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East Central Regional Human Rights Authority
Report of Findings
Case 11-060-9010
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.

Complaint:

1. A provider did not consult the guardian regarding treatment and decision making of an individual with mental health issues.

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), 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 transferred a resident to the hospital and did not consult the guardian. The guardian was unable to effectively advocate for the resident at the hospital, and the resident was given psychotropic medications at the hospital that he was allergic to and has not fully recovered from the effects of those medications.

INVESTIGATION INFORMATION

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 consumer's record were reviewed to investigate the allegations; a HRA investigation team met with and interviewed the Administrator and the Director of Nursing at Decatur Manor.

Per discussion with the staff at Decatur Manor, this nursing home provides intermediate care for residents with mental illness. There are 147 patient beds in the facility and all for serving the needs of those with a mental health diagnosis. It serves a geographic area of about a 100 mile radius**.**

It was explained that this individual had an admitting diagnoses of psychiatric issues and schizoaffective disorder. The Department of Mental Health completes a screening process to see if an individual meets the qualifications. If so they would be admitted. The resident has a brother and a sister who are the co-guardians. The guardian that lived in Illinois was the main contact for the facility. The resident was admitted from a state facility with schizoaffective disorder and noncompliance with medications. He had no insight into his illness.

The HRA inquired whether the guardian was notified of changes in the resident's status and was advised that yes, one of the guardians was notified. It was explained that there had been several attempts to reach this guardian by phone on 9/12/2010 around 4:20 pm. It was an emergency and they tried to call several times, but had to leave messages, asking the guardian to call back. The resident was having psychotic behaviors, was very delusional and was having hallucinations. He was sent to the hospital. He had been exhibiting dangerous and aggressive behaviors toward staff and residents. He left there carrying both of his Bibles with him, because they helped the resident feel more secure. The hospital was informed that he had allergies because it was on his face sheet which was sent with him. The allergies to medicines listed were Thorazine, Zyprexa, and Seroquel. The HRA was informed that when the resident was admitted, Decatur Manor staff would call the guardian who lived closest to the resident. The guardian would always say that they were too busy or would not pickup when they called. The guardian was invited, but did not attend the resident's care plan meeting.

When asked what the protocol is for contacting the guardian when decisions are needed such as changing medicine, the response was that the physician notifies the staff and then the staff would notify the guardian. Any time the facility would get a new physician's order or was sending an individual to the hospital, staff would call the guardian. Guardians are notified of changes in a resident's status, whenever there are increased needs, incidents, and injuries. Either case management or nursing is responsible for keeping the guardian informed. They notify the physician and notify the guardian if there has been a change in circumstances. There was no documentation of any contact with the other guardian that lived out of state.

Decatur Manor staff shared that the treatment team determines the course of treatment needed, and the team includes nursing, social services, dietary, the activities director, a psychiatrist, social services, activities coordinator, and the case manager. When determining treatment, every resident is assessed via a social history and psychological evaluation; the psychiatrist looks at the treatment plan. They look at the behavior plan and interview the

resident. Regarding evaluations of the resident, this would be completed by a third party PAS (Pre-admission screening) agent, social services, medical director, and the licensed psychiatrist. There are regular nursing assessments such as pain levels, falls etc. Regarding the resident, his physician assessed his decisional capacity. Social service would have access to his mental health diagnosis. The resident had only received his routine medications at Decatur Manor. There was not a discharge plan in place, because he had only been there a couple of weeks.

Decatur Manor had no complaints registered regarding the issue in this case. The quality assurance team does meet at a minimum of every three months. Management team meets daily at Decatur Manor. Decatur Manor does have a resident counsel.

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 HRA was shown where the residents have the autonomy to sign out during the day, as they choose to go for walks or outings. There were organized outings too. In the dining area tables were set up family style. The residents had at least two choices of entrees during meal times. Food was served buffet style.

It was brought to the HRA's attention, after the investigation was initiated, that there was a dispute regarding the resident's belongings not being returned to the resident. The HRA did not open another investigation, but did attempt to advocate for the resident inquiring by telephone about the resident's belongings. The HRA was told by the provider that family would not pick up his belongings and the family had asked that his belongings be shipped to the resident. Decatur Manor staff explained that they had told the family that this would be cost prohibitive for the provider. The provider offered to hold the belongings for the resident for a certain amount of time, but no one picked up his belongings. After a certain amount of time the resident's belongings were destroyed since no one picked them up.

