East Central Human Rights Authority
Report of Findings
Case 10-060-9005
Decatur Manor Healthcare

The East Central Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegations concerning residential health services at Decatur Manor Healthcare located in Decatur, Illinois.

Complaints:

1. The staff do not consult the guardian regarding the care and treatment of a resident.
2. The staff have impeded the transfer of a resident to a different facility against the guardians' instructions.

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/1 et seq.), the Nursing Home Care Act (210 ILCS 45/1 et seq.), the Administrative Code for skilled nursing and intermediate care facilities 77 Ill. Admin. Code 300.3300), and the Illinois Probate Act of 1975 (755 ILCS 5/11a-23).

Per its website: "Decatur Manor Healthcare is an intermediate care facility for the chronically mentally ill. It is licensed by the state for 147 beds. It states that the goal is to assist residents in the development of positive behaviors and skills needed in order for successful functioning while allowing them to live as independently as possible in the community. All residents at Decatur Manor Healthcare have a primary diagnosis of a mental illness. The diagnosis of the residents prevents them from living independently without the supportive services and programs of a nursing facility. The psychiatric rehabilitation programs offer residents the opportunity to manage their illnesses in an environment less restrictive and less expensive than in state hospitals. It is not a locked facility, but rather a monitored facility."

COMPLAINT STATEMENT

According to the complaint the facility would not allow a resident unimpeded access to the telephone and visitation with her guardian. Allegedly the guardian could not access the resident by phone to check the quality of the care the resident received. Per the complaint the resident had worn the same clothes for over a week's time. The resident broke out with rashes and infections because she had not received assistance from staff with her personal hygiene and bathing. The complaint further alleges that the guardian was not notified when medicines used to control behaviors were changed. The complaint states that this facility delayed and impeded the transfer of the resident to a different facility.

Interviews

The HRA proceeded with the investigation having received written authorization to review the consumer's record. To pursue the matter, the HRA visited the facility where the program representatives were interviewed. Relevant practices, policies and sections of the resident's record were reviewed to investigate the allegations; an HRA investigation team met

with and interviewed the Administrator, the Director of Nursing at Decatur Manor and Psychiatric Rehabilitative Services Coordinator (PRSC).

Staff explained that guardians are notified when there is a change of resident's status such as increased needs, accidents and injuries. Either case management or nursing management would be responsible for keeping the guardian informed. When asked under what circumstances might communication and\or visitation have been restricted, the response from staff was if a resident or a guardian requested that visitation be restricted because of safety issues, the staff would adhere to the request. Regarding the process for restricting visitation they have to complete an assessment to determine if the restriction is necessary. Usually it is a behavior that is inappropriate.

Staff explained that treatment would be determined by assessing each resident. There would be evaluations and a psycho-social packet would be completed. There would be an interview with the resident, a social history, a psychiatric evaluation, and usually a third party agent is involved in determining services provided to the resident. The treatment team that determines the course of treatment consists of nursing, social services, dietary, activities director, psychiatrist, psychologist, social services coordinator, and the case manager. The psychiatrist reviews the treatment plan and behavior plan.

Regarding residents' use of the phones, the staff explained residents may use the pay phone anytime they want to. They may receive phone calls. There is a house phone where residents may make local calls for free privately. The policy regarding guests and guardians when it comes to visitation is that the facility is open for visitors. Family and visitors may use the conference room to have private visitation with the resident.

When asked about the facility accommodating the guardian’s request to have a ward's hygiene needs met, such as bathing or a clean change of clothing, the staff explained that the resident bathed daily. There are classes provided to the residents on personal care and hygiene because the ultimate goal is independence. Certified nursing assistants assist residents as needed with personal hygiene.

