FOR IMMEDIATE RELEASE

Springfield Human Rights Authority
United Cerebral Palsy of Land of Lincoln
Reports of Finding
Case #18-050-9012

The Springfield Human Rights Authority, a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegations concerning United Cerebral Palsy of Land of Lincoln (UCP):

1. **The facility has failed to ensure the guardian's inclusion and notification,**

2. **The facility did not to adequately supervise the individual pursuant to her services/person plan,**

3. **The facility did not follow physicians' orders and medication consents and to appropriately secure guardian medication consents,**

4. **It was further reported that the facility's CEO has not responded to the guardian's grievances.**

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (MH Code) (405ILCS 5) and Community Integrated Living Arrangement (CILA) rules (59 IL Admin. Code 115).

Complaint Statement

The complaint states that an adult female consumer's guardian, who lives in another state, is not informed of incidents and doctor appointments, medical or psychiatric, or given updates on prescription changes. The individual is to wear a boot for tendonitis per the physician's order, but the facility nurse has decided to discontinue per the complaint. In January she was taken to prompt care and the guardian was reportedly not notified. The complaint states that resident is to have 24-hour supervision as per her services plan but is often left in the home without staff. She was allegedly attacked 2 different times and she eloped once; the guardian was not notified of the incidents. According to the complaint, the guardian learned recently that the individual had access to cleaning fluid and poured some in her drink; she reportedly knows nothing of the outcome to date. The individual has a PRN, or as needed, order for Tylenol for foot pain 4 times per day and the nurse will only allow one or two times as per the complaint. The guardian consented to .5mg Xanax and Ativan and the nurse reportedly changed them both to a full milligram. The guardian consented to 3mg Risperdal and the nurse is allegedly giving 5 mg.; the

nurse had the physician change the medication without the guardian authorization. In providing consent, she has never received any medication information in writing or consent forms to sign and she has not heard from CEO on her complaints as per the complaint.

To investigate the allegations, an HRA team met with and interviewed UCP staff, examined resident records, with consent, and pertinent policies.

First Interview with the Program Manager

Per the staff, UCP has offices in Champaign, Springfield, Bloomington and Decatur. In Springfield there are 51 consumers receiving residential services. In the day training program there are 53 homebased services. There are 16 community integrated living arrangements (CILA) in Springfield. None of the homes have over 6 individuals, and everyone has their own rooms. There are individuals in the day training program who either live in UCP CILAs or elsewhere. At the training center individuals can get paid for the work that they do. They serve anyone with a developmental disability.

The HRA asked about the facility's practice for family/guardian communication and notification of incidents. Per the staff person, every individual is assigned a Qualified Intellectual Disabilities Professional (QIDP). The QIDP should be the person in constant contact with families or individuals. Everything should go through the QIDP. Depending on the family or guardian's request, usually any emergency room visit should be related to the guardian. This guardian has not called the case manager once, according to the staff, and there has not been much direct conversation. They did however meet with the guardian approximately in December 2017. The staff said there have been issues with the guardian in that sometimes she withholds money that is due for the individual's care. The guardian has control of the individual's finances and discussions about finances with her usually do not go well. There was a new treatment or person-centered plan completed in March. An independent service agency participates in the creation of the new plan.

Regarding a process for guardian communication or notification, the staff said there is an on-call phone tree, and the nurse calls the QIDP who then calls the guardian. They did not know of any issues with the current QIDP calling the guardian, and the case manager did not receive a complaint about any issues. She explained that they go over medication changes and any incidents with their behavior and human rights committees. In one instance for example, a day program staff from another agency, not their own, dropped the individual off and there was no staff in the home. It was explained that the guardian would exchange texts with a previous QIDP all hours of the night, often having nothing to do with the individual and that the QIDP had crossed their expected boundaries.

