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Egyptian Regional Human Rights Authority
Report of Findings
Lakeview CILA Home
Case #17-110-9015
June 6, 2018

The Egyptian Regional Human Rights Authority, a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegation concerning Lakeview CILA (Community Integrated Living Arrangement) Home.

A recipient received inadequate care and treatment

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code and regulations that govern Community Integrated Living Arrangements (CILAs).

Lakeview which is located in Marion is a CILA home owned by Liberty Enterprises Inc. which provides residential services to persons with developmental disabilities. To investigate allegations, an HRA team met with the recipient, family, and agency representatives as well as the case coordinator for the recipient. The HRA also examined, with consent, the recipient's records and reviewed pertinent policies and other documents.

COMPLAINT STATEMENT

According to the complaint, when the recipient is sick he is required to go to the main CILA home where there is a daytime staff member instead of having a staff come to him to allow him to stay home when he is not feeling well. Another issue was that medication errors have been occurring frequently. The final issue was that there were no grab bars installed in the restroom and as a result of this, the recipient had some falls and injuries.

FINDINGS

Family Member: The HRA spoke with a family member who is also the recipient's agent under a Power of Attorney (POA) for medical and financial matters. She explained that the recipient had recently had some medical issues and was having to stay home from work more often because of it. He had recently had surgery and when he woke up not feeling well enough to go to work, he would still have to get on the bus and be taken to the main CILA home where staff are during the day as his home does not have staff during the day when residents are at work. When his peers are finished with work, the bus that brings them home also picks him up from the

main CILA home and brings him home at that time. One incident in particular that was described was the day he had a biopsy done. The home knew ahead of time about the appointment but did not make arrangements for staff to be home with him and he had to go to the main CILA home following his biopsy. The family member asked the owner why the recipient could not stay home and rest and the response was that they do not have staff at that home. He did not offer to call in staff or to go to the house himself until staff arrived.

Another concern was that staff had recently been moved around and a good staff person was moved from Lakeview CILA to the main CILA home and a "negligent staff person" took her place at Lakeview. The replacement staff had made 4 medication errors in the 3 weeks prior to our discussion. The family member spoke with the CILA manager about the errors and he said that he would monitor this new staff more closely, but errors were still occurring. Some examples given were that the staff person had given medication at the wrong times. She administers medications at times that are convenient for staff not when the physician ordered them. The recipient is ordered to take his last medication at midnight; all other residents are done by 7-8 p.m. They have given the recipient his midnight medication at 9:30 before. Also, when balancing the medication administration record (MAR) with the physician orders, she left off his Phenobarbital medication; another staff person caught that error. Another example was that when the recipient was going on a home visit for the weekend with family on 8/4/17 this staff person had placed another resident's medications in with this recipient's things and did not send all of his medications for the weekend. The HRA found no medication error reports that documented an error as described by the family member on 8/4/17. To the contrary, the case notes for that date indicated that the recipient was home that Friday night and had not gone for a home visit with his family. None of the other medication error reports or case notes for other dates indicated such an error occurred.

Another situation that was described to the HRA was that the local hospital comes to the CILA home to draw labs to check the recipient's Dilantin levels and they are supposed to notify the physician and the CILA home when his labs are abnormal. His primary care physician is in another network from the local hospital that draws his labs so this sometimes causes a breakdown in communication between the hospital that draws labs and his primary physician. On one occasion, his labs were drawn at 6 am on Monday and the results came back at 11:30 a.m. His Dilantin level was at 10. If it falls below 15 he can have seizures. It was not until that Thursday that the staff notified the nurse that his levels were off. On another occasion, a physician at a local emergency department had given him a dosage of Dilantin that was too high. The home had called an ambulance and then called her as his POA agent for medical care. She met him at the hospital and no staff had accompanied him to the hospital. Most of his drug allergies were not on the list that was sent to the hospital with him.

The family member was also concerned about the staffing at the home. She stated that there is only 1 staff person for every shift for the 4 person CILA home and there is not enough supervision of the residents. The new staff person goes outside frequently to smoke or talk on her phone and leaves the residents inside unsupervised. The first day after his surgery, the recipient had fallen when using the toilet. She said that there is no grab bar near the toilet to hold onto and he loses his balance and has fallen 3 times because of this. She complained to the owner about the grab bar and he did install a bar on the side of the bathtub. The family member

thought that one on the wall would have provided more stability and would have served the purpose better because his issues are when he is using the restroom not getting in or out of the bath tub. She does not feel that staff provides enough assistance when needed with showering because the recipient had mentioned to her that when he asked for help from this new staff person, she refused it saying she was too busy.

