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HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case # 21-090-9014
El Paso Healthcare

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving a complaint of possible rights violations at El Paso Healthcare. The complaint alleged the following:

1- **Resident's Rights are being violated by not including the legal guardian in the care plan process, facility is not returning phone calls or email communication and medication changes are being made without guardian consent.**

If found substantiated, the allegation would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102), the Skilled Nursing and Intermediate Care Facilities (77 Illinois Administrative Code 300) and the Nursing Home Care Act (210 ILCS 45/1).

El Paso Healthcare is a licensed skilled care nursing facility owned by Petersen Healthcare Corporation. Petersen Healthcare Corporation owns 10 skilled care facilities within a 50 mile radius of the 61602 zip code. El Paso Healthcare primarily supports individuals with mental illness diagnoses. Their current census is 80 but their maximum bed capacity is 123 residents. They are monitored and licensed by the Illinois Department of Public Health (IDPH). The facility employs approximately 52 staff. Of this number, there are the following staff: 1 Administrator, 1 Assistant Administrator, 3 Registered Nurses (RN), 7 Certified Nurse Assistants (CNA), 6 Unit Aids (support CNA staff), 3 housekeeping staff, 8 dietary, 2 laundry personnel, and 1 Social Service Director. The facility has been using contractual staff through a temporary agency to fill the positions of Director of Nursing and Assistant Director of Nursing. The facility also has access to a Minimum Data Set (MDS) Coordinator through the corporation on an as needed basis. Contracted or agency staff have a varied schedule and typically there are 2 on first shift and 1 or 2 on third shift. This facility currently has approximately 14 residents with a legal guardian, 22 with a Power of Attorney, and 6 with Healthcare Surrogates.

COMPLAINT STATEMENT

Facility is violating a resident's rights to have their guardian involved in treatment by not communicating with this person's legal guardian via phone or email. The facility is not including the legal guardian in the resident's care planning process and is not communicating medication changes and therefore not receiving consent to medication changes.

FINDINGS

Staff Interviews (4.28.21)

Due to the Covid-19 pandemic the site visit was facilitated via Webex with several people in attendance. Four staff from the facility and three Human Rights Authority Board Members participated. The HRA had a signed and witnessed consent to release information.

The Administrator explained how Residents are informed of their resident rights when admitted to the facility. During the admission process a resident would receive a form that explains their rights. This information comes from the Ombudsman office. A resident has a right to several things while residing at El Paso Healthcare. This information is clearly written on the form. The resident has a right to: stay in the facility, participate in their own care, safety, privacy, manage their own money, and the residents have the right to be given information on their cost of care. The facility does have a Resident Council program that is active and those individuals are very vocal with staff about their grievances within the building. The Administrator encourages residents to use this avenue to communicate their concerns to him.

At admission a resident would sign a contract that includes the resident rights portion. If a person has a guardian or Power of Attorney (POA) then this person would be responsible for signing the form. The paperwork is also reviewed with the resident. Information in this contract also includes the grievance process. Social Services usually follows up with any grievances. If it is a concern that staff are not able to mitigate, then it is brought to the Administrator’s attention. These grievances can be written at any time. Often, they start in the resident council meetings that occur each month. The Activities Director facilitates the council meetings. Staff attending the site visit clearly stated that residents easily communicate their concerns. Any complaint is taken seriously and everyone including staff need to speak-up if they see something of concern. The Resident Council President is very aware of other residents’ needs and is the one who will also give written forms to staff. Minutes are transcribed as well. Grievance forms are reviewed every day in staff’s morning meeting. Guardians and POA agents should be made aware of any concerns. Social Service staff are responsible for following-up on the grievances and bringing them to the Administrator’s attention. The grievance record does not go in the patient chart.

The Service Recipient involved in this case is no longer residing at this facility. Staff explained the resident's chart should have: copies of guardianship/POA paperwork and a face sheet with emergency contact information. Nurses are responsible for keeping the face sheet and other medical information up to date. If staff at the facility felt concern with a resident's capacity, then they would work with the necessary parties to initiate a POA.

