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REPORT OF FINDINGS
LYDIA HEALTHCARE — 10-040-9026
HUMAN RIGHTS AUTHORITY- South Suburban Region

[Case Summary— The Authority did not substantiate the complaint as presented but found that medications were administered without the guardian's informed consent. The public record on this case is recorded below; the provider did not request that its response be included as part of the public record.]

INTRODUCTION

The Human Rights Authority (HRA) has completed its investigation into an allegation concerning Lydia Healthcare. The 309-bed skilled and intermediate care facility is located in Robbins. According to the complaint, a resident was given medication without adequate cause. If substantiated, this allegation would be a violation of the Nursing Home Care Act (NHCA) (210 ILCS 45/2 et seq.), the Mental Health and Developmental Disabilities Code (405 ILC 5/2-107 [a]) and the Illinois Probate Act (755 ILCS 5/11a-23).

METHODOLOGY

The Authority investigated the complaint by gathering information from various sources. The Director of Clinical Services, the Director of Health Care Services, the Director of Medical Records, the Supervisor of Nursing and a Registered Nurse were interviewed. The facility's staff and the resident's guardian attended the Regional Authority public meeting. The adult resident was interviewed privately at the nursing facility. Relevant facility policies were also reviewed.

Sections of the resident's record and a copy of his Guardianship Order, dated October 29th, 2009, were reviewed with written consent. This order appoints guardianship over the resident's personal care.

COMPLAINT STATEMENT

According to the complaint, the resident was given psychotropic medication over his objections and in the absence of an emergency. For example, in March 2010, the resident was allegedly injected with medication because he asked a nurse to call his physician regarding over-the-counter vitamins that the staff had taken from him. In April 2010, a nurse told the resident to leave the floor because he asked about his vitamins again. Although the resident was not loud or threatening, he was escorted to the monitoring room, and a nurse attempted to give him an injection. He reportedly ran out of the facility, he was brought back in, and medication was

administered. It was reported that the resident subsequently filed a grievance with the facility because the staff threw his vitamins in the trash can.

FINDINGS

Information from the record, interviews and program policies

According to the record, the resident was diagnosed with Schizophrenia and admitted to the facility on November 18th, 2009. His mother was with him at the facility on the admission day. An assessment listed the parent as the resident's legal guardian on the 19th, but he was allowed to give consent for services on the 23rd. The form signed by the resident and the Director of Medical Records included the administration of Cogentin, Depakote Extended Release, Risperdal and Ativan. There were no recommended medication dosages, but the form indicated that written and oral medication information was provided to the resident. The first indication of the guardian's consent for psychotropic medication (Clozapine 300 mg daily) was recorded on December 14th. The guardian subsequently gave consent for the administration of other psychotropic medications such as Haldol Decanoate 150 mg Intramuscular (IM) every two weeks, Cogentin 2 mg and Depakene Syrup 1500 mg on January 5th, 20th and February 16th, 2010 respectively.

Medication Administration Records (MARs) from December 28th, 2009 through April 26th, 2010 indicated that scheduled dosages of Cogentin and Depakote Extended Release were administered without the guardian's consent until January 19th and February 15th respectively. Risperdal and Ativan were not found on the MARs, although they were listed on the consent form signed by the resident. According to the MARs, Haldol 5 mg IM was given on February 17th at 3:00 a.m. A corresponding nursing entry stated that the medication was given because of "bizarre behavior" and pacing with his mouth opened. There was no additional information recorded concerning the incident. On March 25th, a nurse wrote that the resident had refused medication. He then accepted the medication and placed the pills in his pocket and refused to give them back to the nurse. A Coordinator of Psychiatric Rehabilitation Services was called to the unit and 1:1 was provided. According to the note, Haldol 5 mg IM was given for agitation on that same day at 8:45 p.m., but this injection was not reflected on the MARs. Mouth checks for medication compliancy were ordered because the staff believed that the resident was not swallowing his pills.