Regarding medication, staff explained that the resident has been evaluated for self-medication and it has been determined that she requires assistance. Each person within the agency has a nursing assessment which determines that individual's ability to administer his/her own medications. The direct service personnel (DSP) administers the resident's medication. The DSP under the authority of the nurse trainer completes a competency-based training on medications. To determine the correct dosage that is administered, the person administering the medication follows the signed physician orders and the nurse completes the administration

records. There was a recent discussion with the resident's guardian about the medication. The physician had sent to the pharmacist a new prescription for psychotropic medications, but it wasn't discussed with the guardian or UCP. For psychotropic medication there should be a guardian consent. The new bubble pack was sent out with the old one. She did not know for sure exactly what happened because the Office of the Inspector General (OIG) is investigating. The OIG has everything related to this issue.

The HRA asked about staffing levels in the 2-bedroom home. It was explained that at least one staff member is there at all times for this individual and if that person needs to leave there should always be an on-call person to help with emergencies. She said that this type of incident happened twice when the individual was left alone. To ensure it does not happen again, DSPs staff have been trained to call certain people in the organization for cover or directions on what to do. The HRA requested a copy of the training, but at the interview it was unavailable. The HRA asked for a copy of the on-call tree, but there was not one available. The HRA asked if the individual ever eloped. Staff responded that she did when she lived in another CILA with a housemate whom she did not like. Reportedly she had gone to the police station and the guardian was notified. This was a long time ago per the staff.

The HRA inquired about the alleged cleaning fluid incident and staff explained that the resident said she put toilet bowl cleaner in a drink and peed blue. She was medically assessed at a prompt care where she was cleared. She then recanted the story. The HRA asked if the guardian was informed of this and the other incidents mentioned and whether the facility maintains a log of incidents. It was explained that incident reports are not done unless there are medication errors. At the time of the interview the staff could not produce a log of incidents. The HRA asked if anyone registered concerns regarding the consumer's care and treatment, and if so, how it was resolved. The QIDP joined the interview and explained that every Friday they send the guardian an update. She typically receives multiple texts and requests daily from the guardian on the QIDP's personal cell phone. She completes the weekly emails on Fridays. The QIDP tried to produce documentation from her personal cell phone, but texts would only go back for a two-week time period.

Home Tour

The HRA observed staffing at the home tour. There was good interaction with individual's roommate and staff. There were no human rights of individuals posted. There was OIG contact information posted.

Follow-Up Interview with Chief Operating Officer, Nursing and Program Manager

The HRA conducted a second interview for more information. Asked for the number of residential employees total, the staff said there are 86 employees for meeting residential needs, but the goal is to be at 93 staff.

The HRA asked how the agency responds to grievances, and the staff explained that there is a chain of command that should be followed. For example, if someone presents an issue it should be first addressed with QIDP, and if not satisfied the supervisor is involved, then the chief operating officer (COO) and lastly the chief executive officer CEO.

The HRA asked what happens when the client/guardian cannot resolve issues with the QIDP. According to the staff, the next step would be for the complainant to go to the program director. Asked for any record documentation by current or previous leadership regarding contact with the guardian to resolve issues, they said that she never complained or made a formal grievance, and the guardian has been informed to follow the chain of command. They also referred to multiple emails in which the QIDP had an opportunity to respond to any questions or concerns. The program manager has tried to reinforce and encourage the guardian to follow the grievance process. The process in writing has also been attached to emails.

The HRA commented on what appears to be the past leadership's failure to respond to grievances and asked what has changed. The COO explained that there had been a lack of follow up and documentation and they are working with staff at every level to get them on board regarding appropriate documentation. They are starting 2 new employees hired to be residential managers to oversee the 16 homes including evening shifts from 2-10 pm. They will be directly supervising staff in the homes. There are 2 new posted mentor positions to increase staffing for another level of supervision and leadership. In this position, experienced lead workers will train all of new hires. They plan to put their stellar employees in this position who will be doing the retraining. The goal is to have them in place within the next 2 weeks. Documentation is a primary training point. There are computers in the homes where all staff can document in a timely manner.

Regarding the process for documentation and interaction between the nurse and the guardian in obtaining consents and determining medical care, including medication and treatment, the nurse explained that she has never changed an individual's medication on her own and without a physician's order. They take a prescription from the physician and send notice to the house that there has been a change. As for the tendonitis boot, she would not discontinue it without an order. As far as notifying the guardian, that depends on the guardian. The ones that want to know are notified promptly. Guardian contact for any medical care is also a training target.