Recipient: The recipient was interviewed twice, one time at his home and at a later date he was interviewed at work. Both times, the recipient said that it does not happen very often that he has to go to the main CILA home but it has happened "a few times." When asked if he has to stay the entire day at the other home, he said that he does not stay all day "just a little bit." He did say that now he has a 1:1 if he needs to stay home when he is sick.

He did admit to having falls in the restroom 4-5 times prior to the bathtub bar being installed but said that he has not fallen since. He thinks his medication was making him dizzy and causing him to fall. When asked, he stated that the bar on the tub is enough help for him to get on and off the toilet. He mentioned another concern to the HRA that the bathroom door locks from the outside when he goes in and then he cannot get out and has to call for staff to assist him. Staff accuse him of doing it on purpose but he said that he is not. Other than that, he had no concerns about his home other than the remote controls being locked up now and controlled by staff, but he said that staff let residents watch what they want to; they just cannot control the remote any longer. He said this was due to the remote control turning up missing once and they found it in another peer's room.

Administration: The HRA met with the administrators for the group that runs Lakeview CILA home. They currently have 3 CILA homes: Lakeview is a 4 bed CILA, the main CILA has 8 beds and they also have another 5 bed home. The census was full at the time of our interview. They have 16 total employees. They have no staff assigned during the day to the Lakeview home as all residents work during the day, however they said if someone is home they will assign 1 staff person to the home. The 5 bed home has 1 staff at home during the day and the main home has 2 staff during the day. They currently have 3 residents that are "retired" and do in-home day training so daytime staff are assigned to those homes where the retired residents reside. Three of their staff rotate between the homes but for the most part, they have certain staff assigned to certain homes and then also have a couple of call-in staff persons they use as needed. As for staff training, the administrators explained that if they are already DSP (direct service person) certified, they will do in-house training and work with staff there on the shift to which they will be assigned. If they are not already certified, they complete the DSP course that is 16 weeks long of approximately 80 hours of class time and 80 hours of on-the-job training.

The recipient has lived in the home approximately one year. He has mild developmental disabilities, is his own guardian and works doing assembly/piece work where he is paid per piece completed. He has family that is very involved with his care and said for the most part he does well, keeps to himself, is not aggressive and has a good sense of humor. He recently had surgery for cancer and was in rehabilitation for 2 weeks and then came back home and returned to work a couple months later. If he is sick and needs to stay at home, the administrators said that they will call someone in, usually their 1 part time staff person that is employed. If that person is not available one of the administrators will come in for him to be able stay home. He said the home

staff may have to bring him to the main CILA home if they do not have enough time to get staff in before the other residents and staff have to leave for the day. As soon as they can get staff in then he is taken back to his home for the remainder of the day. They explained that this may have only happened 1 or 2 times since his admission and he was back at his home in an hour or so. He did not voice any concerns or complaints about this and had no maladaptive behaviors as a result of going to the other home temporarily until staff could be home with him. He typically does not miss a lot of work and his family brings him home with them every Friday through Sunday and every holiday.

They said that previously they did not have grab bars in the restroom at Lakeview or their 5 bed home because none of their residents required one; the main CILA home has them due to resident needs. When this recipient had falls and his family requested it for him, they installed a grab bar on the bathtub. The recipient has not complained about it and has not mentioned any other concerns to them. When asked about the bathroom door lock, administration stated that they have not been notified of a concern with the lock, but agreed to inspect it to make sure it is working properly. The lock on that door is the type that you push and turn the knob from the inside to lock it. This recipient is independent in his activities of daily living skills (ADL) and staff have not noticed any decline in those skills with his latest illness. As far as shower assistance, staff give help when needed. All 4 of the residents at Lakeview require some help in the shower so it is given to them.

