OFFICE OF THE INSPECTOR GENERAL		INVESTIGATIVE REPORT
Case No.	**Report Date**	**Investigator Name**
1117-0259	July 28, 2018	XXXXX
Facility Name		
CTF ILLINOIS		
Facility Address		**Location**
6775 Prosperi Drive Tinley Park, Illinois 60477		CILA XXXXX

Allegation

On December 29, 2016, the Office of the Inspector General received a reported death from CTF ILLINOIS. Individual XXXXX was transported to St. James Hospital on XXXXX, due to seizure and shunt issues. Her condition deteriorated and she was transferred to Rush Hospital where she died on XXXXX, due to complications from failure of her shunt. At the time of reporting to OIG, abuse/neglect was not suspected by CTF ILLINOIS. However, after a review by a OIG, a full investigation was initiated to investigate possible neglect that XXXXX failed to up-date Individual XXXXXs medical component of her Service Plan, which should have included that XXXXX had a VP Shunt, have staff trained of the symptoms of a VP Shunt malfunctioning and insure that XXXXX received her annual medical visits, with her primary physician, addressing her VP Shunt.

Synopsis

The investigation revealed that XXXXX's previous Service Plan, on June 25, 2015, addressed potential issues relative to her VP Shunt and XXXXX diagnosis and staff were to monitor for symptoms such as redness and tenderness, along the line of the shunt, fever, headaches, neck stiffness, headache, followed by vomiting, swelling of the head/face, problems walking and impaired bladder control. The current ISP implemented, June 21, 2016, did not address the VP Shunt or XXXXX monitoring. On June 17, 2016, XXXXX wrote in the physical notes that XXXXX may have problems with her VP Shunt and there is no record provided, as evidence that the VP Shunt was evaluated or that XXXXX received visits to the neurologist or neurosurgeon as ordered. XXXXX was responsible for up-dating XXXXX's medical component of her Service Plan, which should have included that XXXXX had a VP Shunt, have staff trained on the symptoms of a VP Shunt malfunctioning and ensure that XXXXX received her medical visits with her physician(s) to address her VP Shunt.

Findings

Based on the facts in this case the following was concluded: The allegation of neglect is substantiated against XXXXX. The neglect has been determined to be egregious.

Recommendations

The Office of The Inspector General recommends the following: CTF ILLINOIS should address when individuals are to be monitored for specific illnesses or issues, include the specific symptoms, which staff must monitor for, within each Individualized Support Plan and train the direct care staff of such. Per Title 59, Section 116.50(a), CTF ILLINOIS should ensure that individuals' health status is assessed at least annually by the agency registered professional nurse.