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HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case #16-090-9012
ResCare

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving complaints of possible rights violations involving a resident receiving services at ResCare. The allegations were as follows:

1. Inadequate guardian involvement, including guardian not provided psychiatrist name and contact information.
2. Inadequate treatment.

If found substantiated, the allegations would violate the Community Integrated Living Arrangement (CILA) regulations (59 Il Admin Code 115), regulations regarding administration of medication in community settings (59 Ill. Admin. Code 116.50 & 70), the Probate Act of 1975 (755 ILCS 5/11), the Community-Integrated Living Arrangements Licensure and Certification Act (210 ILCS 135/9.1) and the Nursing Care Act (68 Il Admin Code 1300.350). The Peoria ResCare office has homes in Peoria and Pekin but the larger company covers the United States. The Peoria office serves 22 residents in 6 homes and employs 44 staff members including management and nursing.

Complaint Statement

The recipient has been in a ResCare group home since June and the recipient's guardian was reportedly not allowed to speak with the psychiatrist that oversees the facility. The facility allegedly never follows through with allowing her to speak with him and would not provide the name and contact information for the psychiatrist. On one occasion, the guardian discovered that the psychiatrist had been at the facility and asked why she was not contacted to speak with him and was told that they forgot. The facility also reportedly stated that they do not have the psychiatrist's telephone number and the agency nurse will not return the guardian's phone calls. The guardian finally was able to speak with the psychiatrist 8 months after the recipient's admission. Also, the facility is reportedly not sending out quarterly statements about money to

the guardian and will not send the guardian copies of rent receipts needed to send to social security.

Allegedly, the recipient is also to receive bloodwork every 3 months and an electrocardiogram (EKG) twice a year but has not received them. The last EKG was in March 2015 and the complaint date is in December 2015. The facility stated that the tests are unnecessary if the physician does not want them and believes they are not needed. The patient's medication was prescribed in February 2015 by a psychiatrist who reportedly has not seen the patient since. The facility told the guardian that the psychiatrist provided prescriptions for a year in advance. The recipient is also supposed to take two fish oil pills, twice a day, but is only taking two pills, once a day as per the complaint. The recipient attempted to correct the situation but staff reportedly did not comply. The recipient is also supposed to receive 87.5 mg of Thorazine at 8am but has allegedly only been provided 37.5 mg with another 50 mil at 12 o'clock, a change without a physician's order. The recipient told staff that he was supposed to take the full dose at 8am but the staff told him there is no "mark sheet" for it. Currently the facility does not have their own nurse and are using nurses from sister offices and agencies which is causing problems with medication times. A nurse said that she would take care of this issue but all she reportedly did was cross off the noon medication time. Staff would not give the recipient the other 50 mg in the morning. There is no "mark sheet" that indicates the patient receives the 50 mg in the morning, just the 37.5 mg. Also a new nurse from another agency gave the recipient 4pm pills and 8pm pills at the same time. Additionally, the recipient pulled a muscle in his chest and was prescribed pain medication, but the medication was allegedly not picked up from the pharmacy for three days.

The ISP team also determined that the recipient could have 3 hours alone time but the facility has not been following the ISP regarding the time and a facility administrator said that no recipient is supposed to have alone time as per the complaint. The determination that the recipient was to have alone time was because staff were reportedly becoming upset waiting on a job coach to pick up the recipient. Allegedly they were punishing the recipient by making statements to his face. They allegedly called the recipient "Mr. Snitch." Additionally, the recipient's day program takes him home between 3:30pm and 4pm and they have not let the recipient off the bus because staff were not at the facility. Once the bus had to take the recipient to a different house and on another occasion, the staff pulled up at the facility while the bus was waiting.

<u>Interview with staff – Previous facility administrator (3/4/2016)</u>

The administrator explained that when she started at the facility, everyone quit except for one other staff member. When this occurred, she did not even know which residents had a guardian but eventually she found one partial guardian list. As far as the staff, the administrator was new and there was a nurse who started two days before she had. Also they did not have a Qualified Intellectual Disabilities Professional (QIDP). She had to hire a brand new staff and all but one of those individuals also quit the facility. The administrator started the job in August at the time of the first complete turnover and then the second turnover started in February. She said there was a new executive director who had more presence and expectations but otherwise did not know why either group of staff left.

The administrator said that even though the staff left, there was coverage at the houses and the managers had to cover the houses. Now the houses are fully staffed and they have one

new nurse that covers the 6 homes. Some of the facility Direct Support Personal (DSP) are certified to pass medications under the nurse but some are not and some of the DSPs are not medication trained. The nurse assures that the medications and medication administration records (MARS) are at the facility. If there is an incident, she is contacted. The DSP goes through training to get certified to pass medication through the Illinois Department of Human Services (IDHS). Physicians make the medical orders and they are carried out by nurses at the homes. If a resident was taken to an urgent care facility and given a prescription, the nurse is contacted and she picks up the medication and adds it to the MAR. They cannot give medication that is not on the MAR. The nurse has a list of over the counter medications that are approved by physicians. The facility nurse can take the medication pass privilege away.

The administrator said that the resident's issue with the medication went on for a long time under the past nurse. The facility uses its own pharmacy, and the pharmacy made an error about the amount that the resident received and the nurse was trying to get the issue corrected. The administrator spoke with the resident's guardian about the issue. The administrator said that there were several different packs that make up the amount of medication that was taken. The issue was not overlooked; there was contact and answers provided. The nurse was not splitting the medication between times, he was getting the full amount but they were in separate packs.

The administrator explained that the psychiatrist examines patients in the Peoria ResCare office and sometimes he only reviews medications with the nurse. Residents never go to his office. Staff would be given a document stating which resident the physician was examining that day and then they would bring that person to the office. The psychiatrist deals with the nurse on all issues and most interactions are with her. Parents and guardians were notified of the appointments. The physician comes to the facility every couple of months. The administrator believed that the resident's guardian did speak with the psychiatrist but she was not sure if the psychiatrist's number was provided to the guardian. The administrator also did not know that there was an issue. She explained that once an appointment was changed and there was confusion on when the physician was coming to the facility, but that was the only time that facility staff did not know he was coming. The administrator was not aware of the amount of time it took the guardian to be able to contact the physician.

