FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY – NORTHWEST REGION
REPORT 17-080-9011
MOSAIC IN ROCKFORD

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship & Advocacy Commission opened an investigation after receiving complaints of potential rights violations of the residents at Mosaic in Rockford. Allegations were that there is inadequate care regarding the staff to resident ratio, rude treatment by the staff and psychotropic medications were administered without guardian consent.

Substantiated findings would violate rights protected under the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102(a), (a-5); 202), the Standards and Licensure Requirements for Community Integrated Living Arrangements (CILAs) (59 Ill. Admin. Code 115.200(c); 320), and the Illinois Probate Act (755 ILCS 5/11a-17, a-23).

Mosaic operates 3 facilities in Illinois including Rockford, Macomb and Pontiac. According to its website, Mosaic in Rockford began providing an amalgam of services for adults with disabilities in the Rockford area in April 2002 and currently serves 84 adults. Services include assistance in achieving greater independence in home management, vocational skills, community participation, transportation, recreation, leisure and spiritual awareness.

To investigate the complaints an HRA team met at the facility where we interviewed an attorney, the executive director and a qualified intellectual disabilities professional (QIDP). Policies were reviewed as

were relevant sections of the file of the 39 year old resident, with written authorization from his legal guardian.

COMPLAINT SUMMARY

It was said that there is inadequate staff in the CILA where the resident lives being that 1 staff is not enough to properly supervise and assure the safety of the resident who has an intellectual disability. The complaint goes on to allege that the staff have been physically and emotionally abusive with the resident. At one time the staff would not give him soap to take a shower and did not assist him in doing his laundry, including not providing detergent and not opening the laundry room door. These alleged actions by the staff would cause bad behavior from the resident and the staff would physically strike him. The complaint concludes by saying that psychotropic medications were changed without consent from the guardian and were administered incorrectly. The HRA Coordinator referred the abuse and neglect portion of this complaint to the appropriate enforcement agency and monitored its findings.

FINDINGS

The resident began receiving services from Mosaic in September of 2016 and resided in the Harlem House. The executive director stated that at all of the Mosaic group homes the staff to resident ratio is 1:8 at a minimum, with the maximum being 2:8. The QIDP added that during the time that the resident resided at the Harlem House there were 7 individuals with intellectual disabilities living in the home, including the resident. According to the executive director, the resident never actually moved into the Appletree Home. Only trial visits by the resident were conducted which resulted in the guardian not finding this home as a suitable placement. Therefore at the guardian's request, the resident lived with his guardian for a few months until such time that the 2nd Avenue House was found by all parties involved to be a good fit for the resident. The QIDP stated that the staff to resident ratio at the 2nd Avenue House is 1:6, including the resident.

The attorney, executive director, and the QIDP all agree that at no time was the staff rude or disrespectful to the resident, but on the contrary the resident was rude and disrespectful to the staff. In addition, the staff received special training from a local community based support agency and fully cooperated and welcomed other agencies who advocated for community services and supports on behalf of the resident.

The executive director informed the HRA team that the Mosaic nursing staff made an error in January, 2017 in administering the medication Seroquel to the resident. Reportedly, there was incorrect documentation that the guardian was present in an appointment when the physician discussed and prescribed the medication. Therefore, based on that incorrect information, no further approval was sought from the guardian.

RECORDS

According to the Mosaic Health Care Report effective 7/1/16, the active diagnosis for the resident is an impulsive control disorder Axis 1 and a moderate intellectual disability Axis 2. The ISP (Individualized Service Plan) and the BSP (Behavior Support Program) dated 9/28/16 give a comprehensive account of the admission of the resident to Mosaic. There are no notations in the plans that special staffing needs are required for the resident. Neither the program nor the plan was signed by the guardian. On 2/22/17 the Mosaic Vice President of Operations informed the executive director that "there was also an allegation that his name had been inserted into someone else's ISP (Individualized Service Plan) so that his ISP was not his and that we failed to correct this once we were aware of it". The executive director delineated that "It was the BSP (Behavioral Support Program), not the ISP and the QIDP has corrected it with the assistance of the community support agencies and the guardian in attendance. The most recent meeting regarding this issue was on February 13th. The QIDP had cut and pasted some information and accidentally left another individual's name in the resident's BSP". The associate director emailed the guardian on 4/25/17 explaining that "Once a behavior objective is