A care plan requires an interdisciplinary meeting that involves all parties to discuss changes in the treatment plan of a resident. Care plans are currently managed by social services. The meetings occur on Thursdays. It was only recently that the facility has begun to mail out notices for the scheduled care plans two weeks prior to the meeting. Previously, staff would call family the day of or day before a meeting. The mailing now asks that people call and confirm if they will be attending. Even with Covid19 restrictions in place, family can attend virtually. There is not a guideline on how people are invited to a care plan, it is more of a practice. The guidelines that are released by the Illinois Department of Public Health (IDPH) are everchanging during the pandemic so the building has had restrictions when people who were not staff were unable to be in the building. At the time of the site visit, the facility was back on restricted visits due to a positive Covid-19 case and they were following the IDPH guidance for testing. The facility keeps guidance posted, masks and other personal protective equipment are worn by staff, and fully vaccinated residents are able to have in-person visits. Visits are still held outdoors as much as possible.

The facility expects phone calls to the facility to be returned within 24 hours if the call is non-medical and/or emergency related. Anyone can pick-up the phone throughout the building. Emails would be responded to within 24 hours but the facility prefers to limit email communication due to privacy laws, especially with regard to medical care. Any behaviors or hospitalizations are reported immediately. Phone calls could be documented in the chart or a verbal notification is given to the person. The only reason a call would not be returned in a timely manner is if the message never made it to the intended party. From 8am-4:30pm, Monday-Friday, the business office answers the phone. After 4:30pm and weekends, the phone rings to the common area and any staff can answer. The unit aides also move between the wings and answer the phones and then page the hall nurse. When the HRA inquired about the use of email correspondence with legal guardians, facility staff explained sometimes the email firewall blocks some of the emails. Also, the email addresses are not always caught by staff to "whitelist" (which is to mark them as an email instead of Spam) when the email is sent and there can be a delay. If an email is received over the weekend it would not be responded to until Monday.

The Service Recipient does have co-guardians involved in care. The co-guardianship arrangement has recently changed and at the time of the meeting the facility had not received updated Letters of Office. This change recently occurred at court in March 2021. One of the co-guardians involved in the case communicated with the facility frequently. Emails would come through on weekends and an immediate response

was expected. The co-guardian calls on the phone often, as well. If a guardian requests communication via email, then the request would be put in writing, including the date requested. Information is updated with the corporate office. The facility has asked for the co-guardian to put her request in writing.

Medication consents are on-going. If consent is needed, the nurse would call for verbal consent. If it is psychotropic medication, then a consent form would be sent out for signature, as well. If a patient is on a blood thinning medication due to a medical diagnosis, it is very common for the doctor to make changes to the dosage of these medications after reviewing laboratory results. Unless lab work is identified as critical, a call is not usually made. If a resident is refusing medications, then this would be a conversation staff would initiate with the resident, the physician, and their guardian or POA agent.

FINDINGS (Including record review, mandates, and conclusion)

Complaint #1 – Resident's Rights are being violated by not including the legal guardian in the care plan process, facility is not returning phone calls or email communication and medication changes are being made without guardian consent.

A resident was admitted to El Paso Healthcare on 7/7/20. The Service Recipient was admitted for skilled care rehabilitation after living in the community with supportive services. The Nursing Care Determination form completed by the Pre-Admission Screening agent (PAS), on 7/7/20, documented this person being in need of 24 hour Nursing care because "(Service Recipient) needs 1-3 hours of daily skilled therapy with at least two disciplines. (Service Recipient) needs strengthening, functional training, endurance training and gait training and bed mobility."

The Social Services Admit Summary completed on 7/7/20 documents the following information "A 56 year old male transferred from [Skilled Care Facility] in Indian Park, Illinois. Resident is alert and oriented to facility. Resident is comfortable, cooperative and bright. Resident has a diagnosis of Schizophrenia and Bipolar disorders. Resident has a history of seizures. Resident has not demonstrated any behaviors associated with diagnosis. Resident will be on daily one-on-ones for thirty days to address any concerns and provide psychosocial support as needed."

Beginning on 7/8/20 the HRA reviewed the following Social Service Progress Notes written by the facility Social Services Director for the month of July 2020. On 7/8/20 a Social Service Progress Note documents the resident asking to call his guardian and states "…Resident and Case Manager called his brother and arranged for additional property to be delivered. …" On 7/15/20 a Social Service Progress Note documents "…Resident is making one call a day to family. …" On 7/17/20 a Social Service Progress Note documents "…Resident was found having conversation with relatives through the bedroom window. Family was not wearing masks. Case manager explained the importance of Covid19 policies in place. …". On 7/19/20 a Social Service Progress Note documents "1:1 with resident. Case Manager assisted [resident] with making a

phone call to his mother. …". On 7/26/20 a Social Service Progress Note documents "…He did make a call to his Mom. …". On 7/30/20 a Social Service Progress Note documents "1:1 with resident. Resident came to social services office to call his family. Resident enjoys strong social support and involvement from his family. Resident will call several times a day. …".

