FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
LYDIA HEALTHCARE — 13-040-9006
HUMAN RIGHTS AUTHORITY- South Suburban Region

[Case Summary— The Authority made corrective recommendations, although the complaint as presented below was not substantiated. The public record on this case is recorded below; the provider did not request that its response be included as part of the public record.]

INTRODUCTION

The Human Rights Authority (HRA) has completed its investigation into an allegation concerning Lydia Healthcare. The 309-bed skilled and intermediate care facility is located in Robbins. The facility primarily serves people with mental illness diagnoses. The complaint stated that a resident was not allowed to refuse medication in the absence of an emergency. If substantiated, this allegation would be a violation of the Nursing Home Care Act (NHCA) (210 ILCS 45/2 et seq.) and the Mental Health and Developmental Disabilities Code (405 ILC 5/2-107 [a]).

METHODOLOGY

To pursue the investigation, the complaint was discussed with the Facility Director of Nursing and a License Practical Nurse. The adult resident was interviewed privately at the nursing facility. Relevant facility policies were also reviewed.

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

COMPLAINT STATEMENT

The complaint stated that the resident had refused his monthly injection of Haldol on the morning of October 2012. It was reported that the resident later accepted the injection because a nurse on the night shift said that he would be transferred to another floor if he did not comply with medication.

FINDINGS
Information from the record, interviews and program policy

After reviewing the record, the HRA determined that the resident was diagnosed with Schizophrenia, and he was placed at the nursing facility about four years ago. His care plan originated on August 28th, 2012 and listed problem goals such as medication and symptom management, and discharge readiness. According to the Medication Administration Records (MARs), Seroquel 200 mg daily, Haldol Decanoate 50 mg Intramuscular (IM) and medications for his physical problems were administered from August 14th, 2012 through December 11th, 2012, with some exceptions. The medication records documented that the resident was allowed to refuse scheduled medication for the time period above. His guardian's signed consent for Seroquel, Haldol, and Haldol Decanonate were found in the record. However, there was no documented indication of the recipient having provided informed consent for them. There were no recommended medication dosages, but the form indicated that oral medication information was provided to the guardian.

On September 13, 2012, a nursing entry stated that the resident was having auditory hallucinations and that he was responding to internal stimuli. Haldol 5 mg as needed was administered, but this was not documented on the MARs. There was no indication concerning the method of administration or whether he voluntarily accepted the medication. It was recorded that the resident was monitored. On that same day, a psychiatric services note stated that the resident presented with delusional thinking and loose association of ideas. He wanted to file a grievance against a peer who had allegedly bumped into him about two months ago. According to the note, the worker filed a grievance for the resident as requested, and he was referred to the psychiatrist. The next day, the Associate Facility Director wrote that the resident's peer did not recall the incident because the allegation was not reported in a timely manner. Eight days later, the resident was seen by the psychiatrist and Haldol Decanoate 50 mg IM on the 5th of every month was ordered.

On October 5th, 2012, the physician wrote that the resident said that he had changed his name. On that same day, nursing and psychiatric services entries documented that the resident had refused his scheduled injection of Haldol Decanoate. He was reportedly informed about the importance and benefits of medication. The Supervisor of Nursing and the Supervisor of Psychiatric Rehabilitation Services were notified. On that same night, at 10:30 p.m., the resident reportedly accepted Haldol Decanoate after he was counseled by the administrative staff members above. According to the nursing note, the resident was cooperative and tolerated the medication well. He was reportedly monitored at the time.

October 6th, 2012, the resident reportedly was escorted to the nursing office because of delusional and bizarre behaviors. The assigned physician was notified. Haldol 5 mg orally or IM every 6 hours as needed (PRN) was ordered but was written on the medication sheet as every four hours as needed. A nursing note indicated that Haldol 5 mg orally was administered, but this was not documented on the MARs. According to a follow-up psychiatric services note, the resident was provided with individual therapy that focused on coping skills to use when he was experiencing symptoms of mental illness. He was also encouraged to seek help from the staff when he was having these symptoms, and he was monitored for 72 hours. The record contained a behavioral report documenting delusional and bizarre behaviors leading up to the medication, but there was no descriptive information concerning the incident.