Records Reviews

The following is a timeline of services documented in the record:
08/31/10 - The resident is admitted.
Nursing completed an evaluation which included:
The behavioral contract for substance abuse was completed.
The psychosocial was completed.
The independent living skills assessment was completed.
The criterion for a planned discharge was completed.
The drug use inventory was completed.
A screening risk was completed.
The resident's laboratory tests were taken and documented.
The physician's orders were given.

The psychotropic medication consent was completed with the resident and it was documented that phone consent was given by guardian.
Psychotropic medication information was provided to the resident.
The comprehensive care plan was completed.
The tuberculosis record documented that the test was given and follow-up on 9-7-10;
A digital narrative and current status was completed.
The resident's weight and vitals were taken and documented.
The abnormal involuntary movement scale completed.
A comprehensive pain assessment and pain questionnaire was completed.
An oral and foot assessment completed.
The Braden scale for predicting pressure score risk completed.
A fall risk assessment was completed.
An activity progress note was completed.
There were program plan progress notes.
Nursing admission notes completed.
An activity attendance chart was started.
A physical exam was completed.
An admission checklist for the nursing assistant was completed.
A nutritional assessment was completed.
An orientation was completed with the resident;
An inventory of the resident's belongings was completed.
His bathing time preference was completed.
An Activities Assessment was completed.

<u>The resident refused to sign or complete the following documents:</u>
"The Modified Michigan Alcohol - Drug screening test was not completed.
Resident expectations and interest interview was presented.
Safer sex education counseling was presented to the resident.
The mini-mental state examination was presented to the resident.
The behavioral contract for substance abuse was documented that the resident refused to complete.
Pneumonia vaccine was given, but it was documented that the resident refused to complete the authorization and release.
It was documented that the resident refused the flu vaccine.
There was no documentation that the guardian was contacted to assist with the completion of the documents or that the guardian was invited to participate at all.

9/1/10 - The activity chart documents that the resident attended some of the social activities planned for residents.
The Certified Nursing Assistant (CNA) daily documentation sheet documented that the resident completed his daily personal care. The nursing notes document the resident is pleasant and cooperative, physician saw resident. The resident had taken his medications; there were no complaints of pain or discomfort. Vitals were taken.
The psycho-social rehabilitation services coordinator (PRSC) documented on program plan progress notes that resident refused to sign some admittance paper work.

9/2/10 - Nursing notes documented the resident refused to take his 6:10 a.m. medications. He wanted to be left alone and wanted to sleep. The resident had stayed up late most of the night watching television. His vitals were taken. A later note addressed some digestive needs.
The activity chart documents that the resident attended some of the social activities planned for residents.
CNA daily documentation documented that the resident completed his daily personal care.

9/3/10 - CNA daily documentation was not documented in the am. It was in the afternoon and evening that the resident completed his daily personal care.
The activity chart documents that the resident completed a few activities, but he left early and refused some of the other activities. There are no further notes about the resident participating or not participating in activities until it is documented that he is discharged.
There were no further nursing notes until 9/6/10.
There was an activity progress note on 9/10/10.
There were no program plan progress notes until 9/12/10.

9/4/10 - The CNA daily documentation that the resident completed his daily personal care. He did not shower that day.

9/5/10 - The CNA daily documentation that the resident completed his daily personal care. He did not shower that day.

9/6/10 - The CNA daily documentation sheet documented that the resident completed his daily personal care including taking a shower.
Nursing notes documented the resident was going around table to table talking about blacks and whites. He would hold biblical literature in his hands. The resident had put a scarf on his head. He would ask whites "Do you like pig feet and turnip greens and then start laughing." The resident stated he grew up on a farm. The resident was also asking other residents who they wanted for president.

9/7/10 - The nursing notes document that resident stayed awake during the night. Resident refused his 6 a.m. medications stating he is not a republican and doesn't eat pork.
CNA daily documentation shows that the resident completed his daily personal care. He did not shower that day.

9/8/10 - The CNA daily documentation that the resident completed his daily personal care. He did not shower that day. There were no other notes provided to the HRA that documented his care.

9/9/10 - CNA daily documentation that the resident completed his daily personal care. He did not shower that day.
There is a monthly summary completed by an LPN that resident talks about racial economic status of whites which has upset others. It does document that he is social, friendly and cooperative. His speech, vision, and hearing were adequate. His sleep patterns were that he awakens frequently. He requires prompts regarding clean clothes and bathing. He ambulates

independently. He shaves himself, needs assistance with fingernails and toenails. His skin condition was good. There was documentation of labs taken that month.