The nurse said they must have the guardian's approval for any change to psychotropic medication. Regarding changes to other types of medications, they notify only if that is the guardian's preference and as soon as possible. The HRA asked how the consumer was assessed when she allegedly drank cleaning fluid. The consumer was at home, the nurse was called, and the nurse asked if she appeared in pain, was coughing and could talk. This individual has bad gastroesophageal reflux disease (GERD), and she would have been screaming if she had done this. There was nothing to indicate that this had happened at all. She told staff later that she did not do it. The HRA explained that there was no evidence that she had been medically assessed. The nurse admitted to not documenting her consultation with staff. She stated she would in the future. She also stated that they did not believe she needed prompt care or was taken there.

The HRA shared concerns about the lack of documentation regarding incidents, such as eloping or being left alone, and asked if the facility maintains a log of incidents and guardian notification regarding incidents. We further suggested that from all appearances there seemed to be chronic systemic issues with inadequate records and questioned how staff could follow physicians' orders and document medication consents without adequate records. Furthermore, the HRA

questioned how leadership could monitor staff without adequate documentation. The COO explained that they recognize it is an issue. The HRA shared of being told in the previous interview that incident reports are not done unless there are medication errors, which would conflict with the UCP policy regarding incidents. The staff recognized the problem and said that going forward they will have training and a checklist in the home of what to do when incidents occur, what to look out for with certain individuals and daily shift summaries to note any incidents or potential problems.

Regarding concerns about the QIDP staff using personal cell phones to communicate, in lieu of record keeping, and concerns with confidentiality and storing, UCP reported that they will be giving the residential managers UCP cell phones, instead of staff using personal cell phones and training to make appropriate documentation as stated before. The use of personal cell phones will be discouraged.

The HRA brought up the issue of training for on-call and possibly an on-call tree. Staff advised there will be an on-call tree posted in all homes, and all staff will be trained to use as needed. They also agreed to be sure that recipient rights are posted in each home.

Record Review

Emails provided by the guardian from her to staff:

On 11/28/17, the guardian requested notification of all behaviors and stated that staff had not notified her when her daughter eloped.

On 12/02/17 the guardian asked a program manager and the nurse why no one had checked on the dosage change for risperidone from 2 mg-3mg.

On 12/4/17 the program manager had responded that it was "being looked into". However, there was no information showing that staff responded after that.

On 12/5/17 the guardian contacted the QIDP and program manager and stated that the nurse had hung up on her when she inquired about a medication change and requested that this specific nurse no longer provide services to her ward.

On 1/15/18 the guardian alerted the QIDP that the individual had been dropped off at the home at 3:15 p.m. and the staff did not arrive until 3:40 p.m.

There were more emails from the guardian regarding incidents or medication errors with almost no documented responses by staff, via email, to the guardian's inquiries.

Documentation by staff in electronic notes:

On 10/9/17 the DSP wrote: "After the bath the individual sat on the couch for a few hours and watched tv. She then later wrote a letter to staff stating that she had done something 'bad' and didn't want to tell me. She scratched it out, but staff could still see that she wrote she had drank some Clorox cleaning spray while she was bathing. She seemed fine, but staff notified the nurses and she was instructed to sleep it off. The individual did state that she was feeling 'funny' and

had an upset stomach. She went to bed around 10:00 pm and was checked on every hour. She also says her ankle was still in pain and is swollen and that no one has yet to look at it."

On 10/9/17 the nursing staff wrote: "I received a call from staff saying the individual had come out of the bathroom after taking a bath and said she found some Clorox spray cleaner under the sink and drank some. I asked about any symptoms and was told she said her stomach hurt. I also asked why any cleaner was available for the individual to obtain and staff said everything else was locked up. I told her to put that up too. Anyone drinking Clorox bleach would have severe burning in their mouth and throat before it ever got to their stomach, so I told her to go to bed and sleep it off and she would be fine in the morning. Then I called her mother and told her the whole thing. She said she was glad I had handled it that way so I had her approval."