Regarding the medication errors, the administrators recalled one medication error when the Dilantin should have been increased and was not for maybe a day but contended that could have also been due to the physician's order not being received. The recipient's Dilantin has to be adjusted frequently due to what the lab work shows when his levels are checked. The recipient's POA agent was previously deciding when he needs more or less medication just based on the way he acts and staff had to explain to her that the physician orders, based on lab results, have to be followed. When there is a medication error, a separate form is completed for the chart and the nurse is notified and will retrain the staff person on corrective measures and appropriate administration. They have one nurse consultant that does medication training for the direct care staff. The nurse goes to every home at least one time per month and reviews the MARs. The nurse is also notified of new medications and trains staff on it. The nurse also does annual nursing assessments and reviews physician notes. The direct care staff takes the residents to their medical appointments. If any of the residents are sick, the direct care staff calls the nurse for advice and will either continue monitoring or take them to the doctor based on the advice given. This recipient has his own physician in the community which is out of the network to the nearest medical facility to his home, but the POA agent does not want to change physicians.

When the HRA inquired about staff concerns, they said that they have moved 2 staff persons to a different CILA home at the family's request because she did not like them. She said they did not know what they were doing or that they were not capable of doing something. They have spoken with the recipient and also requested his case coordinator to speak with him about staff and he has not voiced any problems with any of the staff at his home to either of them. They have told the family member that if she is not happy she can move him but she does not want to do so.

<u>Caseworker:</u> The recipient's caseworker was also interviewed. She has several clients in this agency's CILA homes. Lakeview CILA is the only home that does not have clients at home during the day as they all go to work, so there is no staff scheduled at the CILA home during the day. This recipient has recently missed work frequently during the day due to illness. He moved to the home about a year ago and went to work daily, but had missed work the last 2 weeks due to having bronchitis and then seizures. He has also fought cancer in the last year. Overall the recipient was described as having a good temperament although he does have a tendency to "pester others" and will sometimes take things from others. The recipient had told her that he would rather stay home during the day when he is not feeling well. She spoke with one of the owners and was told that it was a staffing issue when he has been taken to the main CILA home. There are 2 retired clients at the main home so there are staff in that home during working hours since the retirees stay home all day. The owners do call staff in or go to Lakeview themselves if possible when the recipient is sick, but occasionally (once or twice) they have had to transport him to the main home until staff arrangements could be made, but to her knowledge he has not had to stay there all day when that has happened. She also informed the HRA that if the recipient had an appointment, they would schedule staff to be home for that shift. She also said that recently they had requested funding for him to have a 1:1 staff when needed for medical reasons and she was fairly certain that would be approved due to his recent major illnesses. The staffing ratio for his home is 1 staff for 4 recipients and there are 2-hour shift overlaps where 2 staff members are present for outings, etc. The QIDP for Lakeview home lives in town so if there are any major behavioral or medical issues the QIDP is called in and they can also call other staff in to assist if needed.

The caseworker was unaware of any falls and stated if he had some, she was not notified. The recipient had not complained to her about needing a grab bar in the restroom and said his family just felt that he needed it and the owners put one in either that day or the next when it was requested. The recipient told her the tub grab bar was enough for him. The recipient is independent in his ADL's and staff said he does fine with showering independently, however his family feels that he needs help. She stated that staff do assist when needed but there may have been one incident when he did not have showering assistance due to him making a lewd comment to staff.

The caseworker could not speak to medication errors as they are not reported to her, but she said the nurse is notified if there are any errors. She completes chart reviews quarterly and has not noticed any documentation in recent reviews, monthly notes or incident reports indicating there were medication errors.

<u>Record Review</u>: <u>The case notes</u> were reviewed for January through March for the time period pertinent to this investigation. In regard to shower assistance, a note <u>dated 1/10/17</u> documented that the recipient took a tub bath and staff assisted him in and out of the tub. Another note <u>dated 1/26/17</u> documented that the recipient asked staff if they would help him wash his hair, shave and trim his eyebrows; staff assisted and he went for a home visit after that and his family noticed how he looked. On <u>1/31/17</u> a note documented that he took a shower by himself and "was happy that he done it. He asked staff to hold his hands while getting out of shower for safety issues." Another note <u>on 2/24/17</u> documented that the recipient "went and shaved and asked staff if I could wash his hair. Had a snack with peers and took med. Ate 50% at supper.

Left for home visit with Aunt for the weekend, will be back Sunday night." The same staff person entered a "late entry" note on 2/23/17 documenting that staff asked the recipient if he was ready for a shower and he said "no I want to wait until Friday when it's just him and day shift staff." The same staff also entered a "late entry" note on 2/24/17 which stated that the recipient reported that he did not get a shower, he asked and day shift told him she was busy. On 3/1/17 the case notes indicated that the recipient went into the bathroom and shaved himself and after supper he took a shower and asked staff to help him into the shower and out of the shower.