The administrator said that now they contact the residents' guardians and meet with them as soon as there is an issue and this specific guardian communicates with the facility often. They honor every request asked of them. They do not document every conversation but there are post-it notes that were taken for important parts of the conversation. They also do have some progress notes in the houses. The staff is going to look into keeping a ledger or a log to keep track of phone calls and other items. They do keep track of when the residents are seen by the physician. They tried to explain to the resident's guardian that if it is not on the MAR, then they cannot provide the medication. They have worked to have the fish oil added to the MAR and it is now on the list. The resident's guardian also speaks with the psychiatrist now but she does not know what happened previously. The staff also tells the guardian when the resident has been seen. The administrator said that the psychiatrist comes quarterly and they believed that he provides reviews to the consumer, nurse and guardian if they are all available. The psychiatrist does not speak to the guardian unless the guardian wants him to. The administrator said that she did not know what was done at the facility before she started the job. She said that since August there has been guardian involvement. She explained that the guardian can talk on the telephone with the physician and the new nurse will be reminded to contact the guardians about the appointments. They have a phone in the room that is available for a conference call. The

administrator made the guardians aware of the turnover at the facility and that the nurse had changed. The facility physician is contracted.

The administrator did not know what the process was before she worked at the facility but she was taught to use the Resident Financial Management System (RMNS) where they have access to client accounts. She had heard that residents were not receiving statements before. The statements came from the main office in Tilton. She explained that they would make a request and it would take 24 hours before the QIDP receives an email stating that the residents have funds and a check is printed that can be cashed. The business manager overnights the checks. The administrator stated that previously, she had heard that the residents were not receiving the money. There were a couple of guardians who said that they were not receiving statements and they had made requests for the statements. The Peoria office called the main office to make them aware of the requests when they heard the complaint. The administrator was unsure whether the statements were supposed to be sent monthly or quarterly. The administrator said that she believed residents are supposed to automatically get the financial statement but she thinks it has been inconsistent and has gotten better. The rent receipts also come from the Tilton office and the Peoria office does not deal with the receipts.

The administrator said that she believed that there was no order for an EKG and bloodwork. The nurse communicates to the managers about what is occurring with these situations. The nurse would have to communicate with previous physicians and they would have to get a local physician if the order was a transfer. When there are major health needs that need taken care of, the guardian generally has the issue taken care of at home and the guardian has been in charge of speaking with the physician and taking care of the situation. The resident has been at the facility since 5/28/2015 and the administrator said that there was nothing addressing the EKG in the book. The guardian kept insisting that the resident needed an EKG but she was told it needed to be prescribed. They have not heard that he is on any medication that requires bloodwork. The resident has been seen every 3 months but sometimes he wants his next visit sooner. He was seen by the physician in June, August, November and in January. At that time, they could not find a history of bloodwork. The administrator had said they had not heard about prescriptions being sent out a year in advance. The facility nurse participated in the interview and stated that on her first day, she brought pain medications that was prescribed for the resident's side to the home. The facility was on a medication freeze because they did not have an RN. It was explained in a subsequent interview a DSP can receive training to give medication if there is an RN or LPN on staff because they are providing medication under their license. If there is not RN or LPN on staff, as in this situation, medication cannot be provided. The medication was probably picked up but was held up because it was not explained to the staff or added to the MAR by a nurse. There is an education sheet in the house for the DSP regarding administering medication. Even if the nurse was there, the medication would need documented on the MAR before it is given to the resident. They cannot give an MAR without physician's orders. Staff said they did not know the date that the medication was called into the pharmacy.

The administrator said that the resident receiving alone time was discussed in the ISP and since then, the agency director said alone time is not allowed. The administrator said that she was waiting to have the rule clarified. They think that the resident could handle the alone time but they do not want to be noncompliant with policy. Not every resident has that option and it was in place when the administrator started at the facility. It was discussed but, since then, there was new leadership and the new agency director thought they could not leave the resident alone,

so he was going to receive guidance on the issue. The administrator was not sure how long the resident has been without alone time but she believes it was 2 months.

The administrator had heard that staff retaliated against the resident but they denied that it occurred. The administrator said that she questioned staff and asked other people. They do not condone people being mistreated and after that incident, they moved the staff from the house so that the resident and the guardian would feel more comfortable. The administrator stated that people said they did not hear the statement made by staff so it could have been passed along through other people. The residents pass information along to each other and to staff. The administrator stated that staff receive Illinois Department of Human Service training and also the Illinois Office of Inspector General abuse and neglect training. They also receive training on human rights, individual service plan training and training on basic health and safety.

The administrator discussed the allegation regarding staff not being present when the resident was dropped off, and admitted there was one day that staff were not there. They were not aware that staff were not at the house and they received a call and sent staff to the facility. To remedy this occurring, they made one drop off spot for all residents. The staff was in-serviced and retrained about being on time and there was discipline. Staff is now to walk them out to the bus and greet them when the bus drops them off. This has not happened again since that incident. What occurred is a staff person failed to notify that they would be late. Houses are staffed with 2nd and 3rd shift staff and, based on the need, the staffing is 1 to 4, but one house only has two consumers. 3rd shift sends the residents to work and then the 2nd shift greets the residents when they return. One house has a 1st shift. The 3rd shift staff works from 11pm until 7am, but sometimes they work until 9am. The 2nd shift is from 2:15am until 11 or 11:30pm.

Interview with staff – New facility administrator, nursing staff and Regional Quality Assurance Manager (3/22/2016)

Staff said that they have a letter from the general practitioner because this issue has been investigated before and he sent the letter then. They said that as far back as 2008 there was no record of an EKG and one was not needed. The physician told the resident's guardian that he was not aware of an EKG for the resident. The physician had said that there is no laboratory work needed, with the resident's medication. Staff said the statement about the resident having medications a year in advance might be a misunderstanding. Staff explained that non-control medications can be prescribed a year in advance but they could not think of another situation where that makes sense. The resident is on some psychiatric medications and no controlled medications, which has a more stringent process.

The staff explained that the physician allows the resident one capsule of fish oil. The resident's guardian was expecting a different dosage and the amount has been increased to that. The medicine helps with the psychiatric medication and he was receiving a dose for cholesterol. The resident has a general practitioner and a psychiatric physician, who is used by the facility. Regarding the issue with the pulled muscle, the prescription was at the pharmacy but they did not have a licensed professional pick up the drug and add it to MAR. The prescription was given to the pharmacy on February 18th and a new nurse started at the facility on February 22nd who picked up the medication and took the drug to the house. The nurse also completed a medication education sheet and had a verbal conversation with the staff about the medication. The resident was not given the medication after it was brought to the house. They conversed with him and he said that he no longer needed the medication. The medication was a PRN and he would have

requested it as needed. Staff did not know if there is a policy in place for situations such as this where there is no licensed professional able to retrieve the medication. They said that right now, a trained DSP can retrieve the medication. The way the previous nurse left, the DSP was on a medication freeze. All scheduled medication passes were done for other residents because an RN and LPN were contracted to perform the medication passes during that time. They do not know why the RN and LPN that were hired did not pick up the pain medication and staff explained they were not hired during that time frame. Staff explained that when they have annual and quarterly meetings, they try and provide one-on-one education with the family regarding the drugs. Staff said that for the resident's Thorazine, the resident was receiving 37.5 mg at 8am in the form of 25 mg tablets (1 and 1/2 tablet) and also received a 50 mg tablet at 8am. This is according to the physician's order.