On 12/06/17 the nursing staff wrote: "We received a fax from Omnicare and a delivery of a change in the order. The consumer is now to take Lorazepam 0.5mg in morning and again at bedtime. The staff called to leave a message with the guardian. We will not start the medication until we hear about acceptance."

On 12/06/17 the nursing staff wrote: "A call was placed and a message was left with the guardian regarding the consumer medication Lorazepam. The physician sent the order to pharmacy changing from 2 tabs daily in am to 1 tablet twice daily. We are waiting for a return call to approve the change to medication dosing."

On 12/07/17 the nursing staff wrote: "The pharmacy contacted the staff at 9:00 am when the phone lines were opened. A request for 5 days of Risperidone was to be sent to house this pm. The pharmacy was agreeable to this and the medications were to be sent at no charge."

"Received call from the guardian stating that the medications had not arrived at the home yet. The writer assured the guardian that pharmacy stated they would be delivered. A follow up call was made to the house asking to contact writer if they weren't delivered so that other arrangements could be made to ensure the individual received her medication. The staff indicated understanding."

On 12/07/17 the QIDP wrote "I spoke with the guardian regarding Risperidone dose being incorrect for the individual. There was to be a 3mg card for the month of December and it had not been delivered to the house. Writer informed the guardian that I was of the impression that the order for the 3mg was faxed to pharmacy and was to be delivered on 12-1. Writer told the guardian that she would call pharmacy to follow up and call her back. The guardian was in agreement with this plan. The pharmacy was contacted, it was the afterhours line. The medications had not been sent out on 12-1-17 as they had no record in the system of a new order for the 3mg risperidone. This writer returned call to the guardian regarding this. The plan was made to have 2mg dose delivered to house so that the individual would have some medication in her system until writer was able to investigate why pharmacy didn't have record of increase in dosage. The guardian was agreeable to this plan. This writer will contact the pharmacy in the morning and arrange for delivery of 5 days of medication to ensure that there is dosing until new medication card can be sent out."

On 12/07/17 the QIDP attempted to call the guardian to obtain confirmation regarding changed dose of Lorazepam. The call was unanswered, but a text message was sent. The response was that it was okay for her to have 0.5mg at 8:00 am and 8:00 pm. The guardian stated that if the 8:00 am dose was still making her tired with the reduced amount then we would have to discuss the timing.

According to 12/07/17 Nursing notes: "As soon as I had talked to staff at the physician's office during the consumer's appointment, they gave me the papers from the visit and I immediately faxed those papers with new orders to the pharmacy on 11-22-17 just before I left for Thanksgiving break and received a confirmation. On the following Tues. when I came back to work, I found out the medication had not been sent. I called the pharmacy to find out why and they told me that they didn't have the order, so I immediately faxed it a second time and received a second confirmation. They (the pharmacy staff) said they would get them out that night. Then late in the afternoon Tuesday, the program manager found out that it still hadn't been delivered. First thing on Wednesday, 12-6-17, I called the pharmacy and they said it was delivered on the fourth. When the nurse looked on line at the pharmacy, she said there is no record of anyone signing for that delivery and called the pharmacy back. What actually happened then, was the pharmacy admitted they had made a mistake and would send the medications free of cost stat and they had them to the house by 8:30 pm that night."

On 12/11/17 the QIDP wrote: "I took the individual to her tri-monthly psychiatric appointment with her guardian present. The physician's office was concerned as to why the individual's Risperidone was at 2 mg and not the prescribed 3 mg. The guardian did not remember approving that change and was asking clarification for the change. QIDP was not aware of the change. QIDP was being notified of information regarding question of medication changes by guardian throughout the night."

Other records:
The HRA reviewed the staffing patterns from January 2018 to March of 2018 of the individual's home which showed that UCP had scheduled someone to be there at all times pursuant to the individual's ISP plan.

In the individual's personal plan under the section labeled (Life in the Community) under "Risks include: 'If I become upset I may not be able to express myself well, I may elope from the premises, I am vulnerable around those I do not know well, I may threaten to hurt others or myself, I may state very serious untrue statements, and I should be monitored when crossing streets and parking lots.'" It listed UCP as the entity responsible for providing a 24-hour CILA.