A case note dated 2/28/17 documented that at 11:00 a.m. staff picked up the recipient from the main CILA home and took him home (to Lakeview CILA). A case note on 3/21/17 from the 10:00 p.m. – 8:00 a.m. shift documented that the recipient was complaining of a stomach ache around 10:15 p.m. Staff notified "one of the bosses about him hurting, boss said to check vitals" The staff person documented his vital signs at 12:00 a.m. which were within normal limits. The recipient woke up the next morning at 6:30 a.m. and refused to go to work. Staff notified the owner who said to try to get him to go but he still refused so the owner directed staff to take him to the main CILA home. Staff took him at 8:00 a.m. with his lunch and noon medication. Staff from the 2:00 p.m.-10:00 p.m. shift documented that he "returned from D.T. [day training/work] at 3:20 p.m."

A case note dated 2/28/17 documented that new orders were received from the emergency room doctor to stop Tramadol and to change Tylenol to every 6 hours. Also a new medication was ordered for arthritis in his hip and orders were faxed to the pharmacy and to the Nurse Trainer. The emergency room labs indicated that the recipient's Dilantin level was 21.2 and it was noted that the order was to decrease his 6 p.m. dose to 25 mg and to have repeat labs done 3 days later to recheck Dilantin level. A case note dated 3/21/17 documented that when staff were doing medication counts, it was discovered that his 6:00 p.m. Diazepam medication was not given. Staff notified the nurse and the nurse instructed to give it to him at 10:35 p.m. A case note dated 8/4/17 documented the recipient was at the CILA home during the 10:00 p.m.- 8:00 a.m. shift. The recipient had interrupted staff who were attending to another peer because he needed the staff to fix his glasses that he had just broken. It was also documented that he remained in his rocker in his room watching television until 2:30 a.m. A case note dated 8/7/17 documented that the recipient stayed home due to ear pain.

Medication Error Reports: The HRA found 3 medication error reports during the initial chart review dated 2/7/17, 3/16/17 and 3/20/17 all errors involved different staff persons. On 2/7/17 a documentation error occurred involving the recipient's Phenytoin (seizure medication). The 2:00 p.m.-10:00 p.m. staff had initialed the 11:00 p.m. signature slot. The nurse provided an in-service training update on the correct use of the MAR. On 3/16/17 a mediation error occurred involving his Phenytoin/Dilantin medication. Staff documented that the recipient's 6:00 a.m. Dilantin was not given. The nurse was called at 9:00 a.m. and advised staff to take the 6:00 a.m. medication to workshop and give it to the recipient and adjust the times to 10:00 a.m., 3:00 p.m. and 9:00 p.m. for that day and continue with his regular schedule at 12:00 a.m. The corrective action taken was providing a 1:1 in-service on using the MAR and passing medications. On 3/20/17 staff documented a medication error involving his Diazepam medication. The 6:00 p.m. dose of the medication was given at 10:35 p.m. due to staff not being used to working the 2:00 p.m. to 10:00 p.m. shift with the resident. The corrective action taken section stated "should use

MAR and [illegible] to pass meds on all shifts, it's the same process." The HRA noted that none of the staff names who made the medication errors matched the name of the staff that the family member mentioned as being a "negligent staff person." As a result of a subsequent request for medication error reports in January, 4 more medication error reports were produced. On 8/3/17 the 10:00 p.m.-800 a.m. shift staff person documented that during a medication check, it was discovered that the 6:00 p.m. dose of Loratadine (allergy) was not given by the previous shift's staff. The nurse was contacted and the medication was given at 12:00 a.m. per the nurse's instruction. This staff also found and reported a second error on this same date by the same staff person on the prior shift. The recipient's Phenytoin (Seizure medication) was not given. It was also noted that the date/timesheet was initialed by the staff indicating that it was given, but the medication was still in the bubble pack. Per the nurse's instruction, the medication was not given to the resident. The corrective measures on both of these stated to use the MAR to pass medications and to compare the MAR three times to the bubble pack. On 9/1/17 a staff discovered that the recipient's 6:00 p.m. dose of Diazepam (anti-anxiety) was given with the 6:00 a.m. dose of the medication. The corrective measure listed by the nurse was to follow the MAR for medication pass and compare each card with the order on the MAR. Finally on 9/18/17 it was documented that when the recipient returned from work, staff checked in the noon Phenytoin from the lock box to the medication cart and observed that the dose on 9/17/17 had not been given. The error was reported to the owner and the nurse trainer, but the corrective action taken was not documented on the form. An annual nurse's report/summary on medication errors was also requested but the HRA was informed that there was no such report.