9/10/10- The CNA daily documentation was not documented in the am. It was in the afternoon and evening that the resident did not complete his daily personal care. It is not documented that he showered. The activity progress notes document that resident's speech is good and he makes his needs known. He has fairly good support from a sister. Resident will be encouraged to attend group activities of interest. Resident spends independent leisure time socializing with staff and peers in the commons area, watching TV programs of interest, sitting and reading his Bible. The resident will be encouraged to attend additional group activities of interest.

The Department of Mental Health Clinical Progress notes document that this is a mandated follow-up because the resident was admitted from a state hospital. There was discussion with staff regarding the resident's current status and treatment. The clinician assessed client's chart for treatment planning, implementation of services, medications, current issues of concerns, and signs of symptoms or increase in behavioral symptoms. It documents there has been noncompliance with medications on 9/2/10 and 9/7/10. There was also documentation of inappropriate behaviors referencing blacks and whites and that the resident could be very intrusive and does not accept redirection well. He makes comments stating "We don't like Protestants, do we?" It was documented that he does not respond to redirection well. It was documented that the clinician would continue to meet with him weekly and felt he was best served in an intermediate care facility.

9/11/10 - The CNA daily documentation shows that the resident completed some of his am daily personal care. He did not shower that day nor complete any other personal care.

9/12/10 - At 6:00 a.m. the nurse's notes documented that the resident was going from resident to resident yelling at them and telling them about his religion. The resident was telling staff and other residents they were going to hell. The resident had been redirected several times during the night.

At 4:00 pm the resident was yelling and talking loud. The resident continued to get in staff and residents' faces telling them they are going to hell. The resident was getting in other resident's family members faces and talking loud. Nursing was unable to redirect the resident. The resident was three days medication noncompliant. The resident was sent to the hospital emergency room for evaluation.

The program plan progress notes document that staff listened to him talk about religion and tried to get him to calm down. There was no documentation of guardian notification about behavioral incidents and refusals.

The patient information and transfer form document that the individual was having psychotic behavior, he had been noncompliant with medication for three days and was unable to be redirected. The face sheet went with the resident. The face sheet lists the resident's guardians' names, addresses, and phone numbers. It lists the resident's physician, dentist, podiatrist, pharmacy, and his basic diagnosis. It has his picture on the front. It also listed that he has three

basic allergies which include Thorazine, Zyprexa and Seroquel. These were the same three medications listed on the discharge instructions from the state hospital.

Physician telephone orders document that resident is having psychotic behavior and he was sent to the hospital emergency room for evaluation. An involuntary petition was completed. Family (guardian) had been contacted of the above/treatment change on 9/12/10. It does not say how that contact took place, whether the worker called and left a message or talked to the guardian.

An Involuntary Petition was completed. It documented that a person with mental illness who, because of his or her illness is reasonably expected to inflict serious physical harm upon himself or herself or another in the near future, which may include threatening behavior or conduct that places another individual in reasonable expectation of being harmed and that he was in need of immediate hospitalization for the prevention of such harm. It stated: "The resident was upsetting other residents. He had been getting in other residents faces yelling and telling them they're going to hell. The resident was having bizarre psychotic behavior. The resident was non-med compliant for 3 days. They were unable to redirect the resident. It was documented that the staff did not have a legal interest in the matter, financial interest, or was involved in litigation with the respondent."

It did not list in the section of the petition for guardians that this individual had a guardian. The guardian's name and contact information even though this information was documented in the record and on the face sheet for the individual. The petition clearly states to list guardian and third party information and to even make a diligent inquiry for this information. It was signed and completed by a Decatur Manor staff person.

9/13/10 - Physician's telephone orders document that the resident was admitted to a community hospital due to a diagnosis of Major Depression and psychotic behavior. It also documents that the family (the sister) was contacted by nursing. It does not say how that contact took place, whether the worker called and left a message or talked to the guardian.

After the resident's admission to the hospital, he did not return to Decatur Manor, but was returned to a state hospital as approved by his guardian. There was also a dispute with the community placement giving the resident medication the resident was allergic too, but there was no record of the resident being allergic to that medication at Decatur Manor or from the discharge information from the state facility.

There was a dispute regarding the resident's personal belongings not being returned to the resident that was brought to the HRA's attention after the investigation was opened. The HRA contacted Decatur Manor to request that the resident's belongings be released. The HRA was advised that the resident's family would not pick up his belongings and his family wanted his belongings mailed to him, which was cost prohibitive for the Decatur Manor. His family states they would have picked up his belongings. After a certain amount of time the resident's belongings were discarded. There are no notes after 9/13/10 regarding contact with the guardian.