Follow up on financial statements – Spoke with Business Manager on 3/14/2016

The business manager stated she has spoken with the guardian on numerous occasions and always sent what was needed. They do not actually have rent receipts. On the financial statements, there something called the "Care Cost Transfer" and when rent is deducted, it says care cost and this has been explained to the guardian. The guardian is the representative payee and when they complete a representative payee form, social security asks how much money was for room and board and how much money was for other items. They have explained to the guardian that $50 is deducted from social security and then the rest is for rent. The guardian has been receiving statements because they sent them to her themselves. They do not know if she had any that were missed. They do not recall what quarterly statements were sent to her, she just knows they spoke to her in the past. They know that the guardian received one in December because there was a large withdrawal that was approved and she received the statement at that time.

FINDINGS

The HRA reviewed resident records and facility policy that pertain to the allegations in this case. The dates the HRA interviewed staff were 3/4/2016 and 3/22/2106.

Complaint #1 - Inadequate guardian involvement, including guardian not provided psychiatrist name and contact information.

The HRA reviewed the assessment section of a psychiatric review form, dated 4/4/2016, that reads the resident "… feels that he is doing well today. Melatonin is helping him sleep. [Guardian] concerned about Chronium has been stopped some time. Day program has concerns about him being drowsy during the day." A written nurse's note stated "[Psychiatric Physician] met with [Resident], per [Guardian's] request on phone. Prescribed supplemental Chromium 200 mg in AM. Melatonin decreased to 5mg. [Resident] insisted he did not want his Melatonin changed, [Guardian] on speaker phone insisted it should be done." Another nursing progress note dated 4/20/2016 discusses an Epi-pen being needed for the resident and the note reads "I reminded her of when she was last (here) and saw [Physician] and there was a medication to be picked up …" The physician named is not the psychiatrist. Another set of typewritten nursing progress notes, dated 3/25/2016, appears to cover a medication error issue and indicates that the

psychiatrist did speak with the resident's guardian on that day. The typewritten nurse's notes also states that on 4/4/2016 there was a meeting with the resident, psychiatrist and the guardian on the phone. That note also reads "[Psychiatric physician] also shared with nurse that if [guardian] is ever abuse to him or his resident or any of his staff on the phone again that he will discharge [Resident] as his patient." These interactions occurred after the HRA site visit.

The HRA reviewed a 2/25/2016 nurse's note where the psychiatrist was told that the guardian insisted on continuing Melatonin so he prescribed a lower dosage and then there was another nurse's note on 3/7/2016 when the guardian was on the phone during a psychiatric examination. On 3/17/2016 there is a nursing note that the guardian contacted the nurse to ask a question about an issue she had heard from a physician. On 1/15/2016 there was a nursing progress note stating that the psychiatrist had come to the facility to evaluate medications and there was no indication either way that the resident's guardian had been there for the appointment and another note on 1/4/2016 states that the physician was there to review discontinued medications but the resident was on a home visit and there were no new orders. Other nurses' notes indicate that the psychiatrist visited the facility at 11/2/2015, 11/12/15 and 11/30/2015 and there was no mention of the guardian participating in those examinations.

The HRA received a Resident Account Family Member statement for the resident and the statement period was from 6/25/2015 to 5/31/2016. There is Care Cost deducted from the resident's money, but for that amount of time, the first care cost was deducted in November and the date it was recorded was 11/18/2015. There were no Care Cost for June and July recorded and August, September, October, December and January were all recorded in January but the date on the description was the month and a date in the month, so the date the Care Cost was recorded as being deducted from the account was in January but the description differed. The dates for the January description were as follows: December was 12/15, January was 1/16, August was 8/15, September was 9/15 and October was 10/15. February and March were both paid in the respective months. The HRA was provided no evidence that the statement was provided to the guardian. The HRA requested clarification on why the Care Cost were deducted all at once and were told that there was a routine audit completed in January of that month and it was discovered that those cost of care payments had not been taken out, so they were deducted at one time.

Regarding the complaint that a nurse would not return phone calls, the HRA found one nursing progress note dated 4/20/2016 which reads that the resident's guardian called at 9pm and had called earlier but the nurse was unable to answer due to a medication pass. The nurse did talk to the resident's guardian on that occasion. The HRA reviewed other instances when a nurse spoke with the guardian on the phone dated: 12/24/2015, 3/17/2016, 3/25/2016, 3/28/2016, and 4/7/2016.

The HRA reviewed the facility policy on Interdisciplinary Process which reads that "It is the operating standard of Community Alternatives Illinois to ensure a comprehensive and holistic Interdisciplinary Process through which the Community Support Team (CST) and the agency shall be responsible for preparing, revising, documenting, and implementing a single ISP for all consumers of services." In the procedures section of the policy, it reads "The following shall be included in the interdisciplinary process, at minimum … Family members, friends, significant others, and/or guardian." The policy also states "The ISP shall be signed by the QIDP and receipt and approval form signed by individual and/or guardian … The individual and/or guardian shall be offered a copy of the ISP. This shall be documented on the approval/receipt of ISP form." Another policy titled "Informed Consent" reads that "It is the operating standard of

Community Alternatives Illinois to ensure that all programs involving an individual are conducted with the written informed consent of the individual, parents, or legal guardian." The procedure also states that "Prior to implementation of programs informed consent will be obtained." The HRA reviewed no medical consents signed by the guardian. Another policy titled "Individual Finance Management" reads "It is the operating standard of this operation to responsibly manage and monitor individual finances at all of the locations" and then policy proceeds to state "A quarterly statement of trust fund account activity is provided to the individual and/or legal representative. Financial information can be requested at any time."

The Probate Act of 1975 reads "(a) To the extent ordered by the court and under the direction of the court, the guardian of the person shall have custody of the ward and the ward's minor and adult dependent children and shall procure for them and shall make provision for their support, care, comfort, health, education and maintenance, and professional services as are appropriate …" (755 ILCS 5/11a-17). The Act also reads "(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. Any person dealing with the guardian, standby guardian, or short-term guardian may presume in the absence of actual knowledge to the contrary that the acts of the guardian, standby guardian, or short-term guardian conform to the provisions of the law. A reliant shall not be protected if the reliant has actual knowledge that the guardian, standby guardian, or short-term guardian is not entitled to act or that any particular action or inaction is contrary to the provisions of the law" (755 ILCS 5/11a-23). The Department of Human Services Rule 115 reads "a) The CST [community support team] 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 … c) The CST shall be directly responsible for: … 9) Providing assistance to the individual in obtaining health and dental services, mental health treatment and rehabilitation services (including physical therapy and occupational therapy), and substance abuse services; … 12) Assisting the individual in accessing medication information including observing and reporting effects and side effects of prescribed medications" (59 Il Admin Code 115.200).

