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REPORT OF FINDINGS
CHICAGO RIDGE NURSING HOME– 11-040-9013
HUMAN RIGHTS AUTHORITY- South Suburban Region

[Case Summary— The Authority made corrective recommendations regarding the allegation that were accepted by the service provider. The public record on this case is recorded below; the provider's response immediately follows the report.]

INTRODUCTION

The South Suburban Regional Human Rights Authority (HRA) has completed its investigation into an allegation concerning Chicago Ridge Nursing Home. The complaint stated that a resident was forcibly given medication that she had refused 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).

Chicago Ridge Nursing Home provides 24-hour skilled nursing care and offers a range of programs. The 231-bed facility located in Chicago Ridge did not have any available beds when the complaint was discussed with the facility staff.

METHODOLOGY

To pursue the investigation, the allegation was discussed with the Facility Administrator at the South Suburban Regional Authority public meeting. A site visit was conducted at which time the Facility Administrator, the Director of Nursing and a staff person from social services were interviewed. The complaint was discussed with the resident and guardian by phone. Sections of the resident's record were reviewed with written consent. Relevant policies were also reviewed.

The HRA was provided with a copy of the adult resident's Guardianship Order, dated September 19th, 2003, that was not part of the record reviewed. This order appoints guardianship over the resident's personal care and finances.

COMPLAINT STATEMENT

The complaint stated that the resident does not want to take psychotropic medication because of drooling, constipation and other side effects. It was reported that the resident was given psychotropic medication over her objections and in the absence of an emergency at least

four times. For example, the resident was allegedly given medication without cause about two days after she was admitted to the facility. She was supposedly force-treated twice in her bedroom. She reportedly told another staff person about the fourth injection because of bleeding from the injection site.

FINDINGS

The resident's record indicated that she was transferred to the facility from a private hospital on February 14th, 2011. She was diagnosed with Schizoaffective Disorder and Quadriparesis. The referral informational packet from the transferring hospital documented that the "pt's father is her legal guardian, but pt. states [they do not see her very much]." A cover sheet suggested that the referral information had been faxed to the Facility Administrator on February 4th, but the resident was allowed to sign the "Contract Between Resident and Facility" on the admission day. A medication form recorded that Haldol 2 mg orally at night and 5 mg Intramuscular (IM) every four hours as needed (PRN) was recommended. The resident was asked to sign the medication consent form, but she refused. According to the Medication Administration Records (MARs), Haldol 5 mg IM was given on the 14th, but there was no documentation found in the record explaining the injection.

For February 16th and the 20th, the initial social services admission note and the "Admission Information on Advance Directives" form repeated that the resident's father is her legal guardian, per the record. A social assessment also recorded that the resident said that her parent is the guardian. And, the staff person wrote that the facility had "no proof of guardianship." On the 20th, Risperdal Consta 25 mg IM every two weeks and Thorazine 50 mg orally or IM every two hours as needed were ordered. As before, the resident was asked to give written consent for medication, but she refused. On that next day, social services noted that the facility was trying to determine whether the resident's father is the Power of Attorney for Health Care or the guardian. The staff person wrote that the resident would not discuss this issue or provide her father's contact information. The HRA noticed that her parent's name and telephone number were listed on the above assessment form.

There were many entries found in the record documenting that the resident exhibited hallucinations, delusions and behavioral problems. She was noncompliant with medication and completing activities of daily living and did not want help from the staff. On March 8th, it was recorded that the resident was agitated because the floor in the hallway was mopped daily. She was described as loud and profane; she accused the staff of trying to agitate her and threw the "wet floor" sign down the hallway. On April 21st, the resident was reportedly agitated because she wanted to ambulate in her wheelchair, but the floor had just been mopped. The nurse wrote that the resident became more difficult to redirect when she was informed that the floor needed to dry before accessing this area. She refused medication and she was able to calm down. There was no evidence that medication was given over her objections.

According to nursing entries and medication records, psychotropic medication was administered four or five times during the resident's stay at the facility. On April 23rd, the resident was described as agitated and kicking the "wet floor" sign board. The nursing note stated that Thorazine IM was administered because the resident had refused to accept the

medication by mouth. The MARS do not reflect that this medication injection was given on the 23rd, but they documented that Thorazine 50 mg orally and IM were given for agitation on the 24th. The facility subsequently provided the HRA with another copy of the medication record, and the nurse's follow-up assessment of effectiveness had a line drawn through Thorazine 50 mg orally and "error" was written on the sheet.

On May 12th, a nurse wrote that the resident was actively hallucinating; she reportedly reached behind the ledge at the nursing station and tried to drink soap used for showering. She avoided eye-contact upon redirection and said that she believed that the soap was "Tequila." She was asked to change her urine soaked pants; she started cursing and was combative. She then refused to comply with the nurse's request and was not willing to accept help from the staff. It was recorded that the resident was mumbling, smiling, her eyes were wandering, and she agreed to accept Haldol. She stated "You give it! You bitches fall back" and pointed to the staff. According to the nursing note, the resident was cooperative when Haldol 5 mg IM was administered. And, she accepted the staff's help with showering and changing her clothing minutes later.

