OFFICE OF THE INSPECTOR GENERAL		INVESTIGATIVE REPORT
Case No.	**Report Date**	**Investigator Name**
1617-0730	October 27, 2018	XXXXX/ XXXXX
Agency Name		
Community Support Services		
Agency Address		**Location**
9021 Ogden Avenue Brookfield, Illinois 60513		XXXXXXXXXXXXXX XXXXXXXXXXXXX XXXXXXXXXXXXXX

Allegation

On June 29, 2017, the Office of the Inspector General received an allegation of neglect regarding Community Support Services, Inc. It is alleged that XXXXX and XXXXX did not administer medications to XXXXX, and she was given two dosages of her Depakote medication for three days, which made her levels nine points higher than normal.

Synopsis

On June 16, 2017, XXXXX was admitted for XXXXX to SBH. SBH had concerns about the effectiveness of XXXXX's current psychiatric medications. At the time of her admission, she was prescribed 750 mg of Depakote daily. On June 23, 2017, XXXXX was discharged from SBH and her psychiatric medications were changed including her Depakote which was increased to 1250 mg of Depakote daily in the evening. XXXXX completed XXXXX' NMC form which documents the medication changes. On June 24, 2017, XXXXX signed XXXXX's NMC form. On June 27, 2017, the new medications, including the new Depakote, was delivered from XXXXX. XXXXX claimed she gave the medications to XXXXX to take to the home and remove the old medication but she did not check if this was done. However, according to her job description, she is to ensure all medication prescribed are at the sites and are being accurately administered. Also, XXXXX denied XXXXX gave her the new medication to take to the house and had her take out the old medication. Since it was XXXXX responsibility to put the new medication in XXXXX's medication box and she did not remove the old 750 mg Depakote, thus leaving it in there with the new 1250mg dose of Depakote. On June 27 and 28, 2017, XXXXX administered XXXXX's medication. She assumed the old Depakote medication was already taken out by XXXXX but if she had compared the medication to the Medication Administration Record and followed the instructions as she stated she did and had she followed the instructions on the NMC form she signed, she would have noted the problem with the Depakote medication before administering it. She did not and administered 2000 mg of Depakote (750 mg of the prior order and 1250 mg or the new order) two days in a row. On June 29, 2017, XXXXX signed XXXXX's NMC form which detailed the medication changes. That same night, she administered XXXXX 2000 mg of Depakote (750 mg of the prior order and 1250 mg or the new order) even though she noted issues with how the Depakote was packaged and she had read and signed the NMC. XXXXX then realized she administered XXXXX the wrong Depakote dosage/amount and notified XXXXX of the error, and XXXXX completed XXXXX's MER. On July 1, 2017, XXXXX's laboratory

report identified her blood Depakote level was 106 ug/mL which was determined high.

Findings

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

Recommendations for Agency/Facility:

The Office of The Inspector General recommends Community Support Services address the following:

1. Conduct retraining for XXXXX and the direct care staff and to complete accurate and thorough medication error reports.
2. Community Support Services exhibited failure to ensure XXXXX was taken to her physician or the hospital for a medical evaluation.