
**FOR IMMEDIATE RELEASE**

REPORT OF FINDINGS
LYDIA HEALTHCARE — 09-040-9014
HUMAN RIGHTS AUTHORITY- South Suburban Region

[Case Summary—— The Authority did not substantiate the complaint as presented; the public record on this case is recorded below. A provider response is not included in the public record.]

INTRODUCTION

The Human Rights Authority (HRA) has completed its investigation into an allegation concerning Lydia Healthcare, a 412-bed intermediate care facility located in Robbins that serves people with mental illness. According to the complaint, the facility refuses to honor a resident's request for discharge. If substantiated, this allegation would violate the Nursing Home Care Act (NHCA) (210 ILCS 45/2-111), the Illinois Administrative Code for Skilled Nursing and Intermediate Care Facilities (77 Ill. Admin. Code 300.3300 [a] and 300.4030 [f]), the Centers for Medicare and Medicaid Services, Department of Health and Human Services' (CMS) Requirements for Long Term Care Facilities (42 C.F.R. 483) and the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/2-102 [a]).

METHODOLOGY

To pursue the investigation, the complaint was discussed with the Facility Administrator and the Director of Clinical Services. The allegation was discussed privately with the resident at the facility. The HRA reviewed relevant sections of the resident's record with his written consent. The facility's discharge policy was also reviewed.

The resident is an adult who maintains his legal rights.

COMPLAINT STATEMENT

According to the complaint, the resident objected to his nursing home placement, but he agreed with his physician's request to stay longer at the facility. Subsequently, the recipient gave written notice that he wanted to be discharged to the community, but his request was not honored.

FINDINGS

According to the record, the resident was transferred to the nursing facility from a community hospital on May 19th, 2009 because of non-compliance with psychotropic medications. He was diagnosed with Paranoid Schizophrenia and prescribed psychotropic

medications and other medications for his physical problems. He was described as alert and oriented at intake. A "Discharge Plan Review" form, completed on the admission day, indicated that his anticipated length of stay at the facility was seven to eleven months. According to the form, the resident needed to be medication knowledgeable, comply with all aspects of treatment, and possess knowledge of planning post-discharge services. The resident's care plan goals that originated on May 27th listed problems such as medication and symptom management and social skills.

The first note found in the resident's record regarding his desire to be discharged from the facility was dated June 8th. According to the meeting note, the psychiatrist suggested that the resident should work with his Psychiatric Rehabilitation Services Coordinator (PRSC) and attend group therapy sessions when he inquired about discharge. The resident agreed with his psychiatrist's request, but progress notes later revealed that he wanted to leave the facility. On June 24th, the resident told the PRSC that he wanted to be discharged, and that he was going back to live in his apartment. She asked him if his family was aware of his plans. She said that he had "promised' to let her talk to his sister about them. He was then informed that residents who lack knowledge about their medications cannot be discharged to the community because they needed support. On that next day the resident's family member called the PRSC about his discharge plans. She was informed that the facility recommends that residents who lack knowledge about their medication and have been non-compliant with them should be discharged to family or a group home. His family member told the staff person that the resident could not live with her, and that he had been hospitalized because of problems at his apartment.

A note written on June 25th reflected that the facility's discharge policy and the recommended discharge criteria were explained to the resident. The Director of Clinical Services told him that all discharge plans are individualized, and that he was appropriate for a future group home or family placement. The resident asserted that he had the right to leave the facility, and the Director of Clinical Services replied that "it [was] his right to work towards discharge." According to the note, "Leaving Against Medical Advice" (AMA) was discussed with the resident, and he was encouraged to work on an approved discharge plan. The resident showed his "Residents Rights Book" to the staff person and agreed to learn his medications. On the following day, the psychiatrist saw the resident, but there were no new orders given. The note also documented the resident's compliance with medication, and that he could not identify them as recommended for discharge.