The physician's orders on 12/6/17 document that "Risperidone 3 mg tablet was to be given by mouth, at bedtime."

Quarterly human rights committee meeting notes for 11/29/17 document that "the individual's medications were reviewed showing a decrease in the individual's risperidone to 2mg and an increase in her Fluoxitene 40 mg. The individual had moved to a smaller setting and she has been observed in her home setting. Her guardian would like her to begin counseling."

Quarterly human rights committee meeting notes for 2/21/18 show "the individual's risperidone had increased to 3mg. There was no change to the Fluoxitene at 40 mg, and lorazepam was .5mg BID (twice a day.)."

The individual's personal plan documents that she began counseling on 2/22/18.

Her behavior intervention plan documents as of 2-6-18 her risperidone was increased from 2 mg to 3 mg.

Documented on the Personal Focus Worksheet (start date 6/1/2017 end date 6/30/2018) under comments it states: "Needs continuous 24-hour supervision, and active treatment due to limitations in self-care, self-directions, and capacity for learning/independent living…."

UCP Policies

Policy on Implementation Strategy (7/17) "…The implementation strategy will incorporate details on how the agency will assist the individual to pursue their personal outcomes in the following categories (home, important relationships, career and income, health and well-being, life in the community, future planning and decision making).

The implementation strategy will identify the personal outcomes developed from the person-centered plan. Each outcome will address how the agency will assist the individual to pursuing their outcomes, on-going support needs in the designated area and risk factors with a plan for mitigating the risk."

Policy on Emergency Procedures/Medical Emergency (7/16) "In the event of a medical emergency, it is the policy of UCP to seek medical treatment through the use of emergency the 911 system, hospital emergency room and local physicians as appropriate."

Under the procedures section it states: "In the event of life threatening emergency: An ambulance will be called using 911. Indicate this is a life-threatening situation. When an emergency arises at the individual's home or in the community, the staff on duty should also call the RN and QIDP's pagers."

It further explains 9 follow-up steps that including that should be followed including guardian notification. "Appears to be poisoned" was listed as a life-threatening event.

Policy on Incident Reporting (05/16) "Incidents involving participants must be reported to the supervisor immediately and a General Event Report (GER) in Therap must be completed within 24 hours of the occurrence."

"It should be understood that injury/incident/unusual occurrence includes abuse (physical, sexual, mental), neglect, exploitation, death or suspected abuse, neglect, exploitation of participants. In addition to completing a GER/incident report as outlined below, for incidents that involve death or suspected abuse, neglect, exploitation, the UCP Policy on Abuse and Neglect should be followed. Use of seclusion/restraint are prohibited by UCP policy and should be reported as suspected abuse. In addition, any situation that is out of the ordinary daily routine

and/or has the potential to endanger the life/health/safety of the participants or staff must be reported as outlined below. This may include injuries, aggression/violence, wandering/elopement, vehicle accidents, biohazard accidents, unauthorized use or possession of weapons, unauthorized use of illegal substances, suicide/attempted suicide, sexual assault or other sentinel events.

Medication errors should be reported to the nurse and a GER for the medication error completed in Therap."

Under procedures it documents that a GER must be completed and follow-up by staff, nursing and supervisors depending on the occurrence. It also mentions that the Compliance Huddle will review incidents at least quarterly to identify causes of accidents.

Policy on Conflict Resolution and Grievances (7/16) "Open communication between UCP staff and persons receiving services is essential in the delivery of quality services. Person served, family members and guardians are encouraged to contact the Chief Officer, Managers or any other staff person to discuss concerns about service delivery, staff relationship with other individuals in the program, or any other situation that may arise. The appropriate chief officer or manager will meet with all persons involved in order to resolve the conflict. Information on conflict resolution and the grievance procedures will be explained to the individual or guardian in a manner that is understandable to them. Once a grievance has been filed, a final resolution must be made within 90 days. An individual will not be excluded, suspended or discharged or receive a reduction of services for exercising any of his or her rights.

