FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY - PEORIA REGION
REPORT OF FINDINGS

Case # 11-090-9006
Forest Hill Health and Rehab

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving a complaint of possible rights violations at Forest Hill Health and Rehab. The complaints alleged the following:

1. Forest Hill is administering medication after the court ordered date that the medication is to be administered.
2. Forest Hill is not allowing resident access to their information files.

If found substantiated, the allegations would violate the Mental Health and Developmental Disabilities Code (405 ILCS 5/2), the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/4), and the Nursing Home Care Act (210 ILCS 45/2).

Forest Hill Health and Rehab is a nursing home with a mental health unit that services the entire state of Illinois but receives the most residents from the Quad Cities and Peoria. The majority of the clients have mental health diagnoses. The facility has the capacity for 137 residents and currently has 81 residents, 35-39 of the residents having mental health needs. The facility also has an Alzheimer's Disease unit and a geriatric unit. The facility has 78 staff members that consist of CNAs, LPNs, RNs, Dietary staff, and housekeeping among other positions.

To investigate the allegations, HRA team members met and interviewed Forest Hill Health and Rehab staff and reviewed pertinent policies and records.

COMPLAINT STATEMENT

The complaint states that a resident was court ordered to take psychotropic medication for a time period that does not exceed 90 days. The complaint states that the medication was ordered to be taken until March 15th but the resident was still taking the medication on August 1st. The resident states that she does not want to take the medication any longer. The complaint alleges that a resident had her court orders stolen from her and the facility will not give her a

copy of the court papers. The complaint also states that a resident was told that her grandmother had to come into the facility in order for the resident to review her case folder, where the facility keeps the court order.

FINDINGS
Interview Staff (1/5/2011)

The HRA began its investigation by interviewing Forest Hill staff members. The staff members explained that the resident came from a local hospital behavioral health unit. She had a court order for medication from the hospital. The staff stated that the court order had expired while she was at Forest Hill but the resident took the medication willingly. The staff explained that the medication started working, and the resident knew she was getting better so she kept taking the medication. The staff stated that the resident would even say where she wanted the shot when it was time to take the medication. The medication was a once every two week shot, not daily.

The Forest Hill staff said that the resident was admitted into Forest Hill on 5.13.10. She was court ordered to be admitted to the local hospital and then she was transferred to Forest Hill. The resident was diagnosed with Schizoaffective Disorder, with a history of psychosis and mood disorder. The staff stated she was on the court order for medication for 30 days while at Forest Hill. The staff declared that the resident was not court ordered to come to Forest Hill, and that she approved to transfer, so therefore she was voluntary, but after reviewing the court order during the interview, realized that an involuntary commitment was part of the court order as well as the medication. The court order for commitment had been amended from the local hospital to Forest Hill. The staff explained that, after the 30 days on the court order for medication expired, the resident did refuse medication twice and she was not forced medicated. In August, the resident did not take the medication but she took it through July. The staff also explained that she refused Ambien but the drug was not court ordered. The staff said there was no change in medication between the hospital and Forest Hill and the resident even had the same physician that she had while at the hospital. The staff explained that they believed that she took the medication because she wanted discharged. The staff stated that she was never forced medication, even in the first month of her stay at the facility while she was under court order.

The Forest Hill staff proceeded to explain that the resident signed out of the facility Against Medical Advice (AMA). The staff explained that if they are capable of going home, then they can go home. When the resident was admitted, the facility thought that the resident's grandmother was her guardian, but they later found out that the guardianship was only for a minor, and the resident was no longer a minor. The Forest Hill staff stated that they did not realize that the grandmother was not the guardian until August. The staff stated that even though they thought the grandmother was guardian, they did not ignore the resident's wishes in favor of the guardian's wishes and that the resident did not stay at the facility because of the guardian. The facility staff stated that they review Powers of Attorney and guardianship documentation but they just got confused on this document.