On July 21st, the resident told the Director of Clinical Services that he wanted to be discharged on August 1st. He was reminded about the recommended discharge criteria and told that the discharge process usually takes four to six weeks. He was counseled about learning his medications and complying with his program. He was told that the PRSC would review the discharge checklist with him. Another note stated that the resident had good attendance at symptoms management therapy groups during this month, but he had only attended four of ten medication management sessions. According to the note, the resident had limited insight concerning his illness, and he could not identify his medications. The same day, a goal stating that the resident would successfully obtain an approved discharge to a lesser restrictive setting was developed. The goals included objectives to participate, learn or identify: 1) in group skills training programs at least 80%, 2) the names, times, and reasons for all prescribed medications,

3) an alternative living arrangement besides an independent apartment, and, 4) two reasons why it is important to have supervision regarding medication compliance upon discharge to the community. The goal also included interventions to review, encourage and provide: 1) the discharge policy as needed, 2) progress information upon the resident's inquiries about discharge, 3) the resident to attend all programs, 4) medication education, 5) alternative living arrangement, and, 6) the resident's efforts to meet discharge goals and objectives.

On July 22nd, the recommended discharge criteria was reviewed with the resident, but he did not meet any of them. He also could not identify an alternative placement based on the staff's recommendation. On July 31st, the resident's family member inquired again about him returning to the community. She was informed that he appeared agitated at times, and that he should patiently work on his treatment goals. On that same day the resident was informed about his family's call, he agreed to comply with the care plan, and a meeting to discuss discharge plans was scheduled with his psychiatrist.

Documentation on August 3rd indicated that the resident gave the staff person his apartment manager's phone number for verification purposes. There was no answer when she called, and a message to call the facility was left. On that same day the resident refused to meet with his psychiatrist although he had requested the meeting. Three days later, the resident told the Director of Clinical Services again that he wanted to be discharged from the facility. He was reminded that he had agreed to work with staff regarding this issue. Another message was left for his apartment manager to call the resident or the facility's social worker. On August 21st, Lydia's administrative staff met with the resident regarding his concerns and living arrangements for discharge. According to the meeting note, the resident was reminded as follows: 1) he needed to be compliant with medication, 2) be able to identify his medications, and, 3) attend all in-house scheduled programming. These goals reportedly had been recommended by his psychiatrist. The resident asserted that he did not need all of those programs, and that he was going to his apartment upon his discharge from the facility. During the meeting, the resident's apartment manager was called, and she reported having problems with him over an extended period of time. She said that the resident could only return to his apartment: 1) if he was compliant with medication, 2) if he had a follow up appointment with his physician, and, 3) if his physician's approved his discharge. According to the note, the resident acknowledged that he understood the information discussed at the meeting. An evaluation was scheduled with his psychiatrist for Monday because he continued to exhibit "bizarre behaviors."

On August 24th, the Director of Clinical Services and the psychiatrist met with the resident concerning his potential for discharge. His apartment manager's request for a written physician's approval prior to returning to his apartment was discussed. The resident denied that she had made such a request, and the psychiatrist noted delusional behaviors. According to the note, the psychiatrist said that the resident must fully comply with his treatment goals for a proper discharge. As before, the resident agreed with his psychiatrist, and medication was increased on that same day. Three days later, the resident presented with increased irrational behaviors and threatened to walk out of the facility. He said that he was going home. He reported that a family member had died, and that he was unable to reach his sister. According to a Discharge Summary Report, the resident was sent to the hospital for a psychiatric evaluation on that same day because of increased irritable behaviors, paranoid delusions and physically

threatening staff members. A family member confirmed that his grandfather had recently died upon notification about his transfer to the hospital. Additionally, the report documented that the resident would not be returning to the facility, and he was discharged on September 3rd.