The Physician Order for Dilantin ordered 50 mg four times daily at 6:00 a.m.; 12:00 p.m., 6:00 p.m. and 2 tabs at 11:00 p.m. If his level falls below 16, the Dilantin should be increased by 25 mg at 6:00 p.m. for 3 days and then levels rechecked. Once level is back above 16, the extra 25 mg dose can be discontinued. If his level rises above 20, the Dilantin should be reduced by 25 mg at 6:00 p.m. dose and levels rechecked in 3 days. When the level falls below 20, return to the regular 50 mg dose at 6:00 p.m.

Individual Service Plan (ISP): The HRA reviewed the preliminary ISP dated 6/16/16 which was the most recent at the time of our interview. The recipient's full scale IQ was listed as 53 with adaptive behavior score of 6 years 2 months. His diagnosis is Axis I Anxiety; Axis II Mild Intellectual Disability; Axis III Epilepsy, Hiatal Hernia; Acid Indigestion; Perforation left ear drum; Neuroleptic Malignant Syndrome; Irritable Bowel Syndrome; Axis IV Developmental Delay and Axis V GAF 50. He is his own guardian but has a family member who is the power of attorney agent for medical care. The health medical risk section states that he is unable to self-medicate and listed his allergies. The plan is to continue programming on self-administration of medication. Staff are to insure medications are given as prescribed and the nurse will monitor. The services and supports section noted that he is taken to medical appointments by direct care staff or his POA agent. His medications are administered by direct care staff that are trained and supervised by a registered nurse/nurse trainer who is available by phone for any questions and reviews files monthly. In the event that the recipient has overnight visits with family or friends then the family is directly responsible for the continuity of care including assisting with and maintaining hygiene and medication administration. For his medical supports, the nurse trainer is responsible for ensuring overall health safety and welfare and will use her own system of quality assurance each month to ensure that medications and physician orders are being

followed. The ISP also stated that staff are required to assist the recipient with medication administration and have completed the training by the nurse trainer. If there are questions or errors staff will contact the nurse trainer and the CILA supervisor/coordinator.

The ISP documented that he is independent in self-care but noted staff assistance is needed in trimming facial hair. For home safety, the ISP states that the recipient is well spoken in his wants and needs and can get staff attention when he needs help. The recipient is cared for by direct care staff at all times. The provider will continue to provide daily needs for hygiene and accessibility and exercising. The ISP did not indicate that staff assistance is needed with showering. The ISP also documented that no adaptive equipment was needed at that time but the ISP had a recommendation of using a walker in and out of the home and non-skid shoes and seated shower and bathing. Staff are to prompt him informally in areas that will teach him skills for independent health and cleanliness.

STATUTES

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) guarantees the right to "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…..In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided."

Regulations that govern CILAs (59 Ill. Admin. Code 115.200) describes the community-integrated living arrangement (CILA) as "*a living arrangement which promotes residential stability for an individual who resides in his or her own home, in a home shared with others, or in the natural family home and who is provided with an array of services to meet his or her needs. The individual or guardian actively participates in choosing an array of services and in choosing a home from among those living arrangements available to the general public and/or housing owned or leased by an agency. If, over time, less intensive services are needed, the service array shall be changed rather than requiring the individual to move to a different setting unless specific services as funded and provided are no longer needed. If, over time, the individual needs more intensive services, the agency will make a reasonable effort to modify the service array rather than requiring the individual to move to a different setting. The services must continue to be able to be provided within the scope and resources of the CILA program. The individual may remain in his or her own home. Once accepted for service by an agency, termination of services may only occur by voluntary withdrawal of the individual or resulting from the recommendation of the interdisciplinary process and based on the criteria contained in Section 115.215.*

b) Licensed CILA agencies technically agree to a no-decline option; however, the agency may decline services to an individual because it does not have the capacity to accommodate the particular type or level of disability (e.g., an agency that serves only individuals with autism) and cannot, after documented efforts, locate a service provider which has the capacity to accommodate the particular type or level of disability. No otherwise qualified persons shall be denied placement in a CILA solely on the basis of his or her physical disability. The CILA

agency or service provider associated with such agency must provide a reasonable accommodation for such persons, unless the accommodation can be documented to cause the agency or other service provider an undue hardship or overly burdensome expense.