The HRA reviewed Social Service Progress Notes for the month of August 2020, beginning with 8/2/20. The note documents a call to the Service Recipient's mother and reads similar to a care plan but is not documented as such. There also does not appear to be anyone else in attendance other than the Social Services Director, guardian (via telephone) and Service Recipient. The note reads as follows "1:1 Resident came to social service office to call family. Case Manager spoke with family about resident's tv. Family requested that resident be limited with his time watching it. Resident had no concerns. Resident has been attending additional groups beyond his assigned groups. Resident is out-going and making friends." On 8/7/20 a Social Service Progress Note documents the Case Manager leaving a voice message for the guardian at 9:00am to discuss the resident's concerns about housekeeping taking his clothes hamper. The Case Manager had explained the importance of using facility clothing bins to reduce hazards.

Further along in the record the HRA observes documentation that indicates facility staff were in contact with the Service Recipient's legal guardian. Communication was documented on 9/21/20, 11/4/20, and 11/12/20. On 3/24/21 a Social Service Program note documents an in-person visit with his guardian and co-guardian. The progress note reads "…The visit was very nice and all enjoyed the time. Guardian discussed concerns with the Case Manager and worked to find solutions. Visit covered many topics including bathing, restroom, exercise, nutrition and medication. Guardian was satisfied with Resident and Case Manager discussion." On 3/29/21 a Social Service Program note documents the Case Manager calling the guardian to schedule a care plan meeting. The note documents the tentative date of 4/8/21 at 2pm. On 4/8/21 at 9:00am Social Service Program notes document the Case Manager calling the guardian for a care plan. The note documents the following interaction "… Guardian stated she would like to talk with Administrator also for unrelated questions. Teleconference was arranged for 2:30pm. Case Manager discussed goals and answered questions. Guardian stated that she was satisfied with answers and pleased with resident's progress." A follow-up entry at 3pm documents "Guardian and co-guardian came to facility to speak with Administrator about concerns. …".

Communication with the legal guardian about the Service Recipient's medical needs is documented by nursing and social services. Covid19 updates were regularly occurring based on the record review. On 9/17/20 a Physician's Progress Note documents the following "POA concerned that medications patient is on are causing liver problems. Patient denies complaint." On 10/1/20 a Physician's Progress Note documents a referral to a psychiatrist due to being on two antipsychotic medications. The results of this psychiatric consultation for a medication reduction are unknown based on the information provided in the chart. On 10/20/20, a Nursing Summary Note written by an LPN documents "Resident currently in Physical Therapy (PT) for strengthening.

Guardian would like patient to start taking self to bathroom instead of using urinal and depends. Close monitoring of patient INR/proteomes." The recommended follow-up plan on the 10/20/20 Nursing Summary Note was "EKG and monitor." Notification of a possible Covid19 positive case was documented on 11/4/20 by the Social Service Director and again on 11/12/20. On 11/11/20 a notice was sent to the guardian that patient was discharged from Physical Therapy due to noncompliance. On 11/17/20 a Nurse Note documents a notification to the guardian about the Service Recipient refusing to get out of bed and noncompliant with showers and other behaviors. The guardian asked for the Service Recipient to be sent to the hospital and he was admitted. He returned to the facility the next day. On 11/18/20 there is another Nurse Progress Note that documents a facility nurse speaking with the legal guardian. This nursing note documents the guardian asking for the hospital report to be sent to her. On 11/21/20 a Nurse Progress Note documents a phone call to the Service Recipient's guardian to discuss behaviors and guardian was educated on Resident's Rights and Refusals. A Nurse Progress Note dated 11/12/20 documents a new diagnosis of Deep Vein Thrombosis (DVT) to left leg. The last Nurse Progress Note is dated 12/20/20 and documents new orders for the Service Recipient due to the patient refusing laboratory work. There is a corresponding Physician's Order for 12/20/20 that documents a change in dosage of Coumadin and follow-up laboratory blood work to check this medication's effectiveness on 12/21/20. The last Nurse Progress Note entry observed in the record is on 4/13/21 when the Service Recipient went on a home visit. The facility provided his medications to the co-guardian until 4/15/21.