After the court order ran out, the resident would frequently ask to go home, but they would ask her to stay because she was sick and if she stayed, she would get better. The resident

did not leave Forest Hill until November 1st, and the resident's grandmother, physician, and Forest Hill staff wanted the resident to stay. The resident never asked to sign a 5-day request for discharge document while at the facility. The resident had been going on home visits towards the end of her stay and then she decided to leave AMA. The staff said that the resident would go on furloughs and come back to the facility. The staff explained that once the resident signs out on furlough, they are out and they do not have to come back. The staff stated that once the resident leaves, they will not get medication and the help that they need once they are out.

The Forest Hill staff stated that they never heard that the resident's court order was stolen. They stated that the resident's charts are at the nursing station and the residents can review them. The staff stated that they sit with the resident and review the charts. They stated that they do not just give the residents their charts any longer because a resident once took a chart and destroyed it. The staff also explained that the charts are not under lock and key either. The staff explained the only policy documented that they have regarding the residents reading their charts is in the resident's rights. The staff also explained that they have a care plan meeting every 3 months and they go over the chart during the meeting. Also during that meeting, they are told if they have any questions they can ask. The staff stated that they do not document when they go over the chart with the residents outside of the care plan meetings. They said the care plans cover problems, goals, and interventions. The staff explained that they send letters to family members regarding the care plan meetings every quarter. The staff stated that when residents ask to see their charts, they go over the chart with them as soon as someone is available.

The staff went on to explain that the resident did have a copy of the court order and they actually remember sitting with her to go over the chart. If the resident would have reported that someone stole it, they would have made another copy. The staff also said that they do remember sitting with the resident and going over her file outside of the care plan when the resident requested it. The staff stated that when they sat with her, they went over her diagnosis mostly. The resident already knew her medication, and she was mostly interested in seeing her history. The resident was starting to get better and she wanted to see where she was at before. The staff explained that there are no parts of files that the residents are not allowed to see. They also stated that everything is in the chart, including the resident's medical record. The staff stated that they never told the resident that she could not look at her chart because the guardian did not say she could. The Forest Hill staff went on to explain that if a person has a guardian, they cannot look at the chart without permission. They stated that they have no documentation on the guardianship rule because it is just understood if a person is deemed incompetent.

Tour of facility

In a tour of the facility, the HRA saw that a sign with a number for Public Health was only posted on a bulletin board in the hall outside of the behavioral health unit, which is locked and the residents do not have access to the hallway. Also, it was explained to the HRA that the phones are behind the nursing station and, if the residents need to make a call, they ask the nurse and if they need privacy, they can stretch the cord into the dining room. The HRA also saw a public pay phone in the geriatric section of the facility that was secluded for privacy.

Follow-up phone conversation

In a later telephone conversation, the staff discussed how residents are allowed to use the phone. The residents can use a phone on the B Wing but they are set on a schedule, otherwise the residents would want to constantly use the phone. The residents get certain days that they can use the phone and this is discussed when they are admitted. The staff also explained that the phone policy is documented. If a resident gets a call, they are allowed to take it even if they are not on schedule. Also, the residents have access to a pay phone in A wing, but a staff member may have to walk them over to the phone because it is in different wing.

Policy and Record Review

The HRA reviewed records and policy pertinent to the complaints addressed in this report. In regard to the complaint that Forest Hill is administering medication after the court ordered date that the medication was to be administered, the HRA reviewed a document titled "Residents' Rights for People in Long Term Care Facilities," that was created by the Illinois Department on Aging, which states that "You have the right to refuse any medical treatment."

Another document which describes skilled nursing facilities has a section titled "Refusal of Services." Within that section, it reads that a facility will make "good faith efforts" to provide services to a resident but, if the resident refuses services, they are not responsible for the outcomes of not receiving these services. The document also states "The facility shall not be expected by resident and representative to intimidate or threaten a resident into doing what the facility and/or attending physician believe is best for the resident."