Staff explained that the resident was diagnosed with schizoaffective disorder, paranoid and cognitive disorder. The care plan was completed. Her progress was observed by staff. She was not good at making decisions. She was very antisocial and would not get up for phone calls. The resident was always allowed to talk to the guardian, but many times she did not want to talk to him. The guardian would call and he would get frustrated because it took awhile to get the resident to the phone. The resident would have a series of activities she would do before she would leave her room to come to the phone. According to staff, the guardian was verbally abusive to the resident and the staff.

Per staff emergency medications would never be given without the guardian's consent and the guardian was always called. Regarding the resident's medication, it was assessed by the psychiatrist and nursing at admission. The guardian was consulted on medicine changes. When there was any kind of change with the resident, the procedure was that the guardian was always called. The guardian at one time took the resident on an outing and then left her at a hospital in a

different town. The hospital called Decatur Manor. Decatur Manor sent staff to pick the resident up and bring her back to the home and went through the admission process again. The resident was very close to quite a few of the staff members. She had progressed a lot while she was there. They involved the guardian during treatment. Regarding the arrangements for the second discharge, Decatur Manor staff had no notice, but cooperated with the guardian. No grievance was filed by the resident or the guardian.

The HRA was provided a tour of the facility. Resident's Rights were posted on the wall as was third party advocacy numbers. Residents were engaged in various social activities. There was a calendar that listed different activities in which residents could participate. The walls were painted a warm buttery color. There was decorative art in the hallways. Everything was hung safely so that it could not be pulled off of the walls. This added brightness and color to the entire facility.

The discharging nurse was not available at the site visit; the HRA contacted the nurse by phone and completed the interview with the staff member. The staff shared her experience at the discharge. She stated that when the resident was being taken from the nursing home, by the guardian, the resident grabbed a hold of the staff person and stated that she didn't want to go. The resident was very upset. The resident asked where she was going and why was she leaving. The staff kept trying to reassure her. The resident told the staff she loved her and the resident called the guardian names. The resident did not understand why she was leaving. The guardian would not tell her where she was going. The resident was terrified. She did not want to leave, but was forced by her guardian against her will to leave Decatur Manor.

Records Reviewed

The timeline is based on the documentation of the resident's record:

5/7/09 The resident was admitted. The resident's diagnosis is schizoaffective disorder, paranoid type; mixed and cognitive disorder; asthma and incontinence. Admission documents and an application for Medicaid were sent to guardian to be completed for the resident. The contract between the resident and the facility included a place for the resident's representative to express his wishes. There were numerous documents and all documents were marked where the guardian was supposed to sign.

5/14/09 The resident was discharged. (Reportedly, the guardian took the resident for an outing, drove the resident to a hospital and dropped her off.)

5/15/09 The hospital called Decatur Manor to pick up the resident. Decatur Manor sent staff to pick up the resident and brought her back to the home. It was documented that the resident was placed in the same room she was in before. She was eating a snack and stated that she was happy to be back.

The PRSC asked the guardian to sign the resident's admissions forms. It was documented that the guardian stated he would not sign them today, but would sign them later. There was documentation of rights given to the resident.

The Community Access Assessment documented that the resident may not access the community independently due to being ~~a~~ newly admitted, feeling anxious and fearful. This was the resident's choice and signed by the resident and the staff. A program was written to work with the resident to learn how to sign out of the facility and communicate her own name.

The interdisciplinary narrative documented that a coping method would be developed with the resident to address the ability to communicate her own feelings. It also documented the resident was resistant. The psychosocial assessment was completed. There was a physical examination, drug and alcohol screening test, pain, and fall risk were completed with the resident. Medication, including psychotropic medication (Zyprexa and Ativan) were assessed and prescribed by the psychiatrist with the guardian's written consent.

Independent living skills were assessed and it was documented that the resident would need on-site assistance with personal hygiene

5/19/09 The admission paperwork and application for Medicaid for this resident was sent to her guardian.

5/20/09 The resident stated her guardian told her she had to stay at the nursing home for the rest of her life. The resident stated she wanted to start smoking and stated she was angry at her guardian. The resident was encouraged to not start smoking and go to her room to calm down. She returned to the nursing station and was encouraged to talk to her guardian.