On 12/27/20, Social Services staff document the legal guardian refusing the Covid19 vaccine for the Service Recipient. The vaccine was not given. There are several Pharmacy Consultation Reports in the record. One notable to the HRA, is a pharmaceutical note dated 12/27/20 that indicates the patient being prescribed Warfarin and Tramadol which has a "Severity Level of 3" for a potential adverse drug interaction for patients who are prescribed both medications. The treatment recommendations on this Pharmacy Consultation state that this "…should be monitored for increased Warfarin effects. The dosage of Warfarin may need to be adjusted or a different opioid will need to be used. …". On 1/8/21 there is a Physician's Order to discontinue Coumadin and start taking 5mg Eliquis.

On 1/27/21 and 1/28/21 the HRA reviewed a Quality Improvement Review note that documented a staff meeting discussing the on-going conversation with the resident's guardian about the facility Medical Director (MD) changing medications from Coumadin to Eliquis. The Medical Director documented calling the guardian who was still unhappy with the medication change. The MD was going to refer the resident to a local Blood Disorder Clinic but the guardian refused. On 1/28/21 a follow-up note documents facility staff leaving a message for the guardian to schedule a care plan meeting. The guardian was to confirm the meeting date and time. This note ends and it is not clear if a care plan meeting was ever formally scheduled with the legal guardians. On 3/1/21 a Nursing Note documents the shift nurse contacting the Physician to request an order change for the prescribed medication Tramadol. There is an order request change observed in the record that documents a registered nurse contacting the physician asking for the medication

Tramadol to be discontinued as requested by the legal guardian. On 4/7/20 a Physician's Progress Note documents the patient complaining of left knee pain. The recommended follow-up plan was "Xray of left knee, remove Epilepsy from list of diagnosis." On 4/12/21 a Social Service Program note documents the Case Manager verifying with the guardian that the resident had his cell phone. The last Social Service Program note is dated 4/13/21 at 10:30am and documents the resident going on a home visit approved by the Administrator.

The HRA was able to review a document titled Care Plan Historical Copy with a date of 1/7/21. Several goals listed on the form have a start date of either 7/7/20 or 7/12/20. The Service Recipient does have a "Problem/Need" care plan goal for his psychotropic medications. This goal reads as follows "Resident requires use of psychotropic med to manage mood and/or behavior issues. Candidate for gradual dose reduction. Needs monitored for drug related complication." The following interventions are listed with a start date of 7/7/20 "Administer anti-anxiety medication as ordered. See POS (Physicians Order Sheet) for current med dose and schedule. Administer anti-psychotic medications as ordered. See -POS for current med dose and schedule. Observe for antipsychotic side effects ... Educate resident/family to any potential risks, benefits and alternatives. **Obtain informed consent prior to administration of medication** [emphasis added]. IDT (Interdisciplinary Team) meeting with Resident/Responsible Party quarterly and PRN to discuss psychosocial well-being and medication use. Determine risk/benefit ratio. Attempt/initiate gradual dose reduction as recommended by (pharmacist) and as ordered by Medical Doctor (MD). During trial reduction attempts monitor and report to MD …".

On 1/7/21, the following "Problem/Need" care plan goal was added "Needs monitored for side effects of anti-coagulant med for treatment of deep vein thrombosis (DVT), coagulation disorder." There are thirteen approaches/interventions listed to monitoring this medication through the care plan. The HRA would like to highlight the following "Med doses vary based on lab values-See POS for current med and dosage. … Be aware of substances that can increase the anticoagulant effect … Be aware of substances that decrease the effectiveness … Inform Resident/Family/Caregivers of increased potential for bleeding … ".

The only formal documentation available in the Service Recipient's record that clearly documents a Care Plan Meeting is dated 4/22/21. There is a document titled Care Plan Summary/Participation Record for the Service Recipient. This form shows that the Resident's Decision Maker was invited to the meeting, but it does not confirm if that person attended. The HRA is aware that during the month of April 2021 the resident discharged from the facility but the actual date of discharge is unknown.

A Comprehensive Nursing Assessment was completed by an LPN dated 7/8/20.