On April 1st, a nurse wrote that the resident was observed talking loudly in the dayroom. Upon questioning, the resident told the nurse that he was talking to his friend (the television). He was offered as needed medication and was allowed to refuse. On April 9th, the resident was described as delusional with increased agitation. On that same day, he was hospitalized for trying to kick his peers. According to a corresponding psychiatric services' note, the resident was given as needed medication before leaving for the hospital. What medication and the method of administration were not recorded on the MARs, and there was no more information found in the record concerning the incident. On April 21st, the resident returned to the facility from the hospital. Haldol 5 mg IM or by mouth as needed was added to his treatment plan with the guardian's consent on that same day.

On April 28th at 5:30 p.m., the resident was described as highly agitated and exhibited increased aggression toward the staff and peers. He reportedly eloped from the facility during 1:1 counseling and monitoring. He was verbally and physically aggressive toward the staff after he was taken back to the facility. There was no supportive documentation found in the record that the resident was given an injection after his elopement as the complaint alleged. He was sent to the hospital for an evaluation as ordered by his physician and returned post-hospitalization on May 6th. According to a progress note, the resident was given as needed medication for calming purposes on May 29th. He was reportedly extremely agitated, angry and verbally aggressive leading up to the medication. On July 3rd, at 4:20 p.m., a nurse wrote that the resident exhibited increased agitation, and he was verbally aggressive towards the staff. He was taken to the monitoring room, and Haldol 5 mg orally was administered.

A "Grievance/Complaint Report" dated on July 22nd stated that the resident told a surveyor from the Illinois Department of Public Health (IDPH) that his vitamins had been tossed in the trash can on that previous month. The resident gave conflicting information when he was interviewed by a facility's staff person concerning the grievance. He first denied the allegation. He then claimed that the facility's nutritionist or another staff person had his vitamins. He retracted the allegation again. According to the report, staff members on the floor were interviewed, but they did not remember the resident having the vitamins in question. There was no additional information found in the record concerning the resident's alleged over-the-counter vitamins. According to medication records reviewed, the resident was given two vitamins daily for his physical problems as ordered.

Lydia Healthcare's policy states that the resident or legal guardian's informed consent shall be obtained prior to administering psychotropic medications. The facility's handbook for new residents state that residents have the right to participate in their care plan. The handbook also guarantees a resident the right to file a grievance. According to the facility's grievance procedures, the resident's PRSC should listen to the person's concerns and complete a complaint form if the resident is not satisfied with the resolution. The Director of Clinical Services will then meet with the resident concerning the grievance.

On questioning regarding consent for medication, the Director of Medical Records told the HRA that the facility was not informed of the resident’s guardianship status until about two months after he was admitted. However, an assessment completed on that next day listed the resident's mother as his legal guardian. The staff interviewed said that the resident sometimes can complete his adult daily living tasks without prompting. Sometimes he gets angry when talking about his mother and does not believe that he has a mental illness or needs medication. He reportedly believes in over-the-counter medications, and he usually vacillates about taking prescribed medication. According to the Supervisor of Nursing, the resident has made threatening gestures toward others, but he has never followed through. She said that the resident will comply with medication at times, but she has never witnessed him asking for PRN medication.

According to the staff interviewed, the monitoring room is located on the first floor in the facility. The Supervisor of Nursing explained that the protocol for PRN medication use is to address agitation and physical aggression. She described agitation as punching the wall, pacing

the floor, pushing the table or bumping into others. She said that a thorough assessment should be done before as needed medication is given. Nurses are responsible for following the physician's orders, counseling residents and notifying the physician when needed. There is a physician reportedly in the facility five days a week.

The nurse who administered Haldol 5 mg IM early morning on February 17th remembered the incident. According to the nurse, the resident was laughing and making bizarre facial expressions. These behaviors were reportedly side effects from medication. She stated that the resident did not refuse the medication when offered. She reportedly has known the resident for a long time and has a good relationship with him. According to the staff interviewed, medication was not given after the resident ran out of the facility and prior to his transfer for a psychiatric evaluation on April 28th. They told the HRA that emergent medication was never given, and that the resident accepted all as needed medication when offered.

