OFFICE OF THE INSPECTOR GENERAL		INVESTIGATIVE REPORT
Case No.	**Report Date**	**Investigator Name**
1018-0008	December 13, 2017	XXXXXX
Agency Name		
Ray Graham Association for People with Disabilities		
Agency Address		**Location**
901 Warrenville Road, Suite 500 Lisle, IL 60532		XXXXXXXXXXXXX XXXXXXXXXXXXX

Allegation

On July 7, 2017, the Office of the Inspector General received a reported allegation of neglect from Ray Graham Association. It is alleged that XXXXXX did not schedule a staff who was a certified medication passer at XXXXXXX CILA on the morning of July 7, 2017. XXXXXX worked the 11pm – 7am shift on the date in question; however, it is alleged he did not pass morning medications and did not notify anyone that he had not passed them. As a result of not receiving his medications, Individual XXXXXXXXXXX had a seizure and later that day, XXXXXXXXX fell and hit his head.

Synopsis

On the morning of July 7, 2017, XXXXXX did not pass morning medications to Individuals XXXXXXXXXXX, XXXXXXXXXXX, XXXXXXXXXXXXXX, XXXXXXXXXXXXXX, XXXXXXXXXX and XXXXXXXXXXX because he was in a rush to go to court and he did not notify anyone of the medication error. As a result, XXXXXXXXX had multiple seizures and was taken to Glen Oaks Hospital for treatment. XXXXXXXXXXX, XXXXXXXXXXX, XXXXXXXXXXX, XXXXXXXXXXX and XXXXXXXXXXX did not require or receive medical treatment. XXXXXX admitted neglecting XXXXXXXXX, XXXXXXXXXXX, XXXXXXXXXXX, XXXXXXXXXXX, XXXXXXXXXXX and XXXXXXXXXXX.

Findings

Based on the facts in this case the following was concluded: The allegation of neglect is substantiated against XXXXXX.

Recommendations

The Office of The Inspector General recommends the following: The agency address XXXXXX and XXXXXX failure to ensure a medication certified employee is available for each CILA. The agency update XXXXXXXXX's Risk Assessment to clarify that he is required to wear his protective helmet at all times.