OIG Case Summary

OFFICE OF THE INSPECTOR GENERAL		INVESTIGATIVE REPORT
Case No.	**Report Date**	**Investigator Name**
1018-0108	June 27, 2018	XXXXX
Facility/Agency Name		
Avancer Homes, LLC		
Facility/Agency Address		**Incident Location**
350 Sycamore Road Genoa, Illinois 60135		XXXXXXXXXX XXXXXXXXXXXXXX

Allegation

On September 8, 2017, the Office of the Inspector General received a reported allegation of neglect from the agency. It is alleged that XXXXX was without his Warfarin for seven days.

Synopsis

This investigation was reopened based on a granted reconsideration requested submitted by the agency. Based on new evidence gathered, an amended reported was issued which included changes to the original findings in the investigation. From September 1, 2017 through September 7, 2017, XXXXX did not receive his prescribed Warfarin because there was none in the house. When XXXXX performed the medication switchover on August 31, 2017, he put the Coumadin (hereinafter referred to as Warfarin) bubble packs for September in with the empty bubble packs from August. As a result, on September 1, 2017, XXXXX worked the PM shift and discovered there was no Warfarin. She called XXXXX and XXXXX. On September 2, September 3, and September 4, 2017, XXXXX worked again and there was still no Warfarin. XXXXX reported she called XXXXX again on September 3, 2017. XXXXX said she only received one call. Regardless of the number of calls to XXXXX, XXXXX did not follow-up to ensure XXXXX's Warfarin was obtained. XXXXX worked on September 5, 2017 and September 6, 2017. He documented on the back of the Medication Administration Report (MAR) pages that Warfarin was not given, but he did not complete the medication error report because it was his understanding that the MAR page documentation was all that was needed. XXXXX worked again on September 7, 2017, and noticed XXXXX did not have any Warfarin so he called XXXXX. XXXXX received his prescribed Warfarin on September 8, 2017.

Findings

Based on the facts in this case the following was concluded: The allegation of neglect is substantiated against XXXXX, XXXXX and XXXXX. The allegation of neglect is unsubstantiated against Avancer Homes and XXXXX.

Recommendations

The Office of the Inspector General recommends the following: The agency retrain their staff on the use of Medication Error Reports. The Office of the Inspector General also recommends the agency address XXXXX failure to provide adequate individualized training to the Direct Support Providers for new medication. The Office of the Inspector General also recommends the agency address how staff should know which medications require immediate RN notification when missed and which require 8 hours notification.