Grievance Procedure
Each person served or guardian has the right to appeal any action that denies, modifies, reduces or terminates services. The person served/guardian will be given a copy of the grievance procedure upon entry into the program."

It further explains that a grievance must be presented to the chief officer in writing; the chief officer can than have the grievance reviewed by the human rights committee. If a solution is unreachable it is referred to the CEO, again if unresolvable it can be referred to the Department of Human Services appeals unit within 10 calendar days.

Important Phone Numbers and On Call Procedures (7/11/18) This new list included updated phone numbers and who to call if there are issues in the homes. It lists the new residential managers who oversee the homes to provide back up when there are issues. (Such as when a DSP may be called away.)

Policy on Individual Record and Documentation (7/16) "It is the policy of UCP Land of Lincoln to maintain to maintain complete record with documentation of the daily activities, medical concerns and progress towards individual goals for each person in the program…."

It goes on to explains that notes should be signed and dated. GERs should be entered daily. It explains what to do if there are computer outages when needing to document.

Policy on Guardian notification (No Date) "The QIDP will be the primary person responsible for regular communication with guardians for individual on their caseload. No confidential information should be shared via personal cell phones or personal emails.

At a minimum, the QIDP will communicate in a weekly email (unless an alternative timeframe and format is preferred by the guardian):

- Any doctor, dental, therapy appointments completed with the results,
- Community integration activities completed and plans for the upcoming weekend,
- Behavioral concerns,
- Status of any personal equipment repairs,
- Monthly progress note…."

Policy on Abuse and Neglect (7/16) "To establish a uniform policy and procedures for reporting and responding to all abuse/neglect allegations and deaths."

"It is the policy and the responsibility of United Cerebral Palsy Land of Lincoln (UCPLL) to report all allegations of abuse/neglect and deaths to the Office of the Inspector General in the Illinois Department of Human Services within the required time frames in an appropriate and thorough manner…."

"Neglect: An employee's, agency's, or facility's failure to provide adequate medical care, personal care, or maintenance, and that, as a consequence, causes an individual pain, injury, or emotional distress, results in either an individual's maladaptive behavior or the deterioration of an individual's physical condition or mental condition, or places an individual's health or safety at substantial risk of possible injury, harm or death."

"C. Process for Notification of Alleged Victim and Guardian
After OIG notifies the UCPLL Chief Program Officer (CPO) that an allegation of abuse or neglect has been received, the UCPLL CPO shall notify the victim or his/her legal guardian, if applicable, of the allegation within 24 hours. If the UCPLL CPO is unable to reach the guardian by phone, a letter of notification shall be sent within 24 hours."

"D. Incident Management/Investigation
1. If an allegation would meet the definition of abuse or neglect in OIG Rule 50, the UCPLL CPO shall:

a. Ensure the immediate care and protection of the victim;

b. Obtain medical examinations, when applicable, and fully document the findings…."

<u>Mandates</u>
The MH Code (405 ILCS 5/2-102 (a-5)) states: "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."

Section 5/2-200 a) of the MH Code requires that: "Upon commencement of services, or as soon thereafter as the condition of the recipient permits, every adult recipient, as well as the recipient's guardian or substitute decision maker, and every recipient who is 12 years of age or older and the parent or guardian of a minor or person under guardianship shall be informed orally and in writing of the rights guaranteed by this Chapter which are relevant to the nature of the recipient's services program. Every facility shall also post conspicuously in public areas a summary of the rights which are relevant to the services delivered by that facility."

CILA rules (59 Ill. Adm. Code 50.20) for Reporting an Allegation of Abuse, Neglect, or Financial Exploitation and Death Reports state:
"a) Reporting – by a facility, community agency or employee
1) If an employee witnesses, is told of, or suspects an incident of physical abuse, sexual abuse, mental abuse, financial exploitation, neglect or a death has occurred, the employee, community agency or facility shall report the allegation to the OIG hotline according to the community agency's or facility's procedures."