The HRA reviewed the court order for psychotropic medication, which states that the resident was ordered to receive Risperdal Consta every 2 weeks as a first choice and then a daily dosage of Risperdal, Ambient, and Cogentin as alternatives. This was dated 3/15/10 and would last up to 90 days, which would make the court order expire on 6/15/10. The court orders state that the treatment will be administered by the local hospital physician, who is the same treating physician at Forest Hill, and his designee at the hospital. The HRA also reviewed the amendment to the resident's involuntary commitment order stating that the resident may be transferred to Forest Hill. The date of the document is 5/12/10 and the involuntary admission was effective as of 3/15/10 (also for up to 90 days). The HRA saw no court documentation to extend the involuntary admission. The HRA reviewed the resident's admission assessment and she was admitted to Forest Hill on 5/13/10.

The HRA also reviewed the physician's progress notes. A progress note on 8/31/10 stated that the resident was refusing all psychotropic medication and to discontinue all orders for medication, with a follow-up in 4-8 weeks. The nursing notes from 7/7/10, which is after the court ordered date for medication had expired, states that the resident is back from seeing her physician and there are no new orders and also that the facility should continue with current medication. A nurse's note on 7/23/10 states that the resident wanted to have her Risperdal Consta stopped because it is making her memory bad and then on 8/11/10 the resident's physician states that the Risperdal Consta injection was refused by the resident. A nurse's note on 8/20/10 states that the nurse conversed with the resident regarding the fact that the court ordered medication had expired, and the resident has the right to refuse the medication, but if she

does so, she could end up in a psychotic state. The nurse's notes confirm on 8/31/10 that the physician discontinued all psychotropic medications and then on 9/17/10, the physician ordered Haldol and Congentin. On 9/29/10, the nurse's notes stated that the resident came to the nurse stating that she wanted to leave Against Medical Advice (AMA) and the social services were notified of the request and then on 11/1/10 the notes state "Resident came to facility and signed paperwork to go home against medical advice. Social Services present at time of discharge."

In reviewing the resident's medication administration record, it states that the resident took Risperdal Consta between the dates of 5/13/10 to 7/31/10 (injections were given intramuscularly every two weeks equaling 5 overall injections), and then refused the injection on 8/8/10 and 8/22/10. The record indicates that the medication was discontinued on the chart dated 9/1/10 through 9/30/10 but Haldol and Cogentin was given from 9/17 through 9/30 (minus two days but there is no account for why the medication was not given) and then between 10/1/10 and 10/31/10, the Haldol and Cogentin were given everyday (except for the 27th with no account for why the medication was not given).

The HRA reviewed informed consents. The HRA was provided informed consent forms for Risperdal Consta and Haldol, which was on a form titled "Informed Consent Anti Psychotic" and also an informed consent for Ambien and Lorazepam which was on a form titled "Informed Consent Antianxiety or Antidepressant." Both consent forms were signed by the resident's grandmother who the facility thought was the patient's guardian. The HRA also spoke with the facility because there was not a consent form for Cogentin. The staff member stated that there was no consent form for Cogentin and that they do not complete consents for Cogentin. The staff stated that when the resident takes the medication, the nurse signs stating that they took the medication. The staff stated that otherwise they would have to get consent each time the medication was taken.

In reviewing the resident's PRN (as needed) administrations, the resident was given Haldol on the dates of 5/20/10 and 5/25/10 and then was given Ativan (Lorazepam) on 5/20/10, 5/22/10, 5/23/10, and 5/25/10 for the reason of "Agitation". Both medications appear on the PRN list and are ordered to be given for agitation/psychosis. In the nursing notes, on 5/20/10, it states that the resident was given and Haldol for yelling at staff and, after being redirected, going into the courtyard and rolling on ground. It does not state if the medication was refused or taken willingly. The nurse's notes also state that the medication from the PRN orders was given on the 22nd and 23rd, but neither instance states if the medication was refused or taken willingly. The date of 5/25 was not documented. Although it was not documented, the staff stated in the interview (See Staff Interview) that medication was never forced on the resident.