Policy Reviews

The HRA requested policies regarding grievance procedures, personal belongings, guardianship involvement and personal belongings and was advised that they do not have written policy, but simply follow the law. The HRA requested any information given at admission regarding personal belongings to residents and family members and was advised that information would be sent to the HRA; it was not received.

MANDATES

Chapter 405. Mental Health, Act 5. Mental Health and Developmental Disabilities Code regarding Admission, Transfer and Discharge Procedures for the Mentally Ill Emergency Admission by Certification 5/3-601, addresses the issue of guardian notification in an involuntary admission as follows: "(b) The petition shall include all of the following:

1. A detailed statement of the reason for the assertion that the respondent is subject to involuntary admission on an inpatient basis, including the signs and symptoms of a mental illness and a description of any acts, threats, or other behavior or pattern of behavior supporting the assertion and the time and place of their occurrence.

2. The name and address of the spouse, parent, guardian, substitute decision maker, if any, and close relative, or if none, the name and address of any known friend of the respondent whom the petitioner has reason to believe may know or have any of the other names and addresses. If the petitioner is unable to supply any such names and addresses, the petitioner shall state that diligent inquiry was made to learn this information and specify the steps taken.

3. The petitioner's relationship to the respondent and a statement as to whether the petitioner has legal or financial interest in the matter or is involved in litigation with the respondent. If the petitioner has a legal or financial interest in the matter or is involved in litigation with the respondent, a statement of why the petitioner believes it would not be practical or possible for someone else to be the petitioner.

4. The names, addresses and phone numbers of the witnesses by which the facts asserted may be proved.

(c) Knowingly making a material false statement in the petition is a Class A misdemeanor."

The Code outlines the need to contact the guardian regarding the care and service plan as follows: "Rights of Recipients of Mental Health and Developmental Disabilities Services 5/2-102. Care and services; psychotropic medication; religion.

(a) A 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, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient. The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the treatment plan. 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. The recipient's preferences regarding emergency

interventions under subsection (d) of Section 2-200 shall be noted in the recipient's treatment plan.

(a-5) 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. The physician shall determine and state in writing whether the recipient has the capacity to make a reasoned decision about the treatment. The physician or the physician's designee shall provide to the recipient's substitute decision maker, if any, the same written information that is required to be presented to the recipient in writing. If the recipient lacks the capacity to make a reasoned decision about the treatment, the treatment may be administered only (i) pursuant to the provisions of Section 2-107 or 2-107.1 or (ii) pursuant to a power of attorney for health care under the Powers of Attorney for Health Care Law or a declaration for mental health treatment under the Mental Health Treatment Preference Declaration Act. A surrogate decision maker, other than a court appointed guardian, under the Health Care Surrogate Act may not consent to the administration of electroconvulsive therapy or psychotropic medication. A surrogate may, however, petition for administration of such treatment pursuant to this Act. 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. A qualified professional shall be responsible for overseeing the implementation of such plan. Such care and treatment shall make reasonable accommodation of any physical disability of the recipient, including but not limited to the regular use of sign language for any hearing impaired individual for whom sign language is a primary mode of communication. If the recipient is unable to communicate effectively in English, the facility shall make reasonable efforts to provide services to the recipient in a language that the recipient understands.

(b) A recipient of services who is an adherent or a member of any well-recognized religious denomination, the principles and tenets of which teach reliance upon services by spiritual means through prayer alone for healing by a duly accredited practitioner thereof, shall have the right to choose such services. The parent or guardian of a recipient of services who is a minor, or a guardian of a recipient of services who is not a minor, shall have the right to choose services by spiritual means through prayer for the recipient of services."

Under the Probate Act of 1975 (755 ILCS 5/11a-23) it states, "(b) Every health care provider and other person (reliant) 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. Any person dealing with the guardian, standby guardian, or short-term guardian may presume in the absence of actual knowledge to the contrary that the acts of the guardian, standby guardian, or short-term guardian conform to the provisions of the law. "

CONCLUSIONS

Complaint:

1. The provider did not consult the guardian regarding treatment and decision making of an individual with mental health issues.