According to the Facility Administrator and the Director of Clinical Services, the resident agreed to work with his psychiatrist upon requesting to be discharged from the facility. They said that discharge goals were explained to him, but he did not comply with them. His rights were also explained, but he continued to vacillate about leaving the facility. He refused to accept the facility's recommendations for alternative housing; his family member said that he could not live with her. The staff tried to verify the resident's apartment because he wanted only to return to his apartment. They left several messages for his landlord (with his verbal consent) before they were able to reach her. The resident was present during the phone discussion when his landlord reported having problems with him. She requested a written statement from the resident's psychiatrist that he was mentally stabled prior to returning to his apartment. However, his psychiatrist did not believe that he was ready for discharge, and he did not want to leave AMA. According to the staff, the resident chose to stay at the facility, and he refused to return post-hospital discharge.

Additionally, the staff interviewed reported that residents are given a copy of the "Residents Rights for People in Long Term Care Facilities" at intake. These rights are reportedly explained again 72 hours later and annually. They reported that some residents have left the facility without their physician's approval or AMA. However, the facility's goal is to make residents more knowledgeable about their illness and medication and assist them with re-entering the community. Lydia reportedly has about three to seven residents in the facility's discharge planning group each month.

During the investigation, the resident told the HRA that he had agreed to stay at the facility longer based on his psychiatrist's recommendation. In early July, he reportedly left a discharge note for the Director of Clinical Services at the facility's front desk. There was no discharge notice found during the record review. It was reported that the resident was allowed to return to his apartment after inpatient psychiatric care. However, this was not confirmed because a signed release of information to interview the resident's landlord was not obtained.

According to the facility's Discharge Policy dated January 2009, all residents are entitled and encouraged to work towards discharge. When a resident requests to be discharged, the PRSC will take all aspects of the resident's current level of functioning into consideration. In order to qualify for discharge planning to a lower level of care, the resident is encouraged to meet at least six of the following criteria: 1) Be able to identify his symptoms and relapse triggers and know his diagnosis and understand what it means, 2) Be familiar with names, dosages, administration times and the purpose of his medications, 3) Identify and utilize coping skills for symptoms, maladaptive behavioral issues and conflict management, as evidence by zero verbal or physical aggressive episodes within the last 6 months, 4) Display psychiatric stability as evidenced by zero psychiatric hospitalizations within the last 6 months, 5) Be active or have completed programming identified in their Individual Treatment Plan, 6 and 7) Be 100% compliant will all prescribed medications and activities of daily living skills with or without cues, 8) Successful completion of Community Re-entry skills group (85% attendance and

competency), 9) Be able to state reasonable goals for post-discharge, 10) Be on a pass level of 4 or better, and, 10) Participate in assigned day program ( 85% attendance for at least six months). According to a progress note, the resident did not meet any of above criteria when they were reviewed with him on June 30th

Additionally, the policy states that if a resident does not quality for discharge planning based on the requirements; the PRSC is responsible for developing a treatment plan that focuses on the individual's deficiencies. The HRA believes that goal objectives 3 and 4 for an approved discharge to a lesser restrictive setting were reasonable. All discussions concerning discharge and current criteria met should be documented in the resident's chart. During the admission process, residents are informed of their rights including the right to leave the facility against medical advice. Residents' rights are also reviewed with them annually including the right to give a 30-day notice for discharge.

CONCLUSION

According to Section 45/2-101 of the NHCA, no resident shall be deprived of any right solely on account of his status as a resident of the facility. Section 45/2-111 of the Act and Section 330.3300 (a) of the 77 Administrative Code state that a resident may be discharged from a facility after he gives the administrator, a physician, or a nurse of the facility written notice of his desire to be discharged.

Section 300.4030 (f) of the Illinois 77 Administrative Code states that whenever possible, residents shall be offered some choice among rehabilitation interventions that will address specific Individualized Treatment Plan objectives using techniques suited to individual needs.

CMS' Requirements for Long Term Care Facilities Section 483.15 (b) guarantees a resident the right to self-determination and to make choices about aspects of his or her life in the facility that are significant to the resident.

Section 483.20 (b) (1) (xvi) states that the facility must conduct, initially and periodically, a comprehensive assessment of each resident's functional capacity. The assessment must include discharge potential.