The Community-Integrated Living Arrangements Licensure and Certification Act reads "a) To protect a recipient's funds, a service provider: … (2) Shall maintain a written record of all financial arrangements and transactions involving each individual recipient's funds and shall allow each recipient, or the recipient's guardian, access to that written record. (3) Shall provide, in order of priority, each recipient, or the recipient's guardian, if any, or the recipient's immediate family member, if any, with a written itemized statement of all financial transactions involving the recipient's funds or a copy of the recipient's checking or savings account register for the period. This information shall be provided at least quarterly" (210 ILCS. 135/9.1).

Complaint #1 - Conclusion

The HRA found no direct evidence supporting or denying the claim that ResCare would not allow the resident's guardian to speak with the facility psychiatrist and there did appear that,

since the HRA has interviewed staff, there has been interaction with the physician. There is also no evidence supporting or denying the claim that the facility nurse would not contact the guardian after being called. The facility administrator was unsure if the resident's guardian received quarterly statements and the business manager said that she had received statements but also that she was unsure if there had been any that had been missed and was only sure about the December statements. Facility policy states that the statement is provided but the HRA was not provided any documentation to prove that statements were sent to the guardian. Due to the lack of evidence that quarterly statements were provided to the guardian, which is a violation of the CILA Act (210 ILCS 135/9.1) and facility policy, the HRA finds the complaint **substantiated** and makes the following **recommendations:**

1. **The agency provides financial statements to residents, guardians and resident representatives as required in CILA statutes, regulations and agency policy.**
2. **To ensure compliance with the provision financial statements, document that these items have been provided.**

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

- The facility needs to assure that resident's guardians are allowed to participate in all decisions, both medically and financially and that the facility strives to fully include guardians.
- The HRA did not see any evidence that the facility received consent from the guardian regarding medications and medical services and **strongly suggests** that the facility get consent for all medical services if they are not already.
- If the facility is going to subtract Care Costs from accounts all at once, the HRA **strongly suggests** they provide the explanation to guardians and create a policy explaining reasoning for these actions if these do not already exist. Additionally, the HRA **strongly suggests** that the facility deduct payments for care at the accurate time because it is essential that it is known exactly how much money is in the resident's account due to social security regulations regarding the amount residents are able to have in the account.
- The HRA has concerns regarding the physician's documented reference of discharging the patient due to the guardian's behavior or when a guardian voices concerns and suggests that any guardian conflicts and concerns be addressed in the treatment planning process.

Complaint #2 - Inadequate treatment

The HRA reviewed physician's orders dated 7/2015 until 3/2016 and saw no mention of an order for an EKG or blood work with the exception of one order dated 2/1/2016 for a fasting lab for Depakote and a Lipid Panel. The HRA reviewed a set of nursing progress notes dated 3/25/2016 that describe an instance when there was a medication error and during that description, the recipient's guardian explains to the nurse that the recipient was to have an EKG twice a year because he was taking Propranolol and also bloodwork for the "tegretol level and the effects thorazine can have on kidneys and liver." In the individual's service plan, dated 10/28/15, it reads that the resident is compliant with "getting routine lab work done." There was

also a nurse's note from 3/17/16 which reads that the guardian called the nurse asking a medical question and the nurse said that she was have to "see the lab report" to say for sure.

The oldest physician's order, for August 2015, reads that the resident is to receive 2 capsules of 1200mg of fish oil, twice daily by mouth. The September 2015 physician's order changes to 1 capsule by mouth twice daily and the October physician's order is the same. The November 2015 physician's order remains the same but there is a note written that it is permissible to give pills at workshop. In the December 2015 physician's order there is a handwritten note that the resident is to take 2 tablets at 6am, one 1 tablet at noon and 1 tablet at 8pm to equal 4800 mg per the resident's guardian's request. The order still reads in the print to take 1 capsule by mouth twice daily. The next physician's order, for January 2016, has the same amounts and times hand written in with a note reading "Per [Guardian] Request" but the printed directions are changed by hand to read "take 4 capsule by mouth." The next physician's order is for February 2016 and reverts to the previous orders where the patient is to take 1 capsule of 1200 mg by mouth twice daily. There are no handwritten notes about the fish oil. The next physician's order is dated 2/22/2016 for March 2016 and it consists of one page (page 3). The HRA was not provided any other pages of the physician's order, including a page that has the printed order for fish oil. On that order, there is a handwritten statement that "Fish oil increased to Fish oil 2400 mg PO BID DX [by mouth twice per day due to a diagnosis of] Mood." The HRA reviewed another physician's order that is only handwritten with no printed orders that is dated 3/7/2016 which reads "Fish Oil 2400 mg PO BID DX Mood at 6am and noon."

The HRA reviewed the resident's medication administration record (MAR) for fish oil. In the MAR for 5/28/2015 through 5/31/2015 there is no mention of fish oil and the first MAR when fish oil is provided is in the June 2015 MAR. The June MAR states that the resident is supposed to receive 2 tablets of 1200 by mouth twice a day and there are four days were no medicine was given. The times when no fish oil was given were 12pm on the 21st, 24th, 27th and 28th of the month. The July 2015 MAR also states the resident needs two capsules by mouth twice daily and there are multiple times the medication is not logged. The times when the fish oil were not given were: at 8am on July 3rd, on July 4th at any time, as well as the 8am on the 5th, 7th, 8th, 10th, 11th, 12th, 18th, 23rd, and 26th. Medication notes in the July MAR read that on 7/8 at 12pm, they "Did not have meds" and there were no other notes about medication errors in the MAR. The capsule was also not provided at noon on the 12th, 13th, 15th, 17th, 21st, 22nd, and 23rd. The HRA was not provided an August 2015 MAR. In the month of September 2015 the resident was to receive 1200 mg capsules by mouth twice daily and they were all given, although there was a medical note dated 9/25 which reads that all the medications were not given due to a home visit but there are still initials that medications were given. The MAR does not appear to match the physician's order and reads 2 capsules by mouth twice daily while the physician's order reads one and then has a handwritten note that reads "Fish Oil 1200 mg PO BID" and approval to give at the workshop. The October 2015 MAR reads that one capsule is to be given by mouth twice a day and there is a large gap in providing the medication between the 9th and the 30th but there are similar gaps with the rest of the medication. There is a medication note that some medications were not given on the 8th, 9th and 10th due to a home visit. The other medications do not all have the gap from the 9th and 10th, but some have the 11th while others do not.