The HRA reviewed Petersen Healthcare's policy titled "COMPREHENSIVE CARE PLANNING" last revised on 11/1/17 that provides the following guidance "It is the policy of Petersen Health Care to comprehensively assess and periodically reassess

each Resident admitted to this facility. The results of this Resident assessment shall serve as the basis for determining each Resident's strengths, needs, goals, life history and preferences to develop a person centered comprehensive plan of care for each Resident that will describe the services that are to be furnished to attain or maintaining the Resident's highest practicable physical, mental, and psychosocial well-being. The following procedures shall be utilized in the development and maintenance of care plans: … c. The IDT may determine a Comprehensive revision of the Plan of Care may warrant a Significant Change MDS. Documentation of such a decision shall be contained in the Resident's record. 2. Participants of the Interdisciplinary Team in the development/revision of the CCP should include: the attending physician (or appointee), RN with responsibility for the resident, CNA with responsibility for the resident, member of the food service team and the resident and/or resident representative as possible/appropriate. a. Other appropriate staff or professional's participation in the IDT shall be based on resident care, services and needs. b. Participation/input can be in the form of one on one discussions, video conferencing, conference calls, etc. 3. Components of the (CCP) may include: a. Care Plan Summary/Participation Record- Contains pertinent information about the Resident including a summary listing of healthcare information such as physician orders, dietary orders, therapy services, social services, PASARR recommendations and discharge plans as appropriate for the Resident at the time a conference is held and documents involvement of the resident/resident representative in the development, review and revision of the care plan. The facility will seek to support and include the resident/responsible party as possible in the care planning process utilizing the following measures: a. Include resident and/or resident representative in the development of the CCP thru interview for goals of care, cultural influences, preferences, routines, discharge goals, and etc. for inclusion in the plan of care. … c. Inform the resident/representative of upcoming care conferences and accommodate schedule as appropriate. d. Notify the resident/representative when significant changes are made to and afforded the opportunity to sign after significant changes are made to the CCP. For these purposes significant change is defined to be: i. a new problem with intervention; ii. more than two new interventions added to treat an existing problem; iii. the deletion of more than two interventions of an existing problem. e. Documentation of the notification of the resident/responsible party of Significant Changes to the CCP can be accomplished via signature on the IDT Progress Note, on New CP page, on Care Plan Summary/Participation Record or documentation in the Nurse's Notes or Social Services notes if updates given per phone, refused to sign or attempts to contact have been unsuccessful. f. There shall occur times between RAI/MDS completion that ongoing clinical assessment and identification of resident need may warrant update of the CCP. The resident/responsible party may be notified of these additional orders/interventions by the nursing staff as orders are received by the practitioner. The IDT may review these orders and add the order to the CCP and may also reflect the update with documentation on the IDT Progress note. These changes/new interventions may not constitute a significant change in the plan of care and would not warrant additional resident/responsible party notification via the CCP unless meeting the definition of a Significant Change in the CCP defined here. 7. The Care Plan Conference shall be held as necessary to communicate major revisions to the Comprehensive Care Plan and minimally with every Comprehensive MDS completed. The facility shall make

effort that the conference: a. Be attended by a representative from each discipline involved in the Resident's care as possible. b. Be attended by the Resident unless the Resident is incapable of understanding the proceedings or chooses not to attend. c. Be attended by a representative of the Resident's choice if that person so chooses to attend."

The HRA reviewed Petersen Health Care policy titled "Notification for Change in Resident Condition or Status" which states: "The facility and/or facility staff shall promptly notify appropriate individuals (i.e., Administrator, DON, Physician, Guardian, HCPOA, etc.) of changes in the resident's medical/mental condition and/or status. **Responsibility:** Administrator**,** Director of Nursing**,** Charge Nurse. **Procedure:** 1. The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been: **a. Any symptom, sign or apparent discomfort that is: 1. Sudden** in onset**. 2. A marked change** (i.e. more severe) in relation to usual signs or symptoms. **3. Unrelieved** by measures already prescribed**.** a. An accident or incident involving the resident; b. A discovery of injuries of an unknown source; c. A reaction to medication; d. A significant change in the resident's physical/emotional/metal condition; e. A need to alter the resident's medical treatment significantly; f. Refusal of treatment or medications. g. A need to transfer the resident to a hospital/treatment center; h. A discharge without proper medical authority; i. Instructions to notify the physician of changes in the resident's condition; j. Onset of temperature of a temperature two degrees higher than baseline; k. Symptoms of any infectious process. l. Abnormal lab findings**.** m. 5% weigh gain or loss in 30 days, 7.5% weight gain or loss in 90 days, 10% weight gain or loss in 180 days n**.** Onset of pressure ulcers or stasis ulcers o. Abnormal complaints of pain**.** 1. The nurse supervisor/charge nurse will notify the DON, physician, and unless otherwise instructed by the resident the resident's next of kin or representative when the resident has any of the afore mentioned situations or: a. The resident is involved in any accident or incident that results in an injury including injuries of an unknown source; b. There is a significant change in the resident's physical, mental, or psychological status; c. There is a need to change the resident's room assignment; d. A decision is made to discharge the resident from the facility and/or e. It is necessary to transfer the resident to a hospital/treatment center. 1. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. 2. Regardless of the resident's current mental or physical condition, the nursing supervisor/charge nurse will inform the resident of any changes in his/her medical care or nursing treatments. 3. The nurse supervisor/charge nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status."