In regard to the complaint that Forest Hill is not allowing the resident access to her files, the HRA reviewed nursing notes from 7/23/10 that state "Resident wanting to see her chart nurse [sic] told her she needed to speak to her grandmother about that." In other areas of the nursing notes, the resident's grandmother is referred to as the resident's guardian and at one point in the nursing notes, within the Comprehensive Care Plan, the grandmother is referred to as the guardian. The HRA reviewed a copy of the Letter of Guardianship, (dated 5/17/2001) which does indicate that the resident's grandmother was guardian, but only guardian of the resident as a minor. The resident is now the age of 20 and a document titled "Resident Admission

Information" states that the resident's birth date is 2/13/1990. The HRA found no further evidence of the resident requesting to review her record and found no evidence that the resident had documentation stolen from her.

In another rights document, it states "Right to Inspect and Copy Your Medical Information - You have the right to ask to inspect and obtain a copy of your medical information. You must submit your request in writing to Our Designee. If you request a copy of the information or we provide you with a summary of the information we may charge a fee for the costs of copying, summarizing and/or mailing it to you. If we agree to your request we will tell you. We may deny your request under certain limited circumstances. If your request is denied, we will let you know in writing and you may be able to request a review of your denial."

MANDATES

The HRA reviewed regulations and mandates related to the complaints in this case. In regard to the complaint that Forest Hill is administering medication after the court ordered date that the medicine is to be administered, the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-107.1) describes the process of obtaining court ordered medication for a recipient of services. The process involves an individual petitioning the court for an order authorizing the administration of psychotropic medication. Once the court determines that there is evidence that the individual is in need of the treatment, a court order is given that dictates the individual who will be administering the medication and also stating that the treatment should not exceed 90 days. If the feeling is that the recipient needs services past the first 90 days, another court hearing is needed, otherwise, the order is no longer in effect.

The Nursing Home Care Act states "(b) 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 AMA Drug Evaluations or the Physician's Desk Reference" (210 ILCS 45/2-106.1). The Mental Health Code provides for the same (405 ILCS 5/2-102 a-5).

The Nursing Home Care Act also states that "(c) 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" (210 ILCS 45/2-104). A mental health recipient's right to refuse is established as well under the Mental Health Code (405 ILCS 5/2-107).

In regard to the complaint that the facility is not allowing a resident access to the information in her files, the Nursing Home Care Act states "Every resident shall be permitted to participate in the planning of his total care and medical treatment to the extent that his condition permits . . . (d) Every resident, resident's guardian, or parent if the resident is a minor shall be permitted to inspect and copy all his clinical and other records concerning his care and maintenance kept by the facility or by his physician. The facility may charge a reasonable fee for duplication of a record" (210 ILCS 45/2-104). The Mental Health and Developmental

Disabilities Confidentiality Act states that "(a) The following persons shall be entitled, upon request, to inspect and copy a recipient's record or any part thereof . . . (2) the recipient if he is 12 years of age or older" (740 ILCS 110/4).

CONCLUSION

Complaint #1 - Forest Hill is administering medication after the court ordered date that the medication is to be administered.

The complaint states that Forest Hill administered medication after the court ordered date that the medication was to be administered and a resident involved did not want to take the medication any longer. The Forest Hill facility stated that the resident wanted to take the medication after the court order expired because she knew that she was getting better. The HRA reviewed records and saw that there were instances where the medication was refused and the resident's physician even discontinued medication due to the fact that the resident was not taking the medication. The HRA reviewed facility documentation and, the facility did have documentation that stated the resident has the right to refuse medication. The HRA reviewed the informed consent forms for the psychotropic medication that was given to the resident and both forms were signed by the resident's grandmother, who the facility erroneously thought was the guardian at the time. This is a gross violation of the Nursing Home Care Act which states that psychotropic medication can not be prescribed without the resident's, guardian's, or other authorized representative's consent (210 ILCS 45/2-106.1). Due to the fact that the medication was given without the patient's consent, the HRA finds the complaint **substantiated,** and makes the following **recommendations:**

- Follow Nursing Home Care Act and Mental Health Code provisions and do not give psychotropic medication beyond an expired court order without a properly authorized consent.
- The core of this substantiation is not the consent process itself, but the fact that the consent was given by an individual who was not the resident's guardian. The facility must develop a process that assures the facility collects accurate information regarding resident guardianship, and obtains appropriately authorized informed consent, when residents are admitted into the facility.
- The staff stated that they do not receive informed consent for Cogentin, and, although the drug is not a psychotropic medication in itself, it is part of the psychotropic medication regimen. In the future, when getting informed consent from a resident, include medication that is considered part of the psychotropic drug treatment.

