REPORT OF FINDINGS
SOUTHWEST DISABILITIES SERVICES AND SUPPORTS— 08-040-9004
HUMAN RIGHTS AUTHORITY— South Suburban Region

[Case Summary—– The Authority did not substantiate the complaint as presented; the HRA's public record on this case is recorded below.]

INTRODUCTION

The South Suburban Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission has completed its investigation into allegations concerning Southwest Disabilities Services and Supports located in Chicago Heights. According to the complaint, the agency failed to meet a resident's needs in regard to staff supervision. Additionally, the complaint alleged that the resident was administered psychotropic medications during her hospital stay without informed consent. If substantiated, these allegations would violate the Illinois Administrative Code (CILA Rules) (59 Ill. Admin. Code 115.100 et seq.) and the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5).

This agency manages 10 Community Integrated Living Arrangements (CILAs) in the area for persons with disabilities.

METHODOLOGY

To pursue the investigation, the HRA conducted a site visit and discussed the allegations with the Director of Residential Services, the Director of Nursing and a Qualified Mental Health Professional (QMHP). The complaint was discussed with the resident's legal guardian by telephone. Relevant program policies were also reviewed.

Portions of the adult resident's record and a copy of her Guardianship Order, dated March 28th, 2005, were reviewed with consent. This order appoints guardianship over the resident's personal care.

COMPLAINT STATEMENT

According to the complaint, on September 12th, 2007, the resident ingested a household cleaning product because she was not adequately supervised at her CILA placement. She was reportedly taken to a local hospital for emergency medical care and subsequently transferred to another hospital and admitted for behavioral reasons. The resident was allegedly administered new psychotropic medications without her guardian's consent during her hospital stay. It was reported that the hospital's social worker said that the agency gave consent for the medication change.

FINDINGS

In reviewing the record, the HRA learned that the resident was placed in Southwest Disabilities Services and Supports' (SWDSS) CILA program on December 12th, 2005. Her diagnoses included Major Depression, Schizophrenia, Post Traumatic Stress Disorder, Impulse Control Disorder, Mild Mental Retardation, and some physical problems. The resident's September 26th, 2007 Individualized Services Plan (ISP) clearly documented that she was under guardianship and that 24-hour supervision was needed. Her plan indicated that she was capable of performing activities of daily living with minimal assistance. The plan also stated that no medication changes had been made in the last year.

The record confirmed that the resident was admitted to a hospital's intensive care unit after she allegedly drank disinfectant cleaner on September 12th, 2007. She was transferred to another hospital for a psychiatric evaluation two days later. Her psychotropic medications were listed as Wellbutrin Slow Release (SR) 150 mg, Seroquel 200 mg and Trazodone 100 mg at intake. Contrary to the complaint, a physician's report stated that the resident had ingested something harmful at her workshop. However, laboratory reports showed no traces of the alleged cleaning product.

Documentation further indicated that new psychotropic medications were not administered during the resident's hospital stay as reported. The only change made in her medication regimen was Seroquel. A September 22nd, 2007 hospital's note stated that the resident's guardian gave verbal consent to increase Seroquel to 300 mg nightly. According to the record, the resident was discharged back to the agency on September 25th, 2007. Her annual staffing was held on the following day, and her guardian was at the meeting. The staffing report stated that another placement would be identified, and the resident was discharged from the agency in December 2007. The agency's administration told the HRA that the resident was discharged at her guardian's request.

The complaint that the resident was inappropriately supervised at her CILA was discussed with the agency's staff. According to the Director of Residential Services, the resident reported that she had swallowed some cleaning solution at her day training program, but there was no evidence to support her assertion. She said that the resident made the allegation after returning to the CILA from her day program, which is managed by another agency. The staff person on duty at the CILA reportedly called the Director of Residential Services who notified the Executive Director. She explained that the resident was sent to the emergency room, but laboratory reports did not show any foreign chemicals. On questioning, the investigation team was informed that only one staff person was on duty in the home between 2:00 p.m. and 4:00 p.m. when she reported the alleged incident. It is unclear if the other residents were home during the time in question. Regarding safety with cleaning supplies in the home, the staff said that cleaning supplies are stored in a locked file cabinet, and that the staff person carries the key. The cabinet is reportedly located between the kitchen and the sitting area in the home. The agency reportedly did not follow up with the resident's day program concerning her allegation.

Subsequent to the site visit, the agency provided the HRA with a written report, which reflected that the September 12th, 2007 incident may have happened at the CILA. The HRA noticed that the report's version was different than what the agency had told the investigation team at the meeting. A staff person wrote that she had gone outside to change a light bulb. Upon reentering the home, the staff person observed the resident coming from the basement and assumed that she had been washing her clothes in the basement. Reportedly, the resident went to the bathroom and began coughing. The staff person knocked on the bathroom door and inquired about the resident's well-being. The resident opened the bathroom door holding her throat and crying. She told the staff person that she had drank Pine Sol (a cleaning product). How much she allegedly ingested was unclear in the report. The staff person immediately notified the agency's nurse and then called 911. According to the report, the resident claimed that she had hidden the bottle of cleaning solution in the basement, but the bottle was never found. When the paramedics arrived, the resident informed them that she had drunk the cleaning solution and the amount. How much she reportedly ingested was unclear again. The report documented that the resident was transported to a hospital for emergency care.