The November 2015 MAR changes the amount taken to 2 capsules by mouth twice a day and the only time the medication is missed is at noon on November 5th. The physician's orders indicates it should be 1 capsule by mouth twice daily and also states that it gives permission to take fish oil at the workshop. It also states that on 11/13/2015 there was no more fish oil and on

11/14/2015 the fish oil was not given because it was out. The December 2015 MAR reads to "Take 4 capsule by mouth twice daily" but then has handwritten notes which read 2 capsules at 6am, 1 capsule at noon, and 1 capsule at 8pm. As stated above, the physician's order is printed one tablet by mouth twice daily while there are handwritten notes that indicate 4 tablets per day. The 6am and 8pm capsules were given and then the noon capsules are written in and reads "workshop" but does not show if they were given or not. A medication note reads that all 4pm and 8pm medications were not given from 12/24 through 12/30 due to a home visit. Also, a medical note states that all noon medications were not given on the 12/18 and 12/19 and there is a line through one set of medications that the resident is to take at noon (Carbamazepin) and the noon Fish Oil reads "Workshop" in the noon section. The January 2016 also reads that the resident is to take 4 capsules by mouth daily equaling 4800 mg and they were all taken. The medical notes for the MAR reads that the fish oil was "not here" for 1/13 and 1/14 and then "None" for 1/15. In the MAR, those dates initialed as given, but they are circled and this was explained by staff that this means that staff forgot to put their initials in the box as administering the medication and the nurse has addressed it as a medication error during a quality assurance check. For the February 2016 MAR, the typewritten fish oil section is crossed out and reads that it is discontinued but then it is hand written in later on in the documentation stating that the resident is to take 2 capsules at 8am equaling 2400 mg and then in another section it reads that one capsule should be taken at noon and another at a different time. The medication is not given at 6am on the 17th and 18th and then possibly not on the 28th (the signature for the 29th also covers the 28th). This does not match the physician's order which indicates 1 capsule by mouth twice daily. The documentation for the other two times is illegible. Additionally, the medication notes read that the resident did not receive medication on 2/10 for all medications and on 2/17 for all 12pm medications. Also it was written that the resident did not receive the 2/17 noon medications because he was not there or the 2/3 medications because he was at the workshop. On 2/4 it states a medication was not available but it does not state the medication. From 2/11 to 2/14 it reads that Melatonin is not available and reordered and then from 2/15 to 2/28 (except for 2/17, 2/22 and 2/27) it is noted that fish oil is reordered.

For March 2016, the fish oil is charted in two separate areas. One of the areas start on March 1st through 10th and reads to take one capsule by mouth twice daily at 1200 mg then it reads to see the new order change on page 4. On page 4 it reads 2400 mg and to take 2 capsules by mouth twice daily. All the medication was given. The MAR does not match the physician's order which reads 6am and noon for times the medication is given while the MAR reads 8am and 10am. There is a note in the physician's order about a time change on 2/22/2016 but it is not clarified. It is also logged that on 3/6 and 3/9 noon medications were not given on 3/6 the nurse was made aware and the 3/9 omission was because he was at a workshop. It was also indicated that there were multiple days where the medication was not given because the resident was at the workshop but it is noted the medication was given by the workshop. Also on 3/28 the resident refused his medications. Another set of notes reads that on 3/2 and 3/3 the resident had no fish oil so it was not provided but it's noted that a nurse is aware of it and it would be obtained.

Another group of notes indicates that on 3/6 the resident was not given his noon medications and no reason was given but it was stated that the nurse is aware, there were other situations when the resident was not given medications due to the resident being at the workshop. On 3/13 it reads that all noon medication was not given because there was none in the medicine cabinet. On 3/16 it reads that medication was not given because the resident was "at workshop at noon not documented as being out of home." On 3/25 it states that all noon medications were

not given at noon but they were given late. There were other incidents noted in March when the patient's Topamax and Propranolol were not given.

The HRA reviewed 4 different medication error reports related to fish oil. One report stated that on 7/3/15, 7/4/15, 7/5/15, and 7/7/15, no one signed off as having given the medication. There was another report on 7/8/2015 that had the same statement. These match the MAR except on 7/8 which states that they do not have medications. Another medication error report reads that on 3/1/16, 3/2/16 and 3/3/16 the fish oil was not in the resident's home. On the MAR it indicates that these medications were given. Additionally there are other medication error reports for the resident that dealt with the resident not receiving medication for the noon or PM times.

The HRA viewed another entry into the progress notes which indicates that on 4/10/2016 the resident was not present for his morning medical pass and the times were moved back for receiving the medication. There is another After Visit Summary dated 2/4/2015 for an emergency department (ED) visit when the diagnosis was "Compliance with medication regimen" and the discharge instructions were: "You need to pull the dedication lists that are supposed to be signed by the nurse when a medication is given for the time period you are concerned about and review them with [Physician]. That is how you can find out what medications the patient actually received. Return to ED for concerns."

The HRA also reviewed an incident/accident report dated 4/18/2016 which reads that the staff was transporting the resident after a behavior to work and the resident said he did not get his 8pm medication the night before and he stated that he slept through it. After dropping off the resident, the staff member contacted the nurse and the program director to report it. After checking again, it turned out the MAR medications were signed for but not the bubble packs and the medication was not in the bubble pack from the 8pm pass. There is another set of medication notes for those days that state there were multiple medications missed in February. On 2/1 it reads "Thorazine 50mg po med clarified with nurse and held." On 2/3 it reads "Med error reports for Topamax 100mg 1 tab to be given @ 12pm for 2/1/216 & 2/2/16 med error reports for Topamax ½ tab to be given @ noon 2/1/16 & 2/2/16 nursing notified." A nursing progress note dated 4/28/16 discusses a conversation with the resident's guardian where it states "I asked for clarification of this fish oil. She said it was suppose to be 8am morning and noon. I explained the previous order was 1 capsule for 1200mg 8am and 8pm and the new order was written for 2400mg twice a day. And we could change the PM dose to noon." The HRA reviewed nursing progress notes dated 3/25/2016 that logged a medication error when the resident received his 4pm medication twice, once at 11am and then once before 3:45pm. That error included Thorazine.

There is another letter, written by an RN but not dated, regarding the recipient's ability to self medicate. Part of the letter reads "When I arrived with the Agency in February [Recipient] had obtained an over the counter medication, Melatonin and was taking it as a sleep aid not being administered by the nurses that were giving medication while the company was on 'med freeze' (due to lack of RN on staff). There was no order for this medication. At that time the nursing visiting from another branch of the company had told me that they had already removed one bottle from the home on a previous visit. [Resident] was also insistent that his fish oil was for 2 pills. Although the order obtained from the doctor was for 1 pill at that dose. I do not know how the order was originally obtained in November and if it was correct; but it was the order we had on hand from his physician."