written that you find acceptable, it will be added to the resident's ISP. This should happen quickly and then Mosaic will again ask you to sign off on the resident's ISP and BSP. It is imperative that we have these plans approved and in place if we are to serve the resident in our CILA program". The 2/22/17 email also denotes the behavior issues that the resident was displaying while living at the Harlem House, thus the decision to relocate the resident to another home. The Mosaic employee time/schedule documents for the Harlem House show that during the period of August 2017 through February 2017 the home was staffed at a minimum of 1 staff and a maximum of 2 staff for 8 residents. The trial visits and transition procedures from the Harlem House to the Appletree Home included advocacy from various community support agencies. The associate director sent an email to the guardian on 4/28/17 at 12:18 p.m. informing the guardian that "On Sunday, there is one staff member in the home…I know that you are more comfortable with 2 staff so I am leaving that up to you". The email response from the guardian to the associate director at 12:46 p.m. foretold the concerns that the guardian had regarding her desire to have more than one staff in the Appletree home for the resident. Later that evening, an email from the guardian depicts that there was water in the basement due to a faucet that was left running. Howbeit, the resident never actually moved into the Appletree Home according to the email correspondence between the associate director and the guardian dated 5/8/17. The resident lived with the guardian from February, 2017 until June, 2017 prior to making trial visits to, and finally being placed in, the 2nd Avenue home at Mosaic. According to the Mosaic employee time/schedule records for the period of June 2017 through September 2017, the 2nd Avenue home was staffed at a minimum of 1 staff and a maximum of 2 staff for 7 residents. Email correspondence between the guardian, the director and the associate director during the period of 5/8/17 through 5/23/17 depict that the guardian and the resident are pleased and believe that the resident will be successful at the 2nd Avenue Home.

There is no documentation by the Mosaic staff that supports the allegation that there was rude treatment toward the resident. The Mosaic Training Attendance Record shows that on 3/23/17 the staff specific to

this resident received training from a local community support agency. The training included a basic course as well as hands-on strategies for controlling and restraining aggressive behavior. In addition, the email from a representative of the community support agency confirms that an extension of training was also conducted on 5/26/17.

The following documents highlight the subject in that there were 2 medication errors that occurred. The first error being that the progress notes from the psychiatrist's office dated 1/19/17 at 7:01 p.m. reveal that the Dr.'s nurse practitioner called the Mosaic nurse at 4:30 p.m. concerning the Seroquel dosage being at 200 mg and then called the guardian who requested that the dosage be reduced to 100 mg. Also on 1/19/17 the Mosaic Human Rights Committee Review states that the Mosaic nurse practitioner "discussed medication concerns with the guardian over the phone and the guardian agreed to Seroquel being administered to the resident at 100 mg as needed at 10:00 p.m. daily". On 1/20/17 at 9:30 a.m. the Mosaic nurse emailed the pharmacist depicting the following: "The resident's parents spoke with the nurse practitioner. She placed the resident on Seroquel 100 mg by mouth at 10 p.m. as needed for sleep. He is also on Fluoxetine 10 mg by mouth daily. The parents agreed with these medications. I just need official approval from you to begin these medications". On 1/20/17 at 2:59 p.m. the pharmacist emailed the Mosaic nurse "Approved, thank you and have a good weekend." On 1/20/17 at 4:14 p.m. the QIDP sent an email to the guardian, the executive director, associate director, the nurse and other representatives from community support agencies stating that "First we would like to apologize for the error with the Seroquel. Nursing understood it to be authorized by the guardian as you had recently pursued the addition of Melatonin. The nurse mistakenly thought you had attended the appointment with the resident, but you were actually in a meeting with the associate director and myself that day/time. Going forward, the nurse will contact you directly for any medication changes". It is noted that although the guardian had not approved of the use of the Seroquel at this time, she did later approve of it. The 2nd medication error is in reference to the letter dated 2/2/17 written to Mosaic by the guardian: "Please tell me what to do about