On May 12th, a second note stated that the resident told the Director of Nursing that "I let the bitches [take off] my clothes." She also said that "they gave me a shot." She was asked why she had agreed to the injection because she had been refusing medication. She started laughing loudly and said "I'll get it if I want it [and] when I want it." She was asked to lower her voice and whether Risperdal Consta could be given now. The resident told the staff person that the nurse had drawn blood when the previous injection was administered. She said "I only have so much blood left— I can't make anymore." It was explained that the medication might keep her calmer for a longer period of time. She reportedly agreed to accept Risperdal Consta if the Director of Nursing could be present when the medication was administered. According to the MARS, the medication was given by injection on that same day, but the guardian's consent for the medication was not found in the record. Four days later, the resident called a suicide hotline; she reported feeling depressed and lack of appetite. On that same day, she was transported to the hospital, which had referred her to the facility, for a psychiatric evaluation. She did not return to the facility when she was discharged from the hospital.

When the complaint was discussed with the facility staff, they said that the referring hospital never mentioned that the resident was under guardianship nor was this indicated in the record. The referral informational packet and other documentation in the record contradict the staffs' assertions. The facility's social services staff person, who wrote that the resident has a guardian several times in the record, said that there was no evidence of this. She explained that she would usually talk to her supervisor if a resident reported that he or she was under guardianship. The staff reported that the resident's father visited the individual about two or three times each month but would not let her come home unless she complied with medication. The Facility Administrator reported that she talked to the parent twice, but he never mentioned that he is the guardian. The resident's parent did not remember having any discussion with the staff about guardianship. He told the investigation team that the staff should have addressed this issue with him if it was indicated in the record.

The staff explained that PRN medication is given for agitation and when redirection fails. According to the Facility Administrator, the resident accepted Haldol IM within the first couple of days after she was admitted to the facility. She refused to continue taking medication because she said that the medication made her feel "bad." In regard to the Haldol injection given on the 12th, the resident reportedly positioned herself on the ledge at the nursing station, and grabbed the soap and began swinging at people. The record does not indicate any threats of violence toward others when the medication was given. They said that the resident sometimes would throw things, try to kick others, pour water on the floor, use profane language and propel up and down the hallway in her wheelchair at dangerous speeds. The HRA was informed that many of the resident's peers tried to avoid her but some of them were very ill and were not afraid of her. According to the Facility Administrator, the staff were concerned about the resident's safety because of her hostility towards her peers.

A policy entitled "Psychotropic Medication" states that the resident's or guardian's consent will be obtained for medication and that they will be informed about the medication benefits and side effects. The staff is directed to document on the form and in the resident's record if the individual is only willing to give verbal consent for the proposed medication. There was no date or agency name found on the policy.

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 (a) of the Code,

> An adult recipient of services…must be informed of the recipient's right 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.

Documentation on February 14th, April 23rd or the 24th and May 12th indicated that the resident was administered as needed psychotropic medications, and that Risperdal Consta (a long medication) was also given on the 12th. In regard to the first injection, there was no indication concerning why the medication was given or that the recipient was given her rightful opportunity to refuse as required by the Code. According to nursing entries, the second injection was administered over the resident's objections, but there was no clear indication of an emergency. She reportedly accepted the third and fourth injections, but her guardian's informed consent was not found during the record review. The resident, rather than the legal guardian, also signed the facility contract. According to the facility staff interviewed, they did not know that the resident has a legal guardian, but the referral informational packet from the transferring hospital and forms found in the record indicated this. Also, it was recorded that the resident told the facility's social services staff person that her father is the guardian. Her parent's name and telephone number was listed on the assessment form. The staff reported that the resident's father regularly visited the facility, but there were no documented attempts to verify the guardianship issue with her parent. The HRA was able to reach the guardian by calling the phone number on the above form.

In all medication instances, the Authority concludes that psychotropic medications were administered without the resident's guardian's informed consent and in the absence of a clear documented emergency. Furthermore, the complaint that a resident was forcibly given medication that she had refused without adequate cause is substantiated only in regards to the second injection. The facility violates Sections 45/2-106.1 of the NHCA, 5/2-107 of the Code, 5/11a-23 of the Illinois Probate Act and program policy.

RECOMMENDATIONS

1. Chicago Ridge Nursing Home 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. Confirm the existence of any surrogate decision makers during admission by securing and reviewing appropriate legal documents. When there is a guardian, ensure guardian signature on facility documents, including the facility contract and consent forms where appropriate.

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

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

4. The HRA suggests that the policy be dated and identified with the facility's name.

RESPONSE

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

CHICAGO RIDGE NURSING AND REHAB CENTER
10602 SOUTHWEST HIGHWAY
CHICAGO RIDGE, ILLINOIS 60415

Chicago Ridge Nursing and Rehab has reviewed program policies and consent laws regarding substitute decision making with all appropriate staff.

Facility staff have received training regarding thorough record review during the admission process to determine if there is any surrogate decision makers.

Once confirmed, the staff will secure and review appropriate legal documents.

Facility staff then ensure that guardian / HCPOA sign all appropriate facility documents including facility contracts and consent forms where appropriate.

The facility has provided inservice education to all appropriate staff covering the following:

1. Appropriate documentation which includes all dosages of medications administered on the MAR.
2. Thorough documentation of incidents / situations that warrant PRN or emergency medication administration.
3. Review of facility policies and procedures regarding psychotropic medications.
4. Residents Rights

   Sections 45/2 – 104
   45/2 – 106.1
   5/2 – 107(a)
   5/11a – 23

The facility has updated the Psychotropic Medication Policy to include the facility name and date.