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. Individuals are recognized as persons with basic human needs, aspirations, desires and feelings and are citizens of a community with all rights, privileges, opportunities and responsibilities accorded other citizens. Only secondarily are they individuals who have a mental disability.

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"

Section 115.220 requires CILAs to provide services through a Community Support Team (CST). "a) The CST shall consist of the QMRP or QMHP, as indicated by the individual's primary disability, the individual, the individual's guardian or parent (unless the individual is his or her own guardian and chooses not to have his or her parent involved, or if the individual has a guardian and the guardian chooses not to involve the individual's parent), providers of services to the individual from outside the licensed CILA provider agency, and persons providing direct services in the community…c) The CST shall be directly responsible for:

1) Modifying the services plan based on on-going assessment and recommendations;

2) Linking individuals to resources and services;

3) Advocating on behalf of individuals…"

Section 115.230 requires the CILAs to "*comprehensively address the needs of individuals through an interdisciplinary process"* with input from the resident and guardian.

Section 115.300 governs environmental management of CILAs and requires the following *"b) For individuals who choose to reside in living arrangements owned or leased by an agency, the licensed agency shall insure that buildings containing owned or leased living arrangements shall comply with locally adopted building codes as enforced by local authorities and the applicable chapters of the editions of the NFPA 101, Life Safety Code (National Fire Protection Association, 1991), as cited in the rules of the Office of the State Fire Marshal at 41 Ill. Adm. Code 100 and any local fire codes that are more stringent than the NFPA as enforced by local authorities or the Office of the State Fire Marshal. An agency shall make available the report of an inspection that has been made by the local authorities or the Office of the State Fire Marshal prior to providing services to any individual in any CILA site…c) Each living arrangement shall meet standards as identified in local life/safety and building codes. Living arrangements specified in subsection (b) of this Section shall also meet the following additional standards:*
1) Each living arrangement shall have a smoke detection system which complies with the Smoke Detector Act [425 ILCS 65].
2) No more than eight individuals shall be served in any site.
3) There shall be documentation that living arrangements are inspected quarterly by the licensed CILA agency to insure safety, basic comfort and compliance with this Part.
4) Bath and toilet rooms

A) At least one bathroom shall be provided for each four individuals. A bathroom shall include a toilet, lavatory, and tub or shower.
B) Bathrooms shall be located and equipped to facilitate independence. When needed by the individual, special assistance or devices shall be provided.
C) Bathing and toilet facilities shall provide privacy."

Section 115.320 outlines the administrative requirements and says this about staffing *"1) Mental health and developmental disabilities employees shall be licensed or certified as required by Illinois laws.*
2) When paraprofessional or untrained employees are used in direct services, they shall be supervised in the provision of services by professional employees.
3) An agency shall not employ an individual in any capacity, until the agency has inquired of the Department of Public Health as to information in the Nurse Aid Registry concerning the individual. If the Registry has information of a substantiated finding of abuse or neglect against the individual, the agency shall not employ him or her in any capacity.
c) General program requirements
Agencies funded by the Department shall meet the following general program requirements for all funded services:
1) Service setting
Services shall be provided in the setting most appropriate to the needs of and reflecting the preferences of the individual. This may include the individual's home, the agency, or the community. All settings shall be used innovatively in order to reach the target populations."

Section 116.40 governs training and authorization of non-licensed staff by nurse trainers to administer medications and says *"Non-licensed direct care staff who are to be authorized to administer medications under the delegation of Nurse-Trainer shall meet the following criteria:*
1) be age 18 or older;
2) complete high school or its equivalency (G.E.D.);
3) demonstrate functional literacy;
4) satisfactorily complete the Health and Safety component of the Direct Support Persons Core Training Program or a DHS approved equivalent Developmental Disabilities Aide Training Program prior to the beginning of medication administration training;
5) be initially trained and evaluated by a Nurse-Trainer in a competency-based, standardized medication curriculum specified by DHS;
6) score 80% or above on the written portion of the comprehensive examination furnished by DHS based on the information conveyed to them during a medication administration classroom course; and
7) score 100% on a written or oral competency-based evaluation specifically pertinent to those medications that these staff are responsible to administer."