05/28/09 The PRSC asked the guardian to sign the resident's admission paperwork and he refused. There was another basic assessment that was completed with the resident. Another note documented that the resident was not submitting enough clothing to meet her laundry needs, but she did not have much clothing. It was documented that the resident had some undergarments, 3 pairs of pants, a jacket, and a couple of tops. It was also documented that the resident tried to call her guardian.

6/21/09 The guardian signed that there were no advance directives for the resident.

6/24/09 The resident stated she would accept visits from her guardian.

7/2/09 The guardian called, but the resident told the staff she did not want to talk to him because she was not feeling good.

7/6/09 The guardian called and spoke to a staff member, he then talked to the PRSC. He was angry that the resident did not call him back. The PRSC had a staff person go ask the resident to come to the phone, but she refused because she said she was taking a nap. The PRSC shared that the resident was doing well and was taking a nap. The PRSC asked the resident to call her guardian and the resident did not want to at that time. She was encouraged to call later.

7/13/09 The resident was upset and wanted to call her guardian; staff assisted her in making the call.

7/14/09 The guardian was reminded that he had not signed admission paperwork and said he would sign it later. The guardian stated that someone from the facility had called him four times in the last few minutes. The PRSC let him know that she had no knowledge who had called, but she would see if the resident wanted to talk to him. The resident did not want to talk to him at that time. She offered to talk to the resident to see if the resident would call him later.

7/17/09 An oral assessment and foot assessment were completed for the resident.

7/21/09 The guardian called requesting a room change for the resident stating the resident had made complaints about her roommate to her guardian. Staff attempted to move the resident, but the resident refused the move stating she wanted to stay with her roommate. The PRSC called the guardian and let him know about the resident's choice.

7/22/09 The guardian paid the resident's portion of the cost of care at Decatur Manor for June and July from the resident's social security.

7/29/09 Three staff members documented that the resident would not take phone calls from her guardian. The resident's ring which had been lost was found and taken in to the administrator's office and locked up.

7/31/09 The resident was feeling sick, so the nurse checked her blood and her blood glucose was low so the PRSC went and got her some milk. The resident stated her guardian was supposed to be taking her for an outing and they were going to eat out. The PRSC called the guardian because he was running late and asked when he was coming to pick up the resident. He told her he was not coming to visit that day. The PRSC explained that the resident would not eat because the resident thought the guardian was coming to take her out to eat. It was explained to the resident by the staff that the guardian was not coming to take her out and she was persuaded to eat. She asked if she could be served instead of waiting in line for her food today and her request was accommodated.

The guardian called back to check to make sure the resident had eaten. He also stated he would come to take her out on Sunday. The PRSC explained that when he didn't make it to see the resident, the resident would miss him and this had caused behaviors in the past.

The guardian called back about the resident's missing ring being lost and it was explained that the ring had been found. The ring was locked up in the administrator's office to be given to the resident when the administrator returned.

8/3/09 The guardian called and requested that the resident be given a bath. The PRSC explained that the resident had a bath. Her hair had been washed and conditioner was put on her hair. It was also explained she had attended the chatter box club. The guardian felt she was not in enough activities. He also complained about residents in the lobby. It was explained the residents had the right to be in the lobby and they were there all of the time.

8/6/09 The guardian called about the resident this morning. The PRSC went to the resident to let her know the guardian had called and he wanted her to call him back. The resident went back to

bed and stated she did not want to call. The PRSC called the guardian back and explained the resident did not want to come to the phone.

8/10/09 The guardian was reminded again that he had not signed the admission packet. He stated he refused to sign, because he was taking the resident out of the facility.