their continued mishandling of his meds.…It was specifically discussed, a half dose (100 mg) of what he took before, (200 mg) at ten p.m." The letter goes on to state that the resident was "completely unintelligible at 9 p.m.…The staff was completely unconcerned and said med pass is only at 8 p.m. which is literally ignoring doctor's orders. The floor staff is not medically competent to change med orders. She also refused to check the record to make sure of administer time.…the end game is only us wanting him cared for safely…but this is two major med errors now". The Mosaic medication chart that lists the resident's name, date of birth and Medicaid number also notes the following information: "2/1/17 – Medication Error – Wrong Time, Pharmacy Error….[and] 2/1/17 – Medication Error – Wrong Time, Misunderstanding of MAR".

Reportedly, the senior vice president/chief integrity officer located in the Mosaic corporate office requested a meeting at the Mosaic in Rockford office to "review records, talk with staff and visit the group home where the resident is living" according to the email dated 2/24/17 that was sent to the director. A report from the chief integrity officer dated 4/4/17 reveals that the "incident type" of the report is "compliance & ethics" and the "nature of the report" is "family concerns". The report goes on to elucidate that "There was no active ISP/Behavior Plan from October 2016 through February 2017. Documentation could not be correlated with an Individual Service Plan and was incomplete. Outings were not always documented and routine shopping trips for personal items were not documented. The overall quality of the documentation is lacking. The resident's transition to Mosaic is reported to have been brief. There is no documentation of the transition plan or transitioning activities. The agency does not require this documentation". Additional notations on the report include the date reported as 2/21/17, risk level and priority levels are high, the external investigator is the chief integrity officer and the status is closed as of 4/4/17.

The letter dated 1/20/17 from an enforcement agency to the guardian denotes statements in regard to their 2016 investigation: "Accordingly, your request for reconsideration has been denied and the finding in this case remains unsubstantiated physical abuse and unfounded mental abuse. However, the office is opening a neglect

investigation regarding the behavior plan". The report from the enforcement agency dated 4/12/17 resulted in the "allegation of agency neglect is unsubstantiated" but recommends Mosaic to "work with a bureau of quality assurance to ensure approved plans are put into place for the resident and any issues regarding the delay in having approved plans in place be addressed by a bureau of quality assurance". A letter from the enforcement agency dated 5/2/17 to the guardian states that the request from the guardian for reconsideration of the unsubstantiated finding in the 4/12/17 report "has been denied and the finding in this case remains unsubstantiated".

CONCLUSION

The Mosaic On-Call-Policy and Procedures states that the minimum habilitation level is 1 staff per group home. The maximum habilitation level is 2 staff per group home. The employee timesheets depict that the Harlem House with 8 residents and the 2nd Avenue home with 7 residents were staffed accordingly. Reportedly, the attorney sent an email to the HRA dated 10/15/17 indicating that "the minimum staffing level of 1 and maximum of 2 staff at the Mosaic homes. Mosaic never staffs below the minimum staffing level of 1 staff member on duty at all times that individuals are present in the home". The policy goes on to state that the "Mosaic–Rockford Program shall maintain an administrative staff person as the Primary and Back-Up On-Call designee. The Primary will function in a supervisory capacity for their core group homes during Direct Support Managers off duty hours…. Homes are to be scheduled at habilitation level…homes are not to operate below minimum habilitation level". The policy further expounds that the nurse shall be notified immediately by the direct support staff for any of the following: all medication errors, medication changes with regard to dosages, new medication, questions or concerns regarding medication administration. An RN nurse trainer shall be on duty or on-call at all times. The nurse on-call or the primary on-call

staff will notify the RN nurse trainer of any medication concerns immediately.