The HRA reviewed the physician's orders for Thorazine, which in this complaint the resident was receiving the generic version of Chlorpromaz. The first physician's order is for 8/1/2015 through 8/31/2015 and the first two pages has the date of 7/17/2015 and the third page has an indecipherable date in August. The physician's order reads that the resident is supposed to take one tablet by mouth every morning. The dosage is 25 mg but there is also a note to "take with half-tab – 37.5" and a handwritten note reads plus 50 mg tab equals 87.5 mg total. The time to take the medication is 6am. Also in the physician's order, there is another order for one Chlorpromaz 50 mg to be taken by mouth twice daily at 6am and 4pm. On the third page, that has a different date, it reads that the resident needs to take "one-half" tablet by mouth every morning equaling 12.5 mg and take with 25 mg to equal 37.5 mg. A handwritten note with that reads that plus the 50 mg the dosage will equal 87.5 mg. The HRA reviewed another physician's order for August with the same dates and the same information except the physician's signature appears to be different and the signed date is the same through the document, which is 7/14/2015. Also there is a question mark next to the directions on the third page regarding taking one-half by mouth with a 25 mg pill. The August physician's order has three sections in the actual document for Chlorpromaz that state to take one-half with a 25 mg pill at 6am to equal 37.5 and then one 50 mg pill at 6am and 4pm. One order was for a full, 25 mg tablet with a note to take with another half-tablet and there is also a handwritten note to take with 50 mg tablets. The second order is for the half-tablet with a note to take with the 25 mg tablet and the total will equal 37.5 mg and take with 50 mg. Both orders are for 6am. The third order is for a 50 mg tablet to be taken by mouth twice a day, once at 6am and once at 4pm. The September physician's order has the same instructions without the handwritten reminder to take the morning dose with the 50 mg. The October physician's order has the same dose but the times on the 50 mg are changed to noon and 8pm.

The November 2015 physician's orders include the same but the 50 mg reverted to an administration time of 6am and 4pm rather than noon and 8pm. The December 2015 physician's orders are the same but adds handwritten notes on the first page that indicates that the resident should receive 87.5mg every AM and 37.5 mg should be with the 50 mg tablet. Another handwritten note on the second page makes the same statement and reads "Please note" that the resident is to receive 50mg, 25mg and 12.5mg, equaling 87.5mg every AM. The January 2016 physician's order has the same orders and the same notes reminding when the medication should be taken. The February 2016 has the same medication orders but the AM times were changed from 6am to 8am. The March 2016 physician's orders did not include orders for Chlorpromaz and seemed incomplete as compared to the other orders.

The HRA reviewed the MAR regarding the Chlorpromaz. The MAR starts with the last three days of May 2015 the corresponding physician's orders provided began in August. According to the May MAR, the medication was provided as a 25 mg tablet with a half-dose of that tablet at 8am, and also a 50 mg tablet which equals 87.5. The 50 mg tablet was also provided at 4pm. That same dosage was given in June with the exception of the 50 mg tablet at 4pm on the 19th, 21, 22, 23, and 24th. The July 2015 MAR has the same doses but the AM time is switched to 6am, and the AM dosage, for both the 37.5 and the 50 mg, is not given 10 times through the month. The 4pm is not given for three days which match three of the days with the AM doses. The September 2015 MAR follows the physician's orders and all the medication was given and the October 2015 MAR follows the physician's orders but as stated in the previous section regarding fish oil, there are stretches of time where no medication was provided at all. The dates for the morning medications not being provided are the 19th through the 29th and then

the 30th and 31st. The 50mg dosage dates where the medication is missed is the 12th through the 17th and then the 19th through 28th. This follows a similar pattern to the other medications in the document only with the additional days of the 11th and 28th. The November 2015 MAR only has the records for the 50mg tablets of Chlorpromaz and it appears as though the HRA was not provided the first page of the records. The 50 mgs tablets were being given according to the physician's orders. For the December 2015 medication, it reads that the resident is supposed to take one 25mg tablet in the morning with another half tablet and also a 50 mg tablet is to be given by mouth twice daily. These are all written up as three separate orders with handwritten notes as reminders to take the 50 mg, 25 mg and 12.5 mg together. It is marked that all tablets are taken but there is no separate area for the morning 50 mg to be logged. There is a handwritten note that the noon dosage is discontinued. Outside of that, it appears all medications were given and it matches the physician's order. The January 2016 MAR has three orders for Chlorpromaz and it states one 25 mg tablet is to be taken at 6am with another half tablet. There there is a final order for the 50 mg to be given at 4pm. Handwritten notes with the AM orders state to take the 50 mg with the AM but the 50 mg tablet has no area for initials in its section indicating that the medication was given in the AM with the other doses. On the fourth page of the MAR, there is another handwritten note that states "Please make sure 1) Chlorpromaz in 87.5 in AM 6AM 50 mg @ 4pm." The physician's orders also have three orders and states that the resident is to receive 87.5 mg at 6am and then 50 mg at 4pm. The February 2016 MAR is similar to the January with handwritten notes that the resident is to get a 50 mg tablet at 6am with the 37.5 mg tablets. There is a separate area for the 50 mg evening dosage and then, on the second to last page that is not numbered, there is a handwritten area for the 50 mg AM dosage to be given and initials log that all the medication was given except for a dosage on February 17th. There are medication notes for the March MAR as well and he may have received Tegratol and Chlorpromazine late but still within the 3 hour window and the resident's guardian was aware. The March MAR has three areas for Chlorpromaz; one for the 25mg, one for the "one-half" 25mg tablet and one for the 50 mg tablet. The 50mg tablet has a section for the 8am dosage and the 4pm dosage and it appears that all the medications were given

The HRA reviewed another medication error sheet dated 7/7/2015 that deals with Chlorpromaz and states that the medication was not signed off on the MAR for the dates of 7/3 through 7/5 and 7/7 at 6am (there are actually four medication error sheets describing the same incident, possibly one per error but they all have the same information). There is an additional sheet for 7/8/2015 when Chlorpromaz was not signed off on the MAR (three sheets are completed for this error) before 3:45pm. A set of Nurse Progress Notes from 12/24/2015 reads that the facility received a call from the Guardian who "… was screaming into the phone and cursing – stating that [resident's] medications were wrong and she had taken pictures – I attempted to reassure her that the dose was correct and the time was transmitted to the pharmacy in error or the new MARs but I would confirm with the pharmacy. Ensure her that 87.5mg was to be given in the 8am and 50mg at 4pm." The HRA saw no evidence that the resident told staff about not receiving medication and that staff said that there was no mark sheet. The HRA reviewed the MAR regarding the complaint that the resident received 4pm and 8pm medications together. The MARs gave no indication that the resident was given 4pm pills and 8pm pills at the same time for the duration of the MARs.