Regarding medication administration Section 116.50 *"a) Medications shall be administered in accordance with the Mental Health and Developmental Disabilities Administrative Act [20 ILCS 1705] and the Illinois Nurse Practice Act. b) With the exception of subcutaneous insulin administration by insulin pen by authorized staff and emergency epinephrine administration by epinephrine auto-injector by staff trained in epinephrine administration, non-licensed staff shall not administer any medication in an injectable form…g) A registered professional nurse,*

advanced practice nurse, physician, or physician assistant shall be on duty or on call at all times in any program covered by this Part"

Section 116.70 further states this *"c) In the event of a medication error, authorized direct care staff shall immediately report the error to the registered professional nurse, Nurse-Trainer or person licensed to prescribe medication in Illinois to receive direction on any action to be taken. All medication errors shall be documented in the individual's 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 within 7 calendar days after the occurrence. A copy of the medication error report shall be maintained as part of the agency's quality assurance program. Medication errors must be documented and are subject to review by DHS or DPH, whichever is applicable. Medication errors that meet the reporting criteria of DHS' 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."*

Section 116.100 governs quality assurance for medication and states *"a) A registered professional nurse, advanced practice nurse, licensed practical nurse, pharmacist or physician shall review the following for all individuals:*
1) medication orders;
2) medication labels and medications listed on the MAR to ensure that they match physician orders; and
3) MARs (for persons who are not self-medicating) to ensure that they are completed appropriately for:
A) medication administered as prescribed;
B) refusal by the individual; and
C) full signatures provided for all initials used.
b) Reviews, as described in subsection (a), shall occur at least quarterly, but may be done more frequently at the discretion of the registered professional nurse and/or advanced practice nurse.
c) At least annually, the agency, inclusive of the Nurse-Trainer, shall summarize and analyze all medication errors to identify patterns and trends and establish corresponding corrective action. The analysis and corrective action must be documented and that documentation shall be retained by the agency for at least five years.
d) All quality assurance records shall be confidential and may only be disclosed in accordance with Article VIII, Part 21, of the Code of Civil Procedure [735 ILCS 5/8-2101 through 8-2105]."

CONCLUSION

The complaint alleged that the recipient received inadequate treatment due to being required to go to a main CILA home when he is sick during the day rather than being able to stay in his home. Another issue was that several medication errors had been made by direct care staff. The final issue was that the bathroom did not have grab bars to assist recipients from getting in and out of the bath tub/shower or up and down from the toilet and, as a result, this recipient had fallen a few times while trying to get off and on the toilet.

When reviewing the chart information, the HRA found one case note on 2/28/17 which documented that the recipient was picked up at 11:00 a.m. from the main CILA home and taken to Lakeview. Another case note found was from the overnight shift dated 3/21/17 stating that the recipient refused to go to work and the owners were contacted and he was transported to the main CILA home. It was also documented that staff took him at 8:00 a.m. with his lunch and noon medication to the main home. Staff from the 2:00 p.m.-10:00 p.m. shift documented that he "returned from D.T. [day training] at 3:20 p.m." so the HRA concluded that on that date he remained at the main CILA home all day. When questioned about being transported to the main CILA home when ill, the recipient and his case coordinator both stated that occasionally he is transported due to staffing issues, but that does not happen very often and when it does he only remains at the home for a short period of time until staff can arrive and accommodate him at his home. Although on at least one occasion, it appeared from documentation that the recipient remained at the main CILA home all day, the HRA also found documentation on another occasion when he was picked up early from the main CILA home and brought to Lakeview. The HRA found no other documentation which would prove that this was a regular occurrence and when questioned, both the recipient and his case coordinator stated that it does not happen often and when it does, he does not have to remain there all day which corroborated what the administration had told the HRA. Regulations (59 IL ADC 115.320) require services to be provided in the setting most appropriate to the needs of and reflecting the preferences of the individual. The HRA contends that the agency made arrangements and accommodated the recipient's wishes to stay home when he was ill, with the exception of the one documented day when he appeared to be at the main home all day. However, the agency did seek out and obtain the funding for him to have a 1:1 staff for medical reasons when necessary. Therefore the allegation is **unsubstantiated.**