Complaint #2 - Forest Hill is not allowing resident access to their information files

The complaint states a resident was not allowed access to information in her record. The complaint states that a resident's court orders were stolen from her and the facility would not give her a copy of the court papers. The complaint also states that when the resident asked to review her case folder, where the court order was kept, the facility informed her that her grandmother had to come into the facility in order for the resident to review her case folder. The

staff stated that they had not heard that the resident's court order was stolen and that they do let residents review their charts, although they do have a stated practice that, if a resident has a guardian, they need permission to review their charts. The staff also stated that they even remember sitting with the resident and reviewing her chart. The facility does have policy stating that the residents have the right to inspect their medical information. The Nursing Home Care Act states that every resident is permitted to inspect and copy their medical records (210 ILCS 45/2-104) and the Mental Health and Developmental Disabilities Confidentiality Act states that a recipient of 12 years of age or older is entitled to review and copy his/her records (740 ILCS 110/4). Neither Act makes stipulation on a resident/recipient over 12 having to seek permission from any guardian. In the HRA review of the nursing notes, the HRA saw that the resident was told that she would have to talk to her grandmother about seeing her chart on 7/23/10, which corroborates the complaint against the facility. The HRA found no evidence that the resident had court papers stolen and that the facility would not copy them for her. Due to the fact that there is documentation stating that the resident was told she cannot see her charts and because of the facility's stated practice regarding guardianship permission to review records, the HRA **substantiates** the complaint and offers the following **recommendations**:

- Follow the Nursing Home Care Act and Mental Health Code provisions that guarantee a resident's right to inspect and copy records.
- Stop the practice of telling and requiring residents to seek guardian permission to review their records.
- The HRA recommends that the facility educate staff in following all the Confidentiality Act (740 ILCS 110/4) and the Nursing Home Care Act (210 ILCS 45/2-104) in regards to residents viewing their records.

Comments:

In investigating the complaints in the case, the HRA discovered other violations relating to confidentiality, based on a wrongful understanding of the resident's guardianship status and facility policy. Resident information was erroneously disclosed without the resident's written consent. This action is in direct violation of The Nursing Home Care Act which states that a resident has privacy in their medical and personal care program (210 ILCS 45/2-1-5) and the Mental Health and Developmental Disabilities Confidentiality Act which also protects the resident's right to privacy (740 ILCS 110/3). According to the facility policy, the resident's information is available to be used unless the resident documents in writing that they do not want their information used. The Mental Health and Developmental Disabilities Act states that this policy should work the opposite way, and the resident must provide written consent before his/her information is disclosed (740 ILCS 110/5). The Nursing Home Care Act also states that persons not directly involved in the resident's treatment must have the resident's permission to be involved present and involved (210 ILCS 45/2-105).

Unless the resident made a specific written designation, the fact that the facility allowed the grandmother to partake in decision making for the resident also violates the resident's right to participate in service planning and to "refuse generally accepted mental health or developmental disability services" as stated in the Mental Health and Developmental Disabilities Code (210 ILCS 45/2-104, 405 ILCS 5/2-102 a and 5/2-107). This includes the documentation in the

records of the grandmother suggesting a Depo Provera shot even though the resident did not want to take the shot.