Regarding the complaint about the pulled muscle, the HRA found one medical consult report dated 2/18/2016 that reads the resident had "right pectoral muscle tenderness" and the plan was "rest" but the patient was also prescribed a muscle relaxant called Flexinol and

Naproxen and instructed to be off work for two days. An after-visit summary from an urgent care facility also reads that the patient's primary condition on that date is a pectoralis muscle strain and Naproxen is in the patient's Outpatient Medications but the Flexinol does not appear. From reviewing the document compared to other similar documents for a different incident, it appears as though there is a page missing. In reviewing the MAR for February, there is a PRN (as needed) medication order written in for Naproxen and Flexinol both dated 2/22/2016. The February MAR does not indicate that either drug was given. A nurse's note dated 3/6/2016 reads "Talked to [resident] about Flexerol/Naproxen use – not available when needed after visit (before hire date) to be sure he was not currently feeling the need." The HRA also reviewed a QIDP note for the month of February 2016 which reads "On 2/18/2016 [Resident] was seen at [Urgent Care] in Peoria, IL for right pectoral muscle tenderness. He was prescribed naproxen 500mg TID and Flexeral 10mg TID. He was off work for two days … Part of this month there was DSP passing freeze and LPN staff handled medication administration."

Regarding the complaint that the facility is using medication that was prescribed in 2015 by a psychiatrist who has not seen the patient since and that the facility told the guardian that the psychiatrist wrote out prescriptions a year in advance, the HRA was only provided prescriptions for Albuterol, Ibuprofen, and Acetaminophen and then a new prescription for Thorazine (dated 5/13/2016), which is after the complaint date. There is a medical consult report on 5/12/2016 that stated to discontinue (D/C) the 100mg of Thorazine at night. There was another fax sheet which reads 4/28/16 and states that the patient "… has a new mental health doctor. These are new orders. He D/C some medication but I have not obtained those yet written." A fax dated 4/28/2016 and the new prescription also had that date and it was for Thorazine, Tegretol, Topamoz, and Propranolol.

The facility provided psychiatric review forms signed by physicians when medication was listed along with psychiatric assessments/order/follow-up. The HRA reviewed "Psychiatric Review Forms" with various dates that logged medication, assessments, orders and follow-up and were signed by a physician. The HRA received 6 sheets and the dates reviewed on the sheets were 6/25/2015 (which no previous review date noted), 8/31/2015 (with no previous review date noted), 11/30/2016 with a previous review dated of 10/5/2015, 2/1/2016 with a previous review date of 11/30/2015, 3/7/2016 with a previous date of 2/1/2016 and finally 4/4/2016 with a previous review date of 3/7/2016. The medications on the sheets differ slightly and each of the sheets has assessments written. On each psychiatric review form, there is a checkbox for "yes" or "no" for evidence of tardive dyskinesia (TD) and the same for extrapyramidal side effects. On the 6/25/2015 nothing is checked for either and in the notes, the HRA saw no documentation that the medication side effects were examined. The checkboxes were used in the other review forms, except for the 3/7/2016 form. The HRA did review two "TD Screening" forms, one dated 1/4/2016 and the other dated 2/1/2016. The Psychiatric Review Forms do state, typewritten on each form, "The appropriateness of reducing the prescribed medication shall be evaluated during Psychiatric reviews, and/or when the reduction criterion noted above are met. The Interdisciplinary Team has agreed that this individual's medication should/should not be reduced at this time because of the following clinical concern. Physical aggression, Verbal Aggression, Inappropriate Behavior." No form has reduction criteria listed and none have it noted whether the interdisciplinary team has agreed that the individual's medication should/or should not, be reduced on the forms. In a review of the individual's Behavior Intervention Plan, the HRA saw no Medication Reduction Plan was included in the plan.

Regarding the complaint about alone time, the HRA reviewed a letter written by a behavior analysist on 5/23/2016 which states "Furthermore, continuity of care is lacking as our nursing department does not have any say in medication changes, even when his behavior and affect changes as guardian requests he goes to appointments independently in a cab that she calls for him. This is a concern because [Resident] doesn't have any community alone time." In reviewing the resident's individual services plan and behavioral plan, the HRA saw no direct evidence stating that the resident was to receive 3 hours alone time. The HRA reviewed no other information and was provided no other information regarding the resident receiving alone time, staff "taking it out" on the resident because they had to wait for the job coach, anyone calling the resident "Mr. Snitch", or anything regarding pick-up and drop-off times for the resident. The only information that the HRA saw on the topic was in the resident's ISP which read that the resident attends a "work source" from 8:30am until 3pm Monday through Friday. A van from the "work source" facility picks the resident up with his peers and the same van returns them in the evening. The HRA requested a transportation policy and none were provided.

The HRA reviewed the facility Medication Administration Error policy which reads that "It shall be the operating standard of Community Alternatives Illinois to ensure the accurate, prompt, and efficient administration, and documentation of all medications." The HRA also reviewed a Medications policy which states "All medications and treatments shall be recorded with date, time, dosage, and person exercising oversight." The facility Psychotropic Medication policy reads that "It is the operating standard of Community Alternatives Illinois to ensure that medications prescribed for the purposes of psychiatric treatment and/or for the use of, conjunctive with behavior support programming, management of behavior be monitored and reviewed as required by clinical indications and applicable regulations." The program proceeds to read that "The Psychiatrist shall review psychotropic medications prescribed for individuals on, at minimum, a quarterly basis. For illustrative purposes, this policy shall include the attending Psychiatrist at part of the CST." The policy also reads that "In each Behavior Support Plan for individuals receiving psychotropic medications, there shall be a Medication Reduction Plan which stipulates criterion by which psychotropic medications shall be reduced." Also "Community Alternatives Illinois personnel qualified to conduct evaluations/assessments for abnormal involuntary movements shall do on a quarterly basis, at minimum, as part of the psychotropic medication review process."

The HRA reviewed the Individual Support Plan policy/procedure which reads "It is the operating standard of Community Alternatives Illinois for each consumer to have an Individual Support Plan (ISP). Community Alternatives Illinois will provide services to each individual based on the individual's own goals, strengths and chose so that he/she can realize personal outcomes. Individual's own preferences and needs guide the ISP without regard to the availability of services. It is the responsibility of Community Alternatives Illinois to assure that the recommendations of the ISP are carried out to the fullest extent possible. … The goals and objectives of the individual's support plan are developed from the results of the self-assessments during the annual ISP meeting. The goals are chosen by the individual with the assistance of the team to help this person to achieve the outcomes that are the most important to him/her to help increase independence. Behavioral objectives are measurable steps that will help the person to achieve the overall goal."