The next issue involved medication errors. The HRA reviewed 6 medication error reports for this recipient for the year. The first involved a staff person initialing the wrong time that a medication was given. The next two involved the recipient's seizure medication not being given at the appropriate time. The last three involved the recipient's seizure medication not being given and one instance where 2 doses of his anti-anxiety medication were given. In all occurrences, the direct care staff documented that they contacted the supervising nurse and what directions were given. In all but one instance, the corrective measures were documented which consisted of the nurse trainer speaking with the staff persons involved to provide an in-service training on how to properly pass medications. On one occasion (9/18/17), the corrective measure taken was not included on the medication error report. Regulations (59 IL ADC 116.70) require that *"in the event of a medication error, authorized direct care staff shall immediately report the error to the registered professional nurse, Nurse-Trainer or person licensed to prescribe medication in Illinois to receive direction on any action to be taken. <u>All medication errors shall be documented in the individual's record and a medication error report shall be completed."</u>* Regulations (59 IL ADC 116.100) also require that *"At least annually, the agency, inclusive of the Nurse-Trainer, shall summarize and analyze all medication errors to identify patterns and trends and establish corresponding corrective action. The analysis and corrective action must be documented and that documentation shall be retained by the agency for at least five years."* The HRA requested this medication error summary but was informed that there was no such document/form. The HRA also found no documentation in the chart regarding medication errors as required by regulations listed above, just the medication error forms were completed. The recipient's ISP states that staff are to ensure medications are given <u>as prescribed</u> and the nurse is

to monitor. The HRA found 6 instances over the past year when medication errors occurred by various staff members. For these reasons, this allegation is **substantiated**. The HRA makes the following **recommendations:**

1. Administration and the nurse trainer should review medication error reports regularly and ensure that the forms are completed correctly and that all information is present. An annual summary of all medication errors should be completed by the nurse trainer as required by regulations (59 IL ADC 116.100) to identify patterns and establish appropriate corrective action.
2. Staff should be trained on the requirements for documentation of medication errors and all errors should be documented both in the individual's record and on the medication error reports.

The final issue was that Lakeview home did not have a grab bar in the bathroom which resulted in this recipient falling on more than one occasion. The HRA did not find any case notes documenting falls and the case coordinator was not aware of any falls, however when the HRA questioned the recipient he did admit to having fell in the bathroom a few times. The owners of the home stated they initially did not have grab bars in this home's bathroom because none of the residents needed that accommodation. However, when the family member requested one be installed, the owners complied within a day or two of the request. Although the family member was not convinced the grab bar being installed on the side of the bath tub was helpful, when questioned, the recipient said that it helps and he has not had any falls since then. Regulations (59 IL ADC 115.300) require that bathrooms include a toilet, lavatory, and tub or shower. A grab bar is not required; however, the regulations do state that bathrooms "shall be located and equipped to facilitate independence. When needed by the individual, special assistance or devices shall be provided." There was no documentation to indicate that the owners were aware that the recipient had fallen in the restroom and a grab bar was installed when the family requested it. Therefore, this allegation is **unsubstantiated.** The following suggestions are offered:

1. The ISP documented that the recipient is independent in self-care but noted staff assistance is needed in trimming facial hair. The HRA found several case notes indicating that the recipient shaved himself. Staff should be reminded that ISPs are to be followed and assistance be provided where indicated in the ISP. Although no problems with independent shaving were noted, the HRA suggests that if this is a skill he is independent in, his ISP should be updated to reflect that as an independent skill rather than one needing staff assistance.
2. A 2/24/17 2-10 p.m. shift case note stated that the recipient shaved and asked staff for assistance with washing but a *late entry* note that same day documented that the recipient said that he did not get a shower that day and he had asked day shift staff who told him that she was busy. The HRA suggests that direct care staff be reminded that even when busy, they should make the needs of the residents a priority and provide assistance with ADL's when needed.
3. The HRA was concerned by the statement of the case coordinator that there may have been one occasion when showering assistance was not provided due to the recipient "making a lewd comment" to staff. The HRA found no documentation of this incident in case notes and would like to take this opportunity to suggest that if incidents such as this

occur, detailed case notes should be made regarding the incident and the issue should be brought to the treatment team's attention and addressed in behavioral plans in the future.

RESPONSE

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

To: IGAC

#7 Cottage Dr.

Anna, Il. 62906

From: Liberty Enterprises Inc.

1304 West Mack Ave. Marion, Il. 62959

Marion, Il. 62959

Re: HRA NO. 17-110-9015

Actions taken by Liberty Enterprises the Nurse Trainer and Administration review all medication errors at least quarterly to assure they are done on time and completed correctly. The Nurse trainer retrains all staff on medication procedures and medication error reports. The Nurse trainer and Administration compiles annual reports quarterly for Quality Assurance.

Thank You;

Stephen Brown, Executive Director, Liberty Enterp[rises