received a copy of a new policy after the site visit which addressed the concerns and the discussion held with senior management about the nurse carrying the on call phone while she is passing out medications. In *On Call Phone Procedure Change during Medication Administration (2/19/14)* it states "The on call phone is no longer to be carried by the nurse while the nurse is doing a medication pass….At no time will the nurse be managing the on call phone while the medication pass period is occurring.…The nurse administrating the medications is to solely concentrate on the medication pass is to be free of the distractions and should refrain from conversing with others while engaged in the mediation pass unless it is necessary to do so for the safety of the individuals being served." Included with the policy was documentation of a meeting with all nursing staff to discuss the need to reduce/eliminate medication pass error distractions. Meeting notes documented the issue of the medication being found on the floor. There was documented discussion with the nursing staff for nurses to actually watch all individuals swallow their medications. All nurses acknowledged, verbally and in writing, the new policy.

CONCLUSION

Per the Mental Health and Developmental Disabilities Code, all recipients shall receive adequate and humane care and service, pursuant to individual services plans (405 ILCS 5/2-102).

In section 405 ILCS 5/1-101.2 of the Code it states: "'Adequate and humane care and services' means services reasonably calculated to result in a significant improvement of the condition of a recipient of service confined in an inpatient mental health facility so that he or she may be released or 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."

Per the Department of Human Services' Medicaid Community Mental Health Services Program regulations, Section 132.150, Treatment services, c) Psychotropic medication services 1) Documentation requirements C) state: "Notations shall be made in the client's clinical record regarding psychotropic medication and other types of medication. Notations shall include: All medication prescribed for the client; Any problems with psychotropic medication administration and changes implemented to address these problems; A statement indicating that the client has been informed of the purpose of the psychotropic medication ordered and the side effects of the medication; and Assessment of the client's ability to self-administer medications."

In section 3) for Psychotropic medication administration service it states: "Psychotropic medication administration consists of preparing the client and the medication for administration, administering psychotropic medications, observing the client for possible adverse reactions, and returning the medication to proper storage. Psychotropic medication administration services must be provided face-to-face. Psychotropic medication shall be administered by personnel licensed to administer medication pursuant to the Nurse Practice Act [225 ILCS 65] or the Medical Practice Act of 1987 [225 ILCS 60]. Specific documentation of the delivery of psychotropic medication administration service must include a description of the activity."

In this case the provider did have an issue in which nursing was distracted while passing out medications. In the individual's SAMA it was documented that he was unable to identify rules for safe self-administration of medication even though he received training on medication administration. There is a reasonable possibility that other individuals living at the apartments would also be at risk for sharing medication with others or possibly taking someone else's medication.

The HRA cannot substantiate the statement allegedly made by the residential manager based on one person's word against another. However when the medication error was discovered, nursing or other professional medical staff should have assessed the individual to receive direction on any action to be taken per the agency's medication error report, provided by (DHS). This medication error report was signed by the manager and nursing, but there was no evidence that the individual was assessed. Pursuant to section 132.150 part 3) the individual should have been observed for possible adverse reactions. His MAR incorrectly documents that the medication in question was given.

The HRA **does <u>substantiate</u> that an individual with a disability was not given his medication which had been prescribed by his physician.** At this time the Shelby County Community Services has made reasonable efforts to improve services and has already taken corrective action to address the medication issue. Per the record, staff were trained and acknowledged both verbally and in writing of the new policy created to reduce the distractions so that an accurate medication pass could be conducted on behalf of the individuals served. **The HRA makes the following recommendations regarding medication errors:**

1. **If a medication error is made, upon discovery, the client should be observed for possible adverse reactions per IL 59 ADC/Section 132.150.**
2. **Notations in the MAR should reflect accurate documentation.**

The HRA takes this opportunity to make the following suggestions:

1. Reasonable efforts should be made by staff and documented in the record to encourage and assist the individual with wearing his hearing aid.

2. When conducting a medication pass with this individual have a pill count, consider using a bowl that has a contrasting color to the pills being administered and place a towel underneath the bowl to catch dropped pills.

The HRA appreciates the full cooperation of the staff at Shelby County Community Services. The HRA commends the agency for efforts to provide meaningful paid employment for individuals served. The HRA also commends the staff of the agency for being interactive and relational with individuals served during staff lunch periods and breaks.