The resident came to nursing and was upset because she claimed that the guardian (her ex-husband) had married her sister. She was upset and wanted to call him to talk to him about this. The nurse let her use the phone in her office. Since the guardian did not answer, the nurse left a message for him to just call the facility. The guardian called her back and proceeded to yell at the nurse for calling him. The nurse let him know the individual was upset and what the individual believed. He yelled it was none of the nurse's business or his ward's business.

Per the PRSC notations, the guardian called again and started screaming at her. She could not fully understand the guardian. He was yelling something about the admissions coordinator, the social service worker and herself. He continued to scream so loud the administrator heard him across the room from the phone. The administrator took the phone and spoke with the guardian. The PRSC could hear the guardian become irate with the administrator.

There were notations from the administrator that he explained to the guardian that yelling and screaming was inappropriate. The administrator asked the guardian to use good etiquette. The administrator explained that calls of this nature were not acceptable and would no longer be tolerated. Conversations of this nature would be terminated by the staff.

8/15/09 The guardian did complete the paperwork to apply for Medicaid to pay for the resident's stay at Decatur Manor that would not be covered by her income.

8/17/09 The notes by PRSC document that the individual was being moved by her guardian to another facility. He was given her belongings and her medications to take with her. The resident stated many times she did not want to leave. She was told to stop acting like a two year old.

The notes by another staff assisting at the discharge document that the resident's guardian was rude and impatient with the resident. He told the resident she was acting like a child. She was being more of a baby. He would not tell her where she was going. The nurse asked him the same thing and the guardian ignored her even though the resident was hyperventilating and angry. The resident repeatedly said she did not want to go, but the guardian did not appear to be listening.

8/19/09 The guardian paid the resident's portion of the cost of care at Decatur Manor for the resident's stay for August from her social security.

Policy Reviews

The HRA reviewed the Grievances/Complaints policy and the HRA requested policies regarding guardianship involvement and was advised that they do not have written policy, but simply follow the law.

CONCLUSION

Complaint 1. The staff do not consult the guardian regarding the care and treatment of a resident. According to the complaint the facility would not allow the resident unimpeded access to use the telephone and receive visitation with the guardian. Allegedly staff impeded phone conversations to prevent the guardian from having access to check on the quality of the care that the resident received. Based on the record it showed that the resident was always allowed unimpeded access to use the telephone and to have visitation with the guardian. There was no evidence that a staff member had taken it up themselves to impede the resident and the guardian per the Mental Health Code which states that recipients "….shall be permitted unimpeded, private, and uncensored communication with persons of his choice by mail, telephone, and visitation." (5/2-103). The Nursing Home Care Act also states that every resident "….shall be permitted unimpeded, private and uncensored communication of his choice by mail, public telephone or visitation." (210 ILCS 45/2-108). The Act also specifies, in the same section, that a physician can restrict visitation to protect the resident or others from harm, harassment or intimidation if the physician documents the reason for the restriction in the resident's record. The record documented that the resident had chosen at times to not come to the phone and converse with the guardian.

As far as the statement that the guardian was not notified when psychotropic medicines had been used to control behaviors, there was no evidence that psychotropic medications were changed during the time period the resident was at the facility after her admission on 5/15/09. Medication for the resident was assessed by the psychiatrist at admission and her guardian gave consent in writing for the medication (Zyprexa and Ativan). Information regarding the side effects of the medication was given to the guardian and the resident on that date. There were no documented behaviors by the resident requiring any emergency medications in the record. The guardian was asked to sign the resident's contract on the day of her admission and promised to sign it later. The staff did contact the guardian 5 times requesting he sign the basic admission documents. It did not appear that he signed the contract that would have assisted in guiding and directing the resident's care. The guardian did complete the paperwork to pay for the resident's stay at the home two days before he discharged the resident. The evidence in the record documented that the guardian was consulted regarding the treatment of the resident. The Mental Health Code outlines the need for guardian participation regarding the care and service plan "…. The 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. In determining whether care and 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." (5/2-102). The Code (405 ILCS 5/2-107) also states that a recipient can refuse medication and emergency medication over a recipient's objection can only occur "…to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available. The facility director shall inform a recipient, guardian, or substitute decision maker, if any, who refuses such services of alternate services available and the risks of such alternate services, as well as the possible consequences to the recipient of refusal of such services."