It was clearly known to this provider that the resident had a guardian. It was not documented that the guardian was contacted on 8/31/10 to assist the individual with 8 different documents regarding his care. It was documented that phone consent from the guardian was acquired for medication; these documents should have been addressed too. From the interview portion of the investigation, Decatur Manor staff stated that they had attempted to contact the guardian to participate in the care plan, but there was no documentation of any attempt to contact the guardian regarding the uncompleted forms or the care plan.

On 9/12/10 and again on 9/13/10 it was documented in the physician telephone orders that the guardian was contacted. The HRA could not determine if someone actually spoke to the guardian about the emergency transfer or if a message was left based on notes from the physician telephone order. However the guardian portion of the petition for involuntary admittance of the resident to the hospital was not completed and left blank. The petition itself states: "That the name and address of the spouse, parent, guardian, substitute decision maker, if any, and close relative, or if none, the name and address of any known friend of the respondent whom the petitioner has reason to believe may know or have any of the other names and addresses. If the petitioner is unable to supply any such names and addresses, the petitioner shall state that diligent inquiry was made to learn this information and specify the steps taken." Decatur Manor staff simply had to list the guardians on the petition, from the face sheet they sent to the provider.

Under the Code's petitioning requirements the guardian's permission to petition anyone for involuntary admission is not required, but the guardian's information must be listed with their contact information if the petitioner has the information. If the guardian was not aware of the individual's transfer to the hospital, the guardian would not have been able to advocate for the individual at the hospital. Based on the evidence that there was no documentation to contact the guardian on completion of the admission documents, to keep the guardian informed of behaviors or refusals, to include the guardian in determining the care plan, and guardian information was not included on the involuntary petition, the **Complaint**: **The provider did not consult the guardian regarding treatment and decision making of an individual with mental health issues is substantiated.**

The HRA makes the following recommendations:

1. **Follow the Mental Health Code and involve the guardian in treatment planning, including admission paperwork. If the guardian does not respond, document in the notes that the guardian was contacted.**

2. **Follow the Mental Health Code when completing an involuntary petition. Make sure to list the name and address of the spouse, parent, guardian, substitute decision maker, if any, and close relative, or if none, the name and address of any known friend of the respondent whom the petitioner has reason to believe**

may know or have any of the other names and addresses. Do not leave this section blank when the facility has knowledge of the information about the resident. If as the petitioner, the facility staff are unable to supply any such names and addresses, state that diligent inquiry that was made to learn this information and specify the steps taken.

3. **Staff should be trained to document attempts to contact the guardian or any other substitute decision makers when their assistance is needed, whether they are able to make contact with the guardian or not. Notes should show they made the attempt.**

The HRA makes the following suggestion:

1. Consider creating a policy and procedure that staff can follow in regards to notification of third parties so there is a clear understanding of what is expected of them to protect the rights of the residents.

Regarding the resident's belongings not being returned to the resident by Decatur Manor, the HRA did not open an investigation about the individual's personal belongings, but did try to assist in the return of his belongings. The HRA was not provided any policy regarding personal belongings or any documentation of contact by staff to assist in the release of the resident's personal belongings to his guardian. Nursing facilities like Decatur Manor are required pursuant to the Nursing Home Care Act Chapter 210 45/2-103 to provide adequate storage space for the personal property of the resident. The Act explains further: "The facility shall provide a means of safeguarding small items of value for its residents in their rooms or in any other part of the facility so long as the residents have daily access to such valuables. The facility shall make reasonable efforts to prevent loss and theft of residents' property. Those efforts shall be appropriate to the particular facility and may include, but are not limited to, staff training and monitoring, labeling property, and frequent property inventories. The facility shall develop procedures for investigating complaints concerning theft of residents' property and shall promptly investigate all such complaints." The only evidence the HRA was provided regarding the resident's belongings was that they were inventoried when he was admitted to Decatur Manor. Statements by Decatur Manor staff and the guardian conflict regarding the resident's belongings and the HRA can not substantiate or not substantiate this issue based on one person's word against another's. The HRA does make the following suggestions regarding resident's belongings:

1. Have a policy and procedures for the protection of each resident's property and ensure that all staff are trained on that policy.

2. Provide to all guardians, family, or other substitute decision makers assisting residents, the policy regarding personal belongings at admission for any resident. Have staff document in the record that it was provided to the resident and his guardian.

3. There should be written documentation when a resident leaves the facility that shows that staff have made an earnest attempt to contact the family or the resident to pick up the resident's personal belongings. It should not be one person's word against another's when an individual with a disability has his belongings discarded. Most individuals in nursing facilities usually receive only $30.00 per month that they can spend on purchasing clothing and needed personal items.

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.