On November 5th, 2012, nursing entries indicated that Haldol Decanoate IM was administered as ordered. There was no indication whether the resident voluntarily accepted the medication or was allowed to refuse. On November 6th, 2012, the resident reportedly was given as needed medication, but this was not documented on the MARs. It is unclear what medication or dosage was given. Also, there was no indication concerning the method of administration or whether he accepted the medication. It was recorded that the resident was monitored. On that same day, a psychiatric services note stated that the resident was "incoherent" and asked why he was at the facility during a counseling session on managing his delusional behaviors. According to the note, the resident believed that he did not need medication, but his parent had requested this. He was referred to group therapy that focused on problem solving. His care plan was updated. On that same day, the guardian was notified that the resident was moved to another floor because of socially inappropriate behaviors. A corresponding behavioral report repeated that the resident had been socially inappropriate but lacked descriptive information concerning the incident.

On November 6th, 2012 a behavioral contract was developed after the resident was moved to another floor. It indicated that the resident had agreed as follows: 1) to discontinue making delusional statements, 2) to participate in all assigned groups during that month for at least 80% of the time, and, 3) to discontinue socially inappropriate behaviors and physical aggression toward others. The resident signed the contract stating that he understood that his placement at the facility, community outings and home visits were at risk if he did not comply with the agreement. For December 2012, the medication records indicated that Haldol Decanoate IM was given as scheduled. A psychiatric services note stated that the resident had been absent of delusional or inappropriate behaviors or physical aggression for about twenty days. According to the note, the resident had made progress concerning his behavioral contact, and he would be referred to the psychiatrist if needed.

When the complaint was discussed with the resident, he was initially focused on his mail and especially his driver's license. He said that he had not received these items. He then denied that he was given medication as alleged in the complaint. He told the HRA that he does not want to take Seroquel, Haldol injections or medication for high blood pressure. He reported having low energy and feeling disconnected from people and said that these were medication side effects. According to the resident, he would be transferred to another floor if he refused medication. He has been moved to different floors since he was admitted to the facility about three years ago. He reportedly was transferred from the ninth to the eighth floor for refusing medication, which delays his discharge from the facility.

The nurse, who allegedly said that the resident would be transferred to another floor for refusing medication, reportedly has worked at the nursing facility for about four years. She has been assigned to the ninth floor for about two years, which is reportedly for residents working towards an approved discharge from the facility and where the alleged incident happened. The nurse explained that Haldol Decanoate IM was ordered because the resident does not want to take medication by mouth He is compliant with medication about 50% of the time. He is sometimes delusional and laughs inappropriately. The resident and his guardian reportedly gave written consent for medication that included the administration of Haldol Decanoate IM monthly. Again, we note that the guardian's consent for medication was found in the record, but

the resident's consent was lacking. The nurse remembered that the resident had refused Haldol Decanoate IM as scheduled in October 2012. She said that the resident later accepted the medication after he was counseled by administrative staff members. She explained that residents are informed about the benefits of taking medication when they refuse, although this might exacerbate their symptoms. She said that the resident had already signed the behavioral contract mentioned in the report indicating that he understood that he must comply with medication to stay on the ninth floor. She said that the resident has been moved to the ninth floor several times and that he was not transferred to another floor when he refused the medication injection on the 5th. The nurse could not recall the specific reason for this action; she said that a behavioral report should have been written concerning his transfer to another floor. However, the behavioral report documented that he was socially inappropriate and lacked descriptive information regarding the incident. The nurse also said that the resident has been observed selling his belongings to his peers.

The nurse further reported that residents are usually seen by their assigned psychiatrist monthly unless there is an incident. She said that as needed medications are used as the last resort to maintain a resident's stability. Residents reportedly are asked if they want as needed medication, and they are allowed to refuse medication. The facility's Director of Nursing (DON) explained that the protocol for as needed medication is agitation, aggression and suicidal ideations. She said that the physician is notified about the resident's condition and that medication is administered if ordered. According to the DON, as needed medication should be documented on the PRN medication records when given. However, nursing notes documented that as needed medications were administered on September 13th, October 6th and November 6th, 2012, but they were not documented on the MARs.