According to Section 5/2-102 (a) of the Mental Health and Developmental Disabilities Code,

> Services shall be provided in the least restrictive environment, pursuant to an individual services plan…. In determining whether services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided.

Documentation on a June 8th entry clearly stated that the resident agreed to stay longer at the facility as recommended by his psychiatrist. It was then noted on June 24th and 25th, July 21st and August 6th that he requested to be discharge from the facility. He was informed about Lydia's recommended discharge criteria, the facility's discharge policy, and the right to leave

against medical advice. The June 25th note also suggested the resident's awareness of his right to be discharged from the facility, and that the Director of Clinical Services erroneously informed him that "it [was] his right to work towards discharge." Entries further indicated that the resident was planning to return to his apartment upon his discharge from the facility. But his landlord wanted written assurance that he was mentally stable, and his psychiatrist was not willing to provide such a statement. The resident was eventually hospitalized for behavioral health reasons, and he did not return to the facility.

The HRA believes that the resident was not prevented from leaving the facility, but the staff might have overly influenced his decision to stay with respect to his right to be discharged. We remind the facility of the Illinois Appellate Court, Fourth District ruling - In re Muellner- citing the Mental Health and Developmental Disabilities Code, Section 5/2-114 that defines a mental health facility as "any licensed private hospital, institution or facility… or section thereof, operated by the State… for the treatment of persons with mental illness and includes **all** hospitals, institutions, clinics, evaluation facilities, and mental health centers which provide treatment for such persons." The court ruled that a specialized behavioral health unit in a nursing home meets the definition of a mental health facility under the above Section. The court also ruled that a recipient cannot be admitted to a nursing home that primarily serves individuals with psychiatric needs or held against the recipient's objections without a court order obtained through the involuntary commitment process under Article VII of the Code.

The HRA must caution the facility because the record lacked a written notice concerning his discharge request. Although the resident vacillated about leaving the facility, the staff should have informed him about the written notice requirement under Section 45/2-111 of the NHCA and Section 330.3300 (a) of Administrative Code. We are also concerned because sections of the resident's record reviewed do not clearly indicate that he was offered some choice among rehabilitation interventions under Section 300.4030 (f) of the Illinois 77 Administrative Code. No clear violations of above Sections were found. However, the facility's discharge policy that requires a 30-day notice does not conform to the NHCA. The Authority does not substantiate that the facility refuses to honor a resident's request for discharge.

SUGGESTIONS

1. Lydia's recommended criteria in its Discharge Policy seem very stringent with respect to residents' right to request discharge. The facility shall review its policy clarifying that residents may request discharge at any time under Section 45/2-111 of the NHCA and Section 330.3300 (a) of the 77 Administrative Code. Include provisions for informing residents about the written notice under the Sections. The policy should reflect procedures for providing residents who choose to leave against medical advice with resource information to make needed contacts. Additionally, the staff should be directed to review the recommended criteria when discharge planning begins and as a component of every care plan review.

2. There are no provisions under the NHCA that requires a resident to give a 30-day notice for discharge. The facility shall amend its discharge policy to comply with the Act.

3. Train the appropriate staff member on the facility's revised discharge policy.

COMMENTS

There was no written authorization found from the resident to discuss his care with his landlord or family. The Authority must remind the facility that the Mental Health and Developmental Disabilities Confidentiality Act Section 110/2 defines communication as any … in connection with providing mental health … services to a recipient. We suggest that the facility follow Section 110/5 (a) of the Act stating that,

> Records and communications may be disclosed to someone other than those persons entitled listed in Section 4 of this Act only with the written consent of those persons who are entitled to inspect and copy a recipient record pursuant to Section 4 of this Act.

The Authority is very concerned about the resident's landlord's conditions that placed a considerable unnecessary burden on him. The staff should have informed the landlord about the resident's right to refuse treatment including medication. Additionally, the staff should have immediately called the resident's family (with his written consent) when he reported that a family member had died. This might have de-escalated the situation that lead to his hospitalization.