In Section 115.240 the CILA rules state:
"When medical services and/or medications are provided, or their administration is supervised, by employees of the licensed agency, the licensed agency shall certify that they are provided or their administration is supervised in accordance with the Medical Practice Act of 1987 and the Illinois Nursing and Advanced Practice Nursing Act. The agency shall additionally document:
a) A physician shall be responsible for the medical services provided to individuals, and the management of, individuals' medications.
b) A licensed prescriber shall prescribe and monitor all prescription medications."

Section 115.250 (a) (5) states:
"Every individual receiving CILA services has the right to be free from abuse and neglect….
c) Individuals or guardians shall be permitted to present grievances and to appeal adverse decisions of the agency and other service providers up to and including the authorized agency representative. The agency representative's decision on the grievance shall be subject to review in accordance with the Administrative Review Law [735 ILCS 5/Art. III]. For all individuals enrolled in the Medicaid DD Waiver, their rights to present grievances and to appeal adverse decisions of the agency are detailed in 59 Ill. Adm. Code 120.
d) Individuals shall not be denied, suspended or terminated from services or have services reduced for exercising any of their rights."

Conclusions

The facility has failed to ensure the guardian's inclusion and notification, the facility did not adequately supervise the resident pursuant to her services/person plan, and it was further reported that the facility's CEO has not responded to the guardian's grievances. Per the documentation of the emails to the facility there is little or no documented responses from supervisory staff even when there were medication errors, elopement, the allegation of

drinking cleaning fluid, when the individual had been left alone at the house or just minimum follow-up on the individual's basic care. There were no incident reports on any of these issues by any staff. There was some documentation in the daily logs.

Staff documented on 1/15/18 the guardian alerted the QIDP that the individual had been dropped off at the home at 3:15 p.m. and the staff did not arrive until 3:40 p.m. Even though the individual's ISP stated clearly that she required 24-hour care. It did not appear that this issue was addressed with the guardian from UCP leadership. Per 59 Ill. Adm. Code 115.250 5) Every individual receiving CILA services has the right to be free from abuse and neglect. This resident being left alone put her safety at risk.

The QIPD explained that every Friday they send the guardian an update by email. The QIDP receives multiple requests daily from the guardian on QIDP's personal cell phone. The QIDP explained that she talks and texts to the guardian a lot on her on her personal cell phone. When the QIDP tried to produce documentation from her personal cell phone the texts would only go back for a two-week time frame, so follow-up documentation discussed had been lost. There was also the risk of private information about the individual on a worker's personal cell phone which could be compromised. The guardian had sent multiple emails some of which copied the program manager and the nurse. There was no documented evidence that most of these received UCP responses. The guardian had not stated she was making a formal grievance on these issues, but she should not have been required to when incidents were as serious as medication errors, elopement, the possibility of drinking cleaning fluid or the resident being on her own. The annual attachment to the grievance policy via email may inform a representative of the individual's rights, but when the individual's safety is compromised higher level management should have stepped up to resolve these issues. When the HRA asked for documentation by leadership in the record regarding contact with the guardian to resolve issues, the program manager responded that the guardian never complained nor made a formal grievance, but per the small amount of information in the record she had complained and copied the program manager about these issues via email. Even if there were no good answers for the guardian, higher level management had a responsibility to follow their own chain of command to resolve issues pertaining to neglect pursuant to CILA rules (59 Ill. Adm. Code 115.250 (a) (5)) which state: "Every individual receiving CILA services has the right to be free from abuse and neglect." In part c) it states: "Individuals or guardians shall be permitted to present grievances and to appeal adverse decisions of the agency and other service providers up to and including the authorized agency representative." In the agency's policy regarding abuse and neglect if OIG notifies UCP that an allegation of abuse or neglect has been received, the CPO should have notified guardian, of the allegation within 24 hours. There are OIG complaints regarding these issues, but no documentation that leadership followed-up with the guardian. **All three complaints are substantiated.**

The HRA makes the following recommendations:

1. **Follow the Mental Health Code regarding guardian participation in treatment. UCP must insure there is appropriate follow-up to incidents, allegations, and in some cases Office of Inspector General notification pursuant to CILA rules and UCP's own policies.**