The HRA reviewed Petersen Healthcare policy titled "Psychotropic Medication", last reviewed 11/28/17. The policy provides the following guidelines to employees: "… 5. Psychotropic medication shall not be prescribed or administered without the informed consent of the resident, the resident's guardian, or other authorized representative. **6. Additional informed consent is not required for reductions in dosage level or deletion of a specific medication. The informed consent may provide for a medication administration program of sequentially increased doses or a combination of medications to establish the lowest effective dose that will achieve**

the desired therapeutic outcome. Side effects of the medications shall be described. [emphasis added]

The **Nursing Home Care Act (210 ILCS 45/2-106.1) Sec.2-106.1. Drug treatment** mandates "(a) A resident shall not be given unnecessary drugs. An unnecessary drug is any drug used in an excessive dose, including in duplicative therapy; for excessive duration; without adequate monitoring; without adequate indications for its use; or in the presence of adverse consequences that indicate the drugs should be reduced or discontinued. The Department shall adopt, by rule, the standards for unnecessary drugs contained in interpretive guidelines issued by the United States Department of Health and Human Services for the purposes of administering Titles XVIII and XIX of the Social Security Act.
(b) Except in the case of an emergency, psychotropic medication shall not be administered without the informed consent of the resident or the resident's surrogate decision maker. 'Psychotropic medication' means medication that is used for or listed as used for psychotropic, antidepressant, antimanic, or antianxiety behavior modification or behavior management purposes in the latest editions of the AMA Drug Evaluations or the Physician's Desk Reference. 'Emergency' has the same meaning as in Section 1-112 of the Nursing Home Care Act. A facility shall (i) document the alleged emergency in detail, including the facts surrounding the medication's need, and (ii) present this documentation to the resident and the resident's representative. No later than January 1, 2021, the Department shall adopt, by rule, a protocol specifying how informed consent for psychotropic medication may be obtained or refused. The protocol shall require, at a minimum, a discussion between (i) the resident or the resident's surrogate decision maker and (ii) the resident's physician, a registered pharmacist (who is not a dispensing pharmacist for the facility where the resident lives), or a licensed nurse about the possible risks and benefits of a recommended medication and the use of standardized consent forms designated by the Department. The protocol shall include informing the resident, surrogate decision maker, or both of the existence of a copy of: the resident's care plan; the facility policies and procedures adopted in compliance with subsection (b-15) of this Section; and a notification that the most recent of the resident's care plans and the facility's policies are available to the resident or surrogate decision maker upon request. Each form developed by the Department (i) shall be written in plain language, (ii) shall be able to be downloaded from the Department's official website, (iii) shall include information specific to the psychotropic medication for which consent is being sought, and (iv) shall be used for every resident for whom psychotropic drugs are prescribed. The Department shall utilize the rules, protocols, and forms developed and implemented under the Specialized Mental Health Rehabilitation Act of 2013 in effect on the effective date of this amendatory Act of the 101st General Assembly, except to the extent that this Act requires a different procedure, and except that the maximum possible period for informed consent shall be until: (1) a change in the prescription occurs, either as to type of psychotropic medication or dosage; or (2) a resident's care plan changes. The Department may further amend the rules after January 1, 2021 pursuant to existing rulemaking authority. In addition to creating those forms, the Department shall approve the use of any other informed consent forms that meet criteria developed by the Department. At the discretion of the Department, informed consent forms may include

side effects that the Department reasonably believes are more common, with a direction that more complete information can be found via a link on the Department's website to third-party websites with more complete information, such as the United States Food and Drug Administration's website. The Department or a facility shall incur no liability for information provided on a consent form so long as the consent form is substantially accurate based upon generally accepted medical principles and if the form includes the website links.

Informed consent shall be sought from the resident. For the purposes of this Section, "surrogate decision maker" means an individual representing the resident's interests as permitted by this Section. Informed consent shall be sought by the resident's guardian of the person if one has been named by a court of competent jurisdiction. In the absence of a court-ordered guardian, informed consent shall be sought from a health care agent under the Illinois Power of Attorney Act who has authority to give consent. If neither a court-ordered guardian of the person nor a health care agent under the Illinois Power of Attorney Act is available and the attending physician determines that the resident lacks capacity to make decisions, informed consent shall be sought from the resident's attorney-in-fact designated under the Mental Health Treatment Preference Declaration Act, if applicable, or the resident's representative.