During its tour of the facility, the HRA observed the location of the phone and feels as though the location itself does not lend to privacy because if a resident wanted to call the authorities regarding an incident that happened within the facility, the fact that the nurses know when the individual would be using the phone may deter the resident from calling. The HRA also reviewed a report provided by the Illinois Department of Public Health that states the phone behind the nursing station does not stretch far enough for privacy. Also, the facility phone policy states that there are specific days that a resident is scheduled to be able to use the phone behind the nursing station, but they cannot use it everyday. The staff did state that the residents can use a pay phone, but they do not have direct access to the phone and must have a staff member take them to the phone, which does not lend to privacy and impedes access. The Nursing Home Care Act 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 HRA suggests that the facility adhere to 210 ILCS 45/2-108 in regard to unimpeded, private, and uncensored communication.

The HRA also noticed, during our tour, that the location of the Public Health posting, which was located outside of the locked behavioral health unit, is in direct violation of the Nursing Home Care Act regarding posting of information, which states that a phone number and complaint procedure must be posted in an area that is accessible to residents (210 ILCS 45/3-209).

The HRA asks that the facility update and review their policies in accordance with the regulations stated above.

RESPONSE

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

Guardianship and Advocacy Commission
5407 N. University
Suite 7
Peoria, IL 61614

RE: #11-090-9006

Dear Sirs:

Please consider this our Objections to the findings and recommendations of your 3/23/11 letter.

Complaint #1.

- Enclosed is a page of the contract between this resident and the Facility, wherein the resident's [redacted] was designated as "Resident's Representative". Pursuant to (210 ILCS 45/2 -106.1) of the Nursing Home Care Act that you quote, the informed consent forms can be signed by the Resident's Representative. So even if the [redacted] wasn't [redacted] guardian when [redacted] became an adult, she was entitled to sign the informed consent forms, as Resident's Representative.

- This facility follows the laws of the Federal and State regarding the dispensing of medications. We require our residents to sign informed consent forms, for all classes of drugs that we are mandated to obtain consent on. However, Cogentin, while often given as part of a psychotropic regimen; is only given as a preventative of severe side effects such as Drug Induced Extrapyramidal Disorders. It isn't an anti-anxiety or anti-psychotic, or part of any of the classes of drugs requiring consent. We have checked with IDPH, and they concur with this position. We have also checked with other nursing facilities, and haven't found a single facility that obtains consent forms for Cogentin.

  We also believe that requiring it could actually be counter productive, because if a consent is refused and the nurse doesn't dispense it, the severe side effects could start, and they are irreversible.

Complaint #2.

- Facility is well aware of the requirement of providing residents free access to their charts, and always does provide it. We don't believe that any resident at our facility, was ever refused access to their charts. What happened on 7/23, however, was that the resident asked the night shift nurse to see [redacted] chart at 3:25AM. This nurse wasn't clear about the requirement, due her always working night shift, when all the residents are sleeping, so she stalled for time, by telling the resident

that she needed to speak to [redacted] first. By 8:30AM that morning, after checking with daytime staff, the nurse was reminded of the requirement, and the resident was then immediately provided with [redacted] chart. So, in essence, the resident did receive [redacted] chart within a few hours of requesting it.

Plan of Correction:

Facility has in-serviced its Social Service staff on the need to carefully ascertain and document upon admission, who is the lawful guardian of each resident. Informed Consents need to be signed only by the resident, or those legally permitted to. We enclose evidence of the in-service.

Facility has in-serviced its nursing staff on the requirement to provide residents immediate access to their charts. We enclose evidence of the in-service.

5. All other terms of this Contract shall remain in effect from termination until the resident is transferred from the facility.

H. General

1. (Optional: There is no Resident's Representative unless designated in writing.)
   The Resident's Representative is [redacted]. The resident may cancel or change the "Resident's Representative" in writing at any time.
2. If any part of this Contract is ruled invalid by a court or is in violation of any applicable law, such part shall be deleted and the balance of this Contract shall remain in full force and effect.
3. If any law hereafter requires changes or additions to this Contract, such changes or additions shall be part hereof from the effective date.
4. This Contract may be assigned by the facility to any successor in ownership or operation of the facility.
5. THE UNDERSIGNED RESIDENT HAS RECEIVED A COPY AND HAS READ AND AGREES TO THE TERMS AND CONDITIONS OF THIS CONTRACT.