2. **Follow the MH Code and ensure that services are provided pursuant to an individual's service plan with the involvement of the guardian.**
3. **Ensure appropriate documentation by all staff and complete appropriate documentation when there are incidents pursuant to UCP policy.**
4. **Follow through on training regarding guardian interaction and directives. It is a consumer's right to have her guardian oversee her care.**
5. **Complete incident reports and maintain a log of incidents per the UCP's own policies.**
6. **End the practice of staff texting on their personal cell phones regarding individual's care to protect the individual's privacy and ensure there are accurate and complete records.**
7. **Ensure that grievances are addressed pursuant to CILA regulations and UCP policy; document follow-up contacts and resolutions.**

The HRA also suggests that the facility ensure that potentially hazardous products be kept in locked storage with periodic audits being conducted.

The complaint alleging the facility did not follow physicians' orders and medication consents and to appropriately secure guardian medication consents has similar issues with documentation. Staff explained that this individual has been evaluated and she requires assistance to take her own medication. To determine the correct dosage that is administered, the person administering the medication follows the signed physician orders and the nurses complete the Medication Administration Records.

Regarding medication errors it was very difficult to really understand what had happened. It appeared that there were some recommended medication changes and new prescriptions ordered without involving the guardian; however, it also appeared, from the documentation, that administering the medication may have been delayed pending guardian approval. And, the documentation also indicates that the guardian appeared to have given eventual approval of the changes.

From 11/22/17 to about 12/7/17 there is a question about whether or not the individual was taking the correct prescription dose as ordered by the physician. However, the HRA did not see where the dosage had been changed on 11/22/17 except for a nursing note on 12/7/17. On 12/5/17 the documentation shows the guardian contacted the QIDP and program manager, and the nurse. The guardian alleged that the nurse had hung up on her when she inquired about a medication change and requested that this specific nurse no longer provide services to her ward. It did appear that the guardian was made aware of this medication change per the notes, but staff should have followed-up on 11/22/17 when the physician ordered the change but the pharmacy failed to deliver the correct medications. Per the staff, OIG has everything related to this issue.

The HRA was informed by the nurse that she had never changed an individual's medication and that without a physician's order, she would not make a change; her 12-06-17 note stated: "We have to have the guardian's approval regarding any change to psychotropic medication." The MH Code (405 ILCS 5/2-102 (a-5)) requires that "If the services include the administration of psychotropic medication, the physician or the physician's designee should advise the consumer,

in writing….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."
Pursuant to 59 Ill. Adm. Code 115.240 "When medical services and/or medications are provided, or their administration is supervised, by employees of the licensed agency, the licensed agency shall certify that they are provided or their administration is supervised in accordance with the Medical Practice Act of 1987 and the Illinois Nursing and Advanced Practice Nursing Act…."
On 11-22-17 when the physician ordered a medication change, it does not appear, from the limited documentation, that the agency initiated contact with the guardian either prior to or immediately following the prescription change; however, it did appear, from the available documentation, that the medication change was reviewed with the guardian and guardian approval was secured several days later and perhaps before the change was implemented. Still, physicians' orders, guardian involvement and guardian consents should be handled promptly to ensure compliance with orders, the MH Code, CILA regulations, service plans and UCP policy.

The HRA makes the following recommendation: Follow the Mental Health Code and the Administrative Code when administering medication. Involve the guardian in medication treatment decisions, provide medication education to the guardian and secure guardian consents, even for dosage changes, prior to or as part medication changes. Ensure adequate documentation regarding medication. Have documented follow-up when there are medication errors.

The HRA also suggests that written medication consents be secured and that physicians are fully aware when a CILA resident has a guardian.

The HRA appreciates that during the investigation the following has been stated to occur at UCP by the COO:

- **That a new chief of operations has been hired,**
- **That UCP has hired 2 residential managers and will be hiring 2 mentors as extra levels of leadership to be in all the homes,**
- **There are efforts and directives by the new COO to improve documentation,**
- **There is an expectation for staff to complete incident reports when incidents occur,**
- **That there is now an on-call tree to be posted in the homes,**
- **There is policy and training on guardian notification,**
- **Rights will be posted in the homes,**
- **There is new policy on implementation strategy.**