The psychotropic medication complaint was discussed briefly with the agency's staff because the record revealed that the only change made in the resident's medication regimen during her hospitalization was with her guardian's consent. The HRA inquired about informed consent because the resident's ISP indicated that psychotropic medications had been prescribed prior to her hospital stay and continued after she was discharged from the hospital. However, there were no consents in the 2007 record authorizing the agency to administer psychotropic medications. The Director of Nursing told the investigation team that she had mailed several consent forms to the resident's guardian, but they were never returned to the agency.

CONCLUSION

According to the agency's "Assessments and Evaluation" policy, the Interdisciplinary Team shall determine the resident's programmatic needs based on assessments.

The Illinois Administrative Code (59 Ill. Admin. Code 115.200 [d]) states,

> Based on their needs, individuals shall receive supervision and supportive services which may range from continuous to intermittent. CILAs shall be designed to promote optimal independence in daily living, economic self-sufficiency and integration into the community through the interdisciplinary process.

Although the record does not support that the resident swallowed something harmful, her living arrangement included continuous supervision by on-site staff while encouraging and promoting her independence. However, the incident report indicated the staff person left the resident(s) alone to change a light bulb on the outside of the home.

The agency's administrative staff told the HRA that only one staff person was on duty between 2:00 p.m. and 4:00 p.m. when the resident made the allegation. The Department of Human Services' CILA Individual Rate Determination Model defines "nonprime time" as those hours when fewer direct care staff are needed to train or assist the residents in the home because they may be relaxing or are between major activities. According to the Model, nonprime time is five hours per weekday and eight hours per weekend day. The staffing ratios for nonprime time hours are assumed to include one staff person to six residents with low needs; 1.5 staff to six residents with moderate needs and two staff to six residents with high needs.

Based on the record, this resident's needs determination is moderate. She is able to perform activities of daily living with minimal assistance, and she is able to move about in her home independently. The HRA was unable to determine the other five residents' specific needs or whether they were home when the allegation was made. The Authority finds no clear violation of rights under Section115.200 (d), but encourages the agency to refer to the Model for staffing assumptions at all times. The complaint that the agency failed to meet a resident's needs in regard to staff supervision is unsubstantiated.

SWDSS' "Psychotropic Medication" policy states that written consent must be obtained annually from the resident's guardian for those individuals who are legally incompetent and incapable of giving consent.

Additionally, the specific complaint that the resident was administered new psychotropic medications during her hospital stay without informed consent was not substantiated against SWDSS. The Authority believes that the hospital ultimately has the responsibility for securing consent for medication while she was hospitalized. However, the agency is responsible for getting informed consent for medications administered at the home and according to policy. Supportive documentation indicated that the hospital obtained the guardian's verbal consent for the only change made in her medication regimen. But, there was no evidence of consent for psychotropic medications prescribed by the agency's physician. Furthermore, the Director of Nursing (DON) said that the resident's guardian never returned the consents to the agency. She did not mention that verbal consent was obtained but asserted that the agency would be liable if the medications were not administered. The DON was informed that residents or guardians have the right to refuse psychotropic medication. If refused, medication can only be administered under emergency circumstances or by court-order, according to the Mental Health and Developmental Disabilities Code's Sections below.

> If the services include the administration of electroconvulsive therapy or psychotropic medication, the physician or the physician's designee shall advise the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment, to the extent such advice is consistent with the recipient's ability to understand the information communicated…. If the recipient is under guardianship and

> the guardian is authorized to consent to the administration of electroconvulsive therapy or psychotropic medication pursuant to subsection (c) of Section 2-107.1 of this Code, the physician shall advise the guardian in writing of the side effects and risks of the treatment, alternatives to the proposed treatment, and the risks and benefits of the treatment…. (405 ILCS 5/2-102 [a-5]).

> An adult recipient of services or the recipient's guardian, if the recipient is under guardianship, and the recipient's substitute decision maker, if any, must be informed of the recipient's right to refuse medication or electroconvulsive therapy. The recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication or electroconvulsive therapy. If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent harm to the recipient or others and no less restrictive alternative is available…. (405 ILCS 5/2-107 [a]).

SUGGESTIONS

1. Ensure that all allegations are investigated thoroughly and documented including follow up with day training programs when needed.

2. The agency should review its policy and practices regarding the administration of psychotropic medication.

3. Document attempts to obtain consent for medication in residents' records.

4. Document verbal consent in residents' records.

5. Document that residents and decision makers are provided with written information about proposed psychotropic medications in order to ensure informed consent is obtained.

6. For added safety, require staff to periodically check that hazardous fluids and materials are always locked.