Lydia Healthcare's "Administering Medication Policy" directs the nursing staff as follows: 1) to check each medication order against the original physician's order according to the MARs, 2) to complete all necessary assessments before medication is given, and, 3) to document all dosages of medication given on the MARs.

According to the facility's "Medication Refusal Policy," when medication is refused: 1) the appropriate medication pass code should be used, 2) the importance of medication should be communicated and documented and the reason for the refusal, 3) a behavioral report will be written, and, 4) the physician will be notified, and orders carried out and documented. According to the policy, the physician must be informed if medication is refused three times with or without the presence of active symptoms. It also directs that the proper documentation should be included.

The facility's handbook for residents state that they have the right to file a grievance. According to the facility's "Grievance Policy," the Psychiatric Rehabilitation Services Coordinator is responsible for ensuring that the grievance/complaint form is completed and submitted to the Director of Clinical Services for review. The Director will complete the recommendations or findings sections on the form.

CONCLUSION

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

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

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

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

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

> An adult recipient of services…must be informed of the recipient's rights to refuse medication ….If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent harm to the recipient or others and no less restrictive alternative is available….psychotropic medication or electroconvulsive therapy may be given under this Section for up to 24 hours only if the circumstances leading up to the need for emergency treatment are set forth in writing in the recipient's record.

The complaint stated that a resident was not allowed to refuse medication in absence of an emergency. The resident was reportedly told that he would be transferred to another floor in the facility if he did not accept the medication injection. The nurse who administered Haldol Decanoate IM on October 5th recalled the incident. She said that the resident knew that he must comply with medication to stay on the ninth floor. This floor reportedly is for residents working toward an approved discharge from the facility. She said that the resident later accepted the injection after he was counseled by the facility administration. This was also given as scheduled on November and December of 2012, but there was no indication whether he accepted the medication or refused.

Although the resident told the HRA that he does not want to take any medication, the Authority cannot substantiate the complaint as presented above. The HRA finds no clear violations of the Illinois Department on Aging—Residents' Rights for People in Long Term Care Facilities, Section 45/2-104 of the NHCA, Section 5/2-107 of the Code and the facility's policy that allows a resident to refuse medication. However, this complaint presents some troubling

information because there was no documentation of the recipient's informed consent for medication found in the record, but indication that sometimes he accepts medication. The facility must review this issue with the resident and include his input in treatment planning to ensure full compliancy with Section 45/2-106.1 (b) of the Act. The Authority would also like to comment on the nurse's report that residents who reside on the facility's ninth floor must comply with medication. This practice must be stopped because it is intimidating and punishes the resident for exercising his or her right to refuse treatment.

Additionally, the Authority is very concerned because nursing notes indicated that as needed medications were administered on September 13th, October 6th and November 6th, 2012, but they were not documented on the MARs. There was no medication dosage or method of administration regarding the occurrences on September13th and November 6th. We also found no mention of the medication name that was administered on November 6th. This violates the facility's "Administering Medication Policy," stating that all dosages of medication given must be documented on the MARs. By documentation, the resident filed a grievance concerning medication; we find no violations of the facility's grievance policy.

RECOMMENDATIONS

1. The facility shall follow its "Administering Medication Policy" and document all dosages of medication administered on the MARs

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

SUGGESTIONS

1. Include documentation in the record that the resident has been provided with informed consent regarding medication.

2. The HRA note that the resident's behavioral contract included a goal to discontinuing delusional statements. We suggest that the facility should develop more attainable goals based on the resident's psychiatric diagnosis.

3. The facility should review its practice of requiring residents on the 9th floor to comply with all medications.

COMMENT

The Authority noticed that the physician's order, dated October 6th, 2012, for Haldol 5 mg orally or IM every 6 hours as needed was erroneously written on the medication sheet as every four hours as needed. The facility must ensure that all orders on the medication sheets agree with the original physician's order, per the medication policy.