The HRA reviewed the Individual Rights policy which reads "Community Alternatives Illinois endorses the Declaration of General and Special Rights of the Developmentally Disabled as adopted by the International League of Societies for the Mentally Handicapped; the Rights of

the Mental Retarded Persons as adopted by the Developmental Disabilities Code …" The HRA also reviewed an Individual's Served Independence policy that states "All individuals served by Community Alternatives Illinois Shall be encouraged to be as independent as possible, and to access the community to the fullest extent possible. To fully implement increased inclusion and independence, individuals may be allowed to have periods of time without direct supervision. The safety of the individuals we serve being one of our highest priorities. Individuals must demonstrate their ability to participate in home alone, and/or community involvement." The policy states that the resident, guardian and Community Support Time must all be in agreement that the individual is appropriate to have independent time and the person must pass the CILA safety assessment. The staff must make a schedule for the individual and the Executive Director or Director of Operations must be made aware of the schedule and the schedule must be approved by them and requires and IDT. The HRA was not provided a letter from a general practitioner as discussed in the second site visit.

Rule 115 requires that: "d) Screening for and documentation of abnormal involuntary movements, including tardive dyskinesia, in individuals receiving prescribed psychotropics shall be completed at least every six months by employees trained in performing this type of assessment. e) A physician shall review the medications prescribed and shall see the individual at least every six months, and every three months if psychotropic medications have been prescribed. Physician documentation within the individual's record shall include, but is not limited to, the following: 1) Rationale for continuing current medications and/or initiating new medications; …" (59 Il Admin Code 115.240). Rule 115 also mandates that: "g) The individual integrated services plan shall identify the CILA site chosen with the individual's and guardian's participation and shall indicate the type and the amount of supervision provided to the individual" (59 Il Admin Code 115.230). The Mental Health and Developmental Disabilities Code requires that: "(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 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" (405 ILCS 5/2-102). Rule 116 mandates that: "All medications, including patent or proprietary medications (e.g., cathartics, headache remedies, or vitamins, but not limited to those) shall be given only upon the written order of a physician, advanced practice nurse, or physician assistant…. All orders shall be given as prescribed by the physician and at the designated time…." (59 Ill. Admin. Code 116.70).

The regulations on the administration of drugs in community settings reads "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 (or the Illinois Department of Public Health Regional Office if an individual of an ICF/DD-16 is involved) in accordance with written instructions from the Department's Bureau of Quality Enhancement or DPH rules (77 Ill. Adm. Code 350). All medication errors are subject to review by DHS or DPH, whichever is applicable. Medication errors that meet the reporting criteria pursuant to the Department's rules on Office of

Inspector General Investigations of Alleged Abuse or Neglect or Deaths in State-Operated and Community Agency Facilities (59 Ill. Adm. Code 50) shall be reported to the Office of Inspector General" (59 Il Admin Code 116.60 (c)).

Complaint #2 - Conclusion

The HRA saw no evidence that an EKG or blood work were needed but not occurring, that medication was being prescribed a year in advance, or that information was not being reviewed by a psychiatrist. The HRA reviewed no evidence that the individual was to have alone time on the ISP and the HRA did not receive any policy regarding transportation. Additionally, the HRA saw no evidence to support the name calling allegations. Due to the lack of evidence, the HRA does not substantiate those parts of the allegations.

The MARs and physician's orders for fish oil are confusing and inconsistent and do not always match from month to month. Also they are inconsistent from month to month as to the dosages. The MAR indicates that fish oil and Chlorpromaz were not constantly administered. Additionally, the Chlorpromaz does not have a separate area indicating that the 50 mg dosage was administered in some of the MARs, only handwritten notes that the 50 mg dose is supposed to be taken with the morning dose. The documents meant to instruct staff on how to give residents medical treatment are completed with handwritten instructions; in multiple areas items were crossed out; and, there were inconsistencies in dosages from month to month, and there were separate sections for the Chlorpromaz. The MAR and physician's orders are indecipherable in places and the HRA does not see how employees could successfully understand the instructions. The facility admitted to not providing pain medication to a resident due to a medication freeze and documentation supported the admission. Additionally, the facility staff admitted to the claim that staff were not at the facility when needed for the resident to be dropped off. Because of the evidence found, the HRA finds this complaint **substantiated** and makes the following **recommendations:**

- All staff be retrained on medical administration for residents and that the residents' most current medical administration records and physician's orders be quality controlled to assure that the proper medication is given at the accurate times.
- Staff be trained on each resident's physician's orders and medical administration records to assure there is no confusion on the medications that they should receive and also that the staff understand the records themselves.
- The facility needs to put a process/procedure in place to assure residents are receiving all needed, physician-ordered medication so that there is never a medication freeze at the facility due to lack of staff or any other reason.
- The facility create process and procedure that assures coverage at facilities when residents are to be dropped off to assure the resident's safety and also that they have uninterrupted services.

The HRA requests evidence that these actions have been taken on these recommendations. The HRA also makes the following suggestions:

- The quarterly review of psychotropic medications did not appear to be occurring according to the psychiatric review forms that were presented and neither do the quarterly

evaluations on involuntary movements. The HRA **strongly suggests** the facility assure this is occurring to comply with their own policy.

- The medication reduction plan is not covered in the behavior support plan per the psychotropic medication policy. The HRA **strongly suggests** the facility assure this is occurring to comply with their own policy.
- The facility rights policy uses the term "retarded" which is considered a derogatory term. The HRA **strongly suggests** the facility review their policies and procedures to eliminate language that is considered derogatory and demeaning towards individuals in the population that they serve.
- The HRA received medication error reports for July 2015, March 2016 and April 2016 but through reviewing the MAR for fish oil and Chlorpromaz, there were other instances when the medication was not provided that had no corresponding MAR. Additionally, none of the July 2015 medication errors indicated that they were reviewed by an RN-Trainer, although it was indicated that an RN-Trainer was notified. Additionally 3 of the March medication errors had no notification completed but there was a review by an RN-Trainer and an April medication error had no notification and no RN-Trainer review. One March medication error document only had that a supervisor was notified although there was a review by an RN-Trainer. Because not all the medication errors appeared to be reported and there were inconsistencies in who they were reported to, the HRA **strongly suggests** that the facility train staff on medication errors to comply with the regulations on the administration of drugs in a community setting (59 Il Admin Code 116.60).
- The Standard of Professional Conduct for Registered Professional Nurses reads that an RN shall "Be accountable for his or her own nursing actions and competencies" and there is a requirement to "Report unsafe, unethical or illegal health care practice or conditions to appropriate authorities" (69 Il Admin Code 1300.350). The HRA would like to stress that a medication freeze effects professional licensure standards stated above and the facility is putting medical professionals at risk of non-compliance.
- The regulations on the administration of drugs in the community also state that "A registered professional nurse, advanced practice nurse, physician licensed to practice medicine in all of its branches, or physician assistant shall be on duty or on call at all times in any program covered by this Part [20 ILCS 1705/15.4(j)]" (59 Il Admin Code 116.50 (c). Although the facility stated that they had nursing staff covering the facility during the medication freeze, there was still an occasion when the resident did not receive pain medications due to lack of staff. The HRA **strongly suggests** the facility comply with this regulation in the future to assure medical provisions are covered.