In addition to any other penalty prescribed by law, a facility that is found to have violated this subsection, or the federal certification requirement that informed consent be obtained before administering a psychotropic medication, shall thereafter be required to obtain the signatures of 2 licensed health care professionals on every form purporting to give informed consent for the administration of a psychotropic medication, certifying the personal knowledge of each health care professional that the consent was obtained in compliance with the requirements of this subsection."

Public Health regulations (77 Ill. Adm. Code 300.1210) regarding General Requirements for Nursing and Personal Care mandate: a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)"

Public Health regulations (77 Ill. Adm. Code 300.1220) titled Supervision of Nursing Services require that: a) Each facility shall have a director of nursing services (DON) who shall be a registered nurse. 1) This person shall have knowledge and training in nursing service administration and restorative/rehabilitative nursing. This person shall also have some knowledge and training in the care of the type of residents the facility cares for (e.g., geriatric or psychiatric residents). This does not mean that the director of nursing must have completed a specific course or a specific number of hours of training in restorative/rehabilitative nursing unless this person is in charge of the

restorative/rehabilitative nursing program. (See Section 300.1210(a).) 2) This person shall be a full-time employee who is on duty a minimum of 36 hours, four days per week. At least 50 percent of this person's hours shall be regularly scheduled between 7 A.M. and 7 P.M. A) A facility may, with written approval from the Department, have two registered nurses share the duties of this position if the facility is unable to obtain a full-time person. Such an arrangement will be approved only through written documentation that the facility was unable to obtain the full-time services of a qualified individual to fill this position."

Beginning January 8, 2021: **Public Health regulations (77 Ill. Adm. Code 300.686) on Unnecessary, Psychotropic, and Antipsychotic Medications** now require the following: "… e) *Except in the case of an emergency, psychotropic medication shall not be administered without the informed consent of the resident or the resident's surrogate decision maker*. (Section 2-106.1(b) of the Act) Additional informed consent **is** required for reductions in dosage level or deletion of a specific medication, pursuant to subsection (f)(9). *[emphasis added]* Informed consent is required for a medication administration program of sequentially increased doses or a combination of medications to establish the lowest effective dose that will achieve the desired therapeutic outcome, pursuant to (f)(9). This is an amendment to **77** Ill. Adm. Code 300.686 which went into effect January 8. 2021."

The **Mental Health and Developmental Disabilities Code 405 ILCS 5/2-102. Care and services; psychotropic medication; religion** 2-102 state: "(a) A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient. The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the treatment plan."

The **Probate Act of 1975 (755 ILCS 5/11a-23) regarding the Reliance on authority of guardian, standby guardian, short-term guardian** requires that: "(a) For the purpose of this Section, 'guardian', 'standby guardian', and 'short-term guardian' includes temporary, plenary, or limited guardians of all wards. (b) Every health care provider and other person (reliant) has the right to rely on any decision or direction made by the guardian, standby guardian, or short-term guardian that is not clearly contrary to the law, to the same extent and with the same effect as though the decision or direction had been made or given by the ward. Any person dealing with the guardian, standby guardian, or short-term guardian may presume in the absence of actual knowledge to the contrary that the acts of the guardian, standby guardian, or short-term guardian conform to the provisions of the law. A reliant shall not be protected if the reliant has actual knowledge that the guardian, standby guardian, or short-term guardian is not entitled to act or that any particular action or inaction is contrary to the provisions of the law."

CONCLUSION:

The HRA **SUBSTANTIATES** the allegation that the facility failed to involve the legal guardian with the care planning process. Although it is clear in the record that a variety of staff were communicating regularly with the Service Recipient's legal co-guardian, there was no formal invitation to a Care Plan Meeting documented in the record until 3/29/21 and the Service Recipient had resided in the facility since 7/7/20. Per the facility's own policy, a care plan or Interdisciplinary Meeting should occur at the following milestones; within 7 days of the Resident Assessment Instrument (RAI), annually, when there is a significant change, and quarterly. The meeting should include members of the Interdisciplinary Team and the resident and/or resident representative should be in attendance. Petersen Healthcare's Policy also states that a Care Plan Summary document should be completed. There were no Care Plan Summary documents for the resident's care plan available in the record reviewed for the months of July, September, and December 2020. There were no formal invitations observed in the patient record or anything written in documentation that would indicate the Service Recipient's representative, or in this case, legal guardian, was invited to a formal Care Plan. The Skilled Nursing Facility and Intermediate Care Facility regulations mandate "a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)." (77 Il Admin Code 300.1210). The record only reflects one Care Plan Summary document from the first formal Care Plan held on 4/8/21. The regulations also mandate "a) Each facility shall have a director of nursing services (DON) who shall be a registered nurse. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. **The plan shall be reviewed at least every three months** [emphasis added]." (77 Il Admin Code 300.1220) The facility also acknowledged that they did not have a Director of Nursing and were relying on a corporate nurse through Petersen Healthcare to assist the facility with the important job duty of developing the plan.

With regard to the part of complaint that alleges "…medication changes are being made without guardian consent". The record reflected changes being made to the Service Recipient's blood thinning medications which was discussed with the legal guardian who disagreed with the changes on or around 1/28/21. The record does not provide a clear explanation of the Medical Director's rationale for changing the brand of blood thinning medications. The Medical Director attempted to mitigate the guardian's unhappiness

with this medication change by referring the patient to the local Blood Disorder Clinic but the legal guardian refused this. The HRA was unable to find any mandates that state blood thinning medications require informed consent. The Service Recipient was prescribed Tramadol which was documented in the record to be a "Severe Risk 3" for adverse side effects when administrating in tandem with Coumadin. The legal guardian requested the discontinuation of this medication in March 2021 which was communicated with the Medical Director about discontinuing this medication, and it was. The Service Recipient was prescribed Geodon and Zyprexa and did experience a gradual dose reduction on the Zyprexa in October 2020 and the record does not reflect a conversation of this change with the guardian. At the time this reduction occurred, the mandate read that informed consent on a reduction of psychotropic medication was not required, but beginning January 2021 public health regulations for nursing homes mandate that informed consent is required for a psychotropic medication dosage reduction (77 Il Admin Code 300.686) along with The Nursing Home Care Act (210 ILCS 45/2-106.1b) that provides the legal mandate on informed consent for psychotropic medication reductions from the legal guardian if applicable. The record also reflect that a pharmacy consult recommended another reduction in the Zyprexa on 4/8/21 but it is unclear to the HRA if this occurred based on the chart record provided. The Service Recipient left for a home visit on or around 4/13/21 and discharged from the facility the same month on an unknown date.

With regard to the portion of the complaint that alleges "… facility is not returning phone calls or email communication …". The HRA did not see any information in the chart record provided that indicated the facility was not returning phone calls or that medication changes were being made without guardian consent. During the site visit the Administrator acknowledged that due to confidentiality concerns email communication is discouraged since most email addresses are not secure. Emails that are sent over a weekend are not received until the next business day. The facility has also had difficulties with the firewall settings on their employee emails and emails are sent to a spam folder or flagged as suspicious and are not seen.

The HRA makes the following **RECOMMENDATIONS:**

- Amend Petersen Healthcare Policy titled Comprehensive Care Planning last revised on 11/1/17 section "7. The Care Plan Conference shall be held as necessary to communicate major revisions to the Comprehensive Care Plan and minimally with every Comprehensive MDS completed. The facility shall make effort that the conference: a. Be attended by a representative from each discipline involved in the Resident's care as possible" to "…Resident's care when applicable." This will reflect the language found in (**77 Ill. Adm. Code 300.1210) General Requirements for Nursing and Personal Care** to ensure that the legal guardian or power of attorney agent is being invited.

- Provide evidence of the updates to the HRA that the Petersen Healthcare Policy COMPREHENSIVE CARE PLANNING.

- Train the necessary staff at El Paso Healthcare of the change in policy language and provide evidence to the HRA that this has occurred.

- Provide evidence to the HRA that legal guardians and other legal decisionmakers are being invited ahead of a scheduled care plan as reported in the site visit.

- Update the Petersen Healthcare Psychotropic Medication Policy to reflect the new Public Health regulations for Nursing Homes (77 Ill. Adm Code 300.686) on the informed consent requirement for medication reductions. Provide documentation to the HRA that verifies the changes.

- Train staff on the updated regulation regarding informed consent and provide evidence to the HRA that this occurred.

The HRA makes the following suggestions:

- Hire a Director of Nursing Services.

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, provider responses appear verbatim in retyped format.