CONCLUSION

According to the Illinois Department on Aging—Residents' Rights for People in Long Term Care Facilities and Section 45/2-104 of the NHCA,

> Every resident shall be permitted to refuse medical treatment and to know the consequences of such action, unless such refusal would be harmful to the health and safety of others and such harm is documented by a physician in the resident's clinical record.

According to Section 45/2-106.1 (b) of the Act,

> Psychotropic medication shall not be prescribed without the informed consent of the resident, the resident's guardian, or other authorized representative. "Psychotropic medication" means medication that is used for or listed as used for antipsychotic, antidepressant, antimanic, or antianxiety behavior modification or behavior management purposes in the latest editions of the American Medical Association Drug Evaluations or the Physician's Desk Reference.

According to Section 5/2-107 of the Code,

> An adult recipient of services…must be informed of the recipient's rights to refuse medication ….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….psychotropic medication or electroconvulsive therapy may be given under this Section for up to 24 hours only if the

> circumstances leading up to the need for emergency treatment are set forth in writing in the recipient's record.

The Illinois Probate Act, Section 5/11a-23 states,

> Every health care provider and other person (reliant) has the right to rely on any decision or direction made by the guardian … as though the decision or direction had been made or given by the ward.

It is the intent of the law that a resident' guardian be directly involved in any decisions that directly affect the well being of the resident. Although the Director of Medical Records reported that the facility did not know that the resident was under guardianship until two months after he was admitted to the facility, an assessment, completed on November 19th documented that the resident was under guardianship. However, the resident was allowed to give consent for services including the administration of psychotropic medications on November 23rd. Medication records documented that Depakote Extended Release and Cogentin were initially used in his care plan without the guardian's consent. The first indication of the guardian's medication consent was for the administration of Clozapine on December 14th.

Documentation indicated that Haldol 5 mg IM was administered on February 17th, March 25th, April 9th, May 29th and July 3rd. According to the facility's staff, the resident accepted the medication in the absence of an emergency. Although it is unclear whether the resident was given the opportunity to refuse the medication, there was no evidence of informed consent for Haldol prior to April 21st. Dosages of Haldol administered on April 9th and May 29 were not documented on the MARs, and the method of administration for the April 9th as needed medication was not recorded. The HRA found no evidence that medication was given after the resident attempted to run away from the facility on April 28th as alleged in the complaint. A report further indicated that the facility investigated the resident's grievance regarding his alleged over-the-counter vitamins.

Based on the investigation, the Authority cannot substantiate the complaint that a resident was given medication without adequate cause. No violations of Sections 45/2-104 of the NHCA and 5/2-107 of the Code were found. The facility violates Sections 45/2-106.1 (b) of the NHCA, 5/11a-23 of the Illinois Probate and program policy because medications were administered without the guardian's informed consent.

RECOMMENDATIONS

1. Lydia Healthcare shall obtain guardians' consent prior to administering scheduled and non-emergent psychotropic medications pursuant to Section 45/2-106.1 (b) of the NHCA, the Illinois Probate Act, Section 5/11a-23 and program policy.

2. Review program policies and consent laws regarding substitute decision making with all appropriate staff. Under the Probate Act of 1975, if a court adjudges a person to be disabled, as in this resident's case, a guardian of his person is appointed because it was found by clear and

convincing evidence that the resident lacked sufficient understanding or capacity to make or communicate responsible decisions concerning personal care (755 ILCS 5/11a-3).

SUGGESTIONS

1. Document all dosages of medication administered on the MARs.

2. To ensure that residents/guardians have sufficient information to give informed medical consent, include medication dosages on medication consent forms.

3. Thoroughly document incidents that warrant prn or emergency medication administration.