The Rights of Individuals form that is presented upon admission to Mosaic in Rockford establishes that "You have a right to report any infringements on your rights to the human rights committee at your agency. You have the right to considerate and respectful care and to be treated with honesty and dignity. It is recognized you are an individual who has feelings, preferences, personal needs and requirements". The document continues in that it contains the contact information for the Illinois Guardianship & Advocacy Commission, as well as other agencies where complaints can be filed relating to allegations of abuse, neglect, or exploitation.

The Exercising Human Rights booklet proposes that the individual has "the right to participate in the planning of your total care and medical treatment".

The Mosaic Bill of Rights attests that "Except in an emergency, no medical or dental services will be provided to you without the informed consent of you or your guardian."

According to Part 115.200 Standards and Licensure Requirements for Community-Integrated Living Arrangements with regard to Service Requirements:

Description

c) Services shall be oriented to the individual and shall be designed to meet the needs of the individual with input and participation of his or her family as appropriate.

d) Based on their needs, individuals shall receive supervision and supportive services which may range from continuous to intermittent. CILAs shall be designed to promote optimal independence in daily living, economic self-sufficiency and integration into the community through the interdisciplinary process.

According to the Mental Health Code (ILCS 5/2-102) regarding care and services;

§ 2-102. (a) A resident 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…and the recipient's guardian…
a-5) If the services include the administration of electroconvulsive therapy or psychotropic medication, the physician or the physician's designee shall advise the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment, to the extent such advice is consistent with the recipient's ability to understand the information communicated. The physician shall determine and state in writing whether the recipient has the capacity to make a reasoned decision about the treatment. The physician or the physician's designee shall provide to the recipient's substitute decision maker, if any, the same written information that is required to be presented to the recipient in writing.

And in Section 5/2-112 Freedom from abuse and neglect:
§ 2-112. Freedom from abuse and neglect. Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect.

According to Part 115.320 Standards and Licensure Requirements for Community-Integrated Living Arrangements: Administrative requirements:
c) General program requirements
Agencies funded by the Department shall meet the following general program requirements for all funded services:
3) Behavior management and human rights review

Each agency is required to establish or ensure a process for the periodic review of behavior intervention and human rights issues involved in the individual's treatment and/or habilitation. Agencies required to have behavior intervention and human rights review policies and procedures

under licensure or certification standards shall continue to comply with those standards.

According to the Illinois Probate Act (755 ILCS 5/11a-17), Duties of personal guardian:
(a) To the extent ordered by the court and under the direction of the court, the guardian of the person ...shall procure for them and shall make provision for their support, care, comfort, health, education and maintenance, and professional services as are appropriate….

And under Section 5/11a-23. Reliance on authority of guardian, standby guardian, short-term guardian:

a) 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.

According to the 59 Ill. Adm. Code 116.70 Medication Administration Record and Required Documentation:
a) 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.

Complaint: There is inadequate care regarding to the staff to resident ratio. The Mosaic On-Call Policy has established that the minimum staff to resident ratio is 1:8 and the maximum is 2:8. The policy continues to explicate that the Mosaic group homes are to be scheduled at the minimum habilitation of 1 staff per group home and the maximum habilitation level of 2 staff per group home. Reportedly, homes are not to operate below the minimum habilitation level. During the period of

8/2016 through 9/2017, the employee timesheets and schedules depict that the Harlem House with 8 residents and the 2nd Avenue home with 7 residents were adequately staffed in accordance with the Health Care Report, ISP and BSP that do not state that the resident is in need of special staffing accommodations. According to emails during the month of May, 2017 between the director, the associate director and the guardian, the resident is experiencing a favorable and desired outcome at the 2nd Avenue home. CILA regulations do not specify staff levels but required that services meet the needs of the residents; the HRA found no evidence that a resident's needs were not met. It is therefore concluded that the complaint is unsubstantiated.

Complaint: The resident experienced rude treatment from the Mosaic staff. The director and the QIDP both stated that there was never any rude, impolite or discourteous treatment by the staff toward the resident. The Mosaic chief integrity officer conducted a review and documented in a 4/4/17 report that there were no findings in regard to rude treatment by the staff. A 2016 investigation by an enforcement agency resulted in no findings with regard to physical and mental abuse. Given the supportive documentation, the complaint is found to be unsubstantiated.