There was no evidence that the resident broke out with rashes and infections because she had not bathed. There was documentation in the record that resident received training in personal hygiene. There was no evidence to support or not support that the resident wore the same clothing for over a week's time. It would have been the resident's choice regarding what outfit she chose to wear. The record documents there were not very many clothing items for the resident to choose from. Based on the evidence, the Complaint 1., The staff do not consult the guardian regarding the care and treatment of a resident **is unsubstantiated.**

Regarding the Complaint 2., the staff have impeded the transfer of a resident to a different facility against the guardian's instructions. The Administrative Code for skilled nursing and intermediate care facilities state "…. if a guardian has been appointed for a resident or if the resident is a minor, the resident shall be discharged upon written consent of his or her guardian or if the resident is a minor, his or her parent unless there is a court order to the contrary. In such cases, upon the resident's discharge, the facility is relieved from any responsibility for the resident's care, safety or well-being. "(77 Ill. Administrative Code 300.3300 Transfer or Discharge). The home did assist the resident in returning to the facility when she was left at the hospital, but went through the entire admission process again with the resident and the guardian when she returned. The evidence in the records shows that the guardian completed the Medicaid application for the resident two days before he discharged her.

The record shows that the staff tried to assist the resident in preparing for the transfer and cooperated fully with the resident's guardian. Pursuant to the Probate Act of 1975 which states, every health care provider "… 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."(755 ILCS 5/11a-23). There was no evidence in the record that staff in any way impeded the transfer of this individual. The Complaint 2. the staff have impeded the transfer of a resident to a different facility against the guardian's instructions **is unsubstantiated.**

The HRA does commend Decatur Manor for posting the decorative art in the hallways, adding the warm color to the facility and resident's choices regarding entrees during meal times. The HRA would like to thank Decatur Manor for their cooperation with this investigation.

The HRA also takes this opportunity to offer the following suggestions for consideration:

1. That the facility should consider including a portion of the care plan for discharge planning especially when a resident's continued placement in the home is questionable. Such review at the care plan meeting might have allowed for some discussion with the resident and her guardian.

2. Facility staff reported that a guardian's request for a visitation restriction would be honored. The HRA notes that the Nursing Home Care Act requires that a physician be involved in a visitation restriction and document the reason for a restriction in the

resident's chart. The HRA suggests that the facility ensures that any visitation restriction follow Act requirements.

3. Facility staff reported that emergency medications would not be given without guardian consent, however, the Mental Health Code states that emergency consent can only occur to prevent imminent physical harm to the recipient or others and when no less restrictive alternative is available. The HRA suggests that the facility ensure that Code standards and requirements are followed when administering emergency medications. The Code further requires (405 ILCS 5/2-201) that a notice of rights restriction be issued when emergency medications are administered.

4. Facility notes indicate the resident's dissatisfaction with the guardian, the resident's unhappiness with the guardian's decision to transfer the resident out of the facility and possible verbal abuse by the guardian. The HRA suggests that when a resident voices dissatisfaction with a guardian or there is a concern about the manner in which a guardian is interacting with his/her ward, that the resident be referred to an external advocacy organization or the Probate Court in which the guardianship was established for assistance. The HRA also notes that the Probate Act (755 ILCS 5/11a-14.1) has some limitations with regard to a private guardian's ability to place a ward in a residential facility unless a court order allows for residential placement. Absent a court order for residential placement, the guardian is to return to court regarding residential placement decisions. With a court order the Probate Act requires that placement decisions be made "…in conformity with the preferences of the ward unless the guardian is reasonably certain that the decisions will result in substantial harm to the ward…."