For the Facility:

[redacted]

Signature of Licensee, or by Administrator of the facility as an agent of the Licensee

Administrator

Date of Signature

Title of Facility Representative

For the Resident:

[redacted]

Resident, Resident's Guardian, Resident's agent under a Power of Attorney executed pursuant to the Illinois Power of Attorney Act or a member of Resident's immediate family

Date of Signature

Specify Capacity if Signer is not the Resident

STATE OF ILLINOIS
Pat Quinn
Governor

GUARDIANSHIP & ADVOCACY COMMISSION
Dr. Mary L. Milano, Director

HUMAN RIGHTS AUTHORITY
LEGAL ADVOCACY SERVICE
OFFICE OF STATE GUARDIAN

May 27th, 2011

[redacted], Administrator
Forest Hill Health and Rehab Center
4747 11th Street
East Moline, IL 61244

Re: Human Rights Authority Case #11-090-9006

Dear [redacted]

At its regularly scheduled May 18th, 2011 meeting, the Human Rights Authority discussed the response from your facility regarding the above mentioned case. The HRA appreciates the facility's plan of correction regarding in-service training for the social service staff concerning ascertaining and documenting guardianship upon admission and the in-servicing of the nursing staff regarding the requirement to provide the residents with immediate access to their charts. The HRA still has some remaining concerns about the response. The response states that the resident's [redacted] was designated as "Resident's Representative" in accordance with 210 ILCS 45/2-106.1 in the contract between the resident and the Facility. In reviewing the regulations, a resident's representative is defined as "... a person other than the owner, or an agent or employee of a facility not related to the resident, designated in writing by a resident to be his representative, or the resident's guardian ..." (201 ILCS 45/1-123). The contract presented to the HRA showed no indication that the resident had approved the individual as the resident representative.

When the HRA originally spoke with the facility, it was stated that there was a mistake regarding guardianship of the individual and there was no mention of the individual having a resident representative on file. Due to these facts, the HRA would still like to see evidence of its original recommendation where the facility was asked to "... develop a process that assures the facility collects accurate information regarding resident guardianship, and obtains appropriately authorized informed consent, when residents are admitted into the facility."

Also, due to the fact that an in-service was already performed regarding resident representation, the HRA would like to see an in-service conducted when the new procedure is in place which educates staff on the proper means to obtain resident representation. Please send evidence of the requested process and in-service, by June 15th, or the HRA may consider an enforcement referral.

PEORIA REGIONAL OFFICE
✦ 401 Main Street, Suite 620 ✦ Peoria, IL 61602
✦ Telephone (309) 671-3030 ✦ Fax (309) 671-3060
✦ Statewide Toll Free Intake (866) 274-8023 ✦ Statewide TTY (866) 333-3362

Please send all correspondence to the HRA's new location at:

Illinois Guardianship and Advocacy Commission
401 N. Main Street, Suite 6
Peoria, IL 61602
Attn: Gene Seaman

Also, if you have any questions, please contact Gene Seaman, HRA Coordinator, at 309-671-3030. Thank you and we appreciate your cooperation with this matter.

Yours truly,

Steven Watts (SS)

Steven Watts, Chairperson
Regional Human Rights Authority

Policy and Procedure for Resident Representative

Policy: Upon admission, facility will determine representative for the resident.

Procedure: Facility will obtain appropriate forms to determine residents representative.

If the resident does not have appropriate forms facility will provide an initial resident representative form upon admission.

Resident will determine who they would like there representative to be. The resident, the representative and a witness will sign the form.

FOREST HILL
HEALTH & REHAB CENTER

RESIDENT REPRESENTATIVE

I_____,do appoint_____

to be my representative while I am a resident at Forest Hill Health &

Rehab effective_____.

RESIDENT NAME_____

RESIDENT SIGNATURE_____

REPRESENTATIVE NAME_____

REPRESENTATIVE SIGNATURE_____

WITNESS_____