Complaint: Psychotropic medications were administered without guardian consent. During the investigation meeting with the HRA, the executive director stated that in January 2017 a medication error occurred. On 1/19/17 and 1/20/17 documentation from the psychiatrist's nurse practitioner, the Mosaic nurse and the Mosaic human rights committee review depict that the authorization for use of the medication Seroquel was approved by the guardian. The email dated 1/20/17 from the QIDP clarifies that the guardian did not approve of the Seroquel and in fact, the QIDP apologized that the error was made. According to the Mental Health Code, if services by the physician include psychotropic medication, the physician shall advise the recipient as well as the guardian in writing of the side effects, risks and benefits of such medication. The Illinois Probate Act establishes the standard in that "To the extent ordered by the court and under the direction of the court, the

guardian of the person …shall procure for them and shall make provision for their support, care, comfort, health, education and maintenance, and professional services". Additionally, the 2/2/17 letter from the guardian foretold her concern with regard to the time and dosage of the Seroquel. The Mosaic Medication Chart dated 2/1/17 confirms that the error was made in the dosage of the Seroquel as well as the time that it was administered to the resident. The findings of the HRA are quite convincing, and the complaint is substantiated.

RECOMMENDATIONS

1. Ensure accurate communication between the nurse, direct support staff and the guardian with regard to any and all medications for the resident. (59 Ill. Adm. Code 116.70) (755 ILCS 5/11a-23)

2. Ensure guardian consents are secured for medication.

The rude treatment/abuse and neglect portion of this complaint was referred to the appropriate enforcement agency. As a result, in relation to the staff of Mosaic in Rockford, the allegation of mental abuse was unfounded. The allegations of neglect and physical abuse were unsubstantiated.

Suggestions:

1. Secure guardian signatures on ISPs and behavior plans.
2. Ensure ISPs and behavior plans are individualized by resident.

RESPONSE

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

SORLING
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May 23, 2018

Via Federal Express

Dr. Erin Wade, Chair
Human Rights Authority
Illinois Guardianship and Advocacy Commission
4302 N. Main Street, Suite #108
Rockford, IL 61103

Re: #17-080-9011 Mosaic in Rockford

Dear Dr. Wade:

Enclosed is Mosaic in Rockford's response to the HRA's report in the above-referenced matter.

Sincerely,

Zach Dinardo

E. Zachary Dinardo

EZD/jkb

Enclosure

cc: Carla Saelens

NORTHWEST REGIONAL HUMAN RIGHTS AUTHORITY

HRA CASE NO. 17-080-9011

MOSAIC IN ROCKFORD

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:

_X_ 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.

Carla Saulter
NAME

Executive Director
TITLE

5/17/18
DATE

Mosaic Agency Response to HRA Case #17-080-9011

Recommendation #1-Ensure accurate communication between the nurse, direct support staff and the guardian with regard to any and all medications for the resident. (59 Ill. Adm. Code 116.70) (755 ILCS 5/11a-23)

Agency Response-Mosaic agency nurses will communicate medication changes to Direct Support Staff through the secure Therap Electronic Documentation System used by the agency. Notification of medication changes will be logged by nursing and read by Direct Support Staff in electronic T-logs. Hard copy paper notification of medication changes will also be communicated in the CIILA home on Authorized Direct Care Staff Medication Alert forms. These forms list the medication name, dosage, purpose, time of administration and start/stop dates if applicable. Mosaic agency nurses will communicate medication changes to the guardian through email or telephone. In the case of psychotropic medications, the guardian will be provided a Mosaic Informed Consent Sheet stating the name(s) of a medication, purpose and potential side effects of the medication.

Recommendation #2-Ensure guardian consents are secured for medication.

Agency Response- Once a medication has been approved by the guardian it will be added to the resident's Therap electronic MAR. With regard to all medications prescribed to the resident, once the guardian has approved or denied the medication a follow up email will be sent to the guardian confirming the disposition of guardian approval. A copy of that email will be placed in the resident's file.