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HUMAN RIGHTS AUTHORITY-PEORIA REGION

REPORT 14-090-9004
Royal Oaks Care Center

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving a complaint of possible rights violations at Royal Oaks Care Center in Kewanee. It was alleged that the facility does not have adequate safety precautions, treatment and discharge planning.

Substantiated findings would violate protections under the CMS Requirements for Long Term Care Facilities (42 C.F.R. 483), the Nursing Home Care Act (210 ILCS 45) and Subpart S of the Skilled Nursing and Intermediate Care Facilities Code (77 Ill. Admin. Code 300), unique criteria for residents with serious mental illnesses.

Royal Oaks cares for 141 adult residents, many of whom have serious mental illness diagnoses. We visited and toured the facility where management representatives were interviewed. Some assessments forms were reviewed as were sections of resident records with identifiable information redacted.

COMPLAINT SUMMARY

The complaint states that one resident took cocaine into the facility and one or more others on a psychiatric unit tested positive for the drug. It was said that although there are contracted mental health services, there is no psychiatrist available to residents who need psychiatric care. Royal Oaks reportedly discharges psychiatric residents to hospitals and then refuses to take them back. Specific identities or occurrences were not provided in this complaint.

FINDINGS

Managers verified the cocaine incident and explained that the resident who brought the drug in was the only one who tested positive for its use. He had been at Royal Oaks for about a month when he started becoming aggressive. He had two hospital evaluations and his lab work

came back with cocaine traces during one of those visits. They confronted him on return and he assured them he had nothing in his possession, but after the second hospital visit he admitted to stashing some, and a staff member eventually found a suspicious empty bag inside a cable box. The managers said they counseled him on the dangers and illegalities and even had local police come just to talk with him about all the potentials. They also kept his guardian informed about the situation, and she discharged the resident soon after.

We were told this was a one-time incident and that they have no specific drug safety or prevention policy. Prescreening for alcohol and drug use or dependence is part of a behavior assessment that is done on admissions. They strive for as much information as possible about drug histories and then arrange services through various programs should there be any. They have relapse and AA programs on site although it is preferred to link residents with community services so they already have those connections upon discharge. They also told us that residents undergo drug screenings at a local community mental health clinic where services are contracted. If there is reasonable suspicion of drug use then their medical director can order a drug test; so far no one has refused and there have been no further problems. As far as protections against dangerous items coming in, they have no authority to search people who visit. Visitors must sign in, and although their belongings are not inspected, anything brought in for residents is checked for safety and so that property can be labeled.

We reviewed the Illinois Department of Public Health investigation of the issue. Inspectors found the complaints invalid, with no negligence or improper care noted.

A pre-screening and assessment for harmful behaviors form was reviewed as well. It included evaluation of potential harmful, sexual and addictive behaviors. A history of substance abuse is also listed for identification on a suicide assessment. The forms are completed with everyone during admission as described. The contract for resident conduct states that maintaining security and safety are primary focuses and that residents who cause concern will be assessed for behavioral interventions. Evidence of substance abuse is one noted example. It states that alcohol and illicit drugs are not allowed on property.

Regarding claims against psychiatric care and treatment planning, the facility contracts with a local mental health clinic that provides two psychiatrists for any resident with mental health needs and they also arrange care with other psychiatrists from an area hospital for older residents. The psychiatrists come to the facility or can be seen at their own locations. A psychiatrist from the local clinic appears at Royal Oaks once per week and some residents are taken to the clinic every Tuesday. Sometimes appointments are done via Telemed, where a session is conducted on a monitor. The psychiatrist from a local hospital comes about once per month and brings a nurse with her. Social services staff go to psychiatry appointments with residents to ensure continuity of care and that plans are appropriately integrated. Resident care plans are completed by the nursing home while treatment plans are completed by psychiatry in conjunction. The psychosocial component of services at Royal Oaks includes medication management, diagnosis education and attention to sexuality issues. One on one counseling is provided at the clinic but clinic staff come to the facility for any crisis.

We looked to a couple records for support. Resident A's chart showed that s/he was

diagnosed with bipolar disorder and major depression and therefor met Subpart S eligibility criteria; four psychotropic medications were prescribed. Sad/depressed mood, social isolation, self injury, psychotropic medication management and referral to a psychiatrist were targeted within the comprehensive care plan by an interdisciplinary team following assessment. Services at a local mental health clinic where the resident would participate in group and individual counseling and psychiatry were noted. The treatment plan component of the care plan, developed by the clinic, included goals to address medication education, compliance and monitoring, reducing symptoms of illness, community support, i.e., keeping appointments, etc., and improving communication skills through various counseling and therapy avenues. The resident's preferences to engage in group and psychiatric services were also noted. The plans list a primary care physician and a psychiatrist. Social service progress notes reflect consistent trips to the clinic over a three month sample period. Resident B's chart revealed much of the same. S/he was diagnosed with bipolar disorder and schizophrenia and met Subpart S eligibility criteria; up to five psychotropic medications were prescribed. Working towards a group home move, reducing theft tendencies, use of a bladder elimination catheter, community integration, and managing paranoia, self injury, medications and smoking were targeted within the comprehensive care plan by an interdisciplinary team following assessment. Services at a local mental health clinic where the resident would see a therapist and a psychiatrist were identified. The treatment plan component of the care plan included goals to address symptoms through community support, client centered consultation, individual therapy and medication management. The resident's preference to continue care as developed was noted. The plans list a primary care physician and a psychiatrist. Consistent trips and periodic referrals to the clinic or other mental health services are reflected in social service notes as well.

Managers refuted the claim that Royal Oaks discharges psychiatric residents to hospitals and then refuses to take them back. They said that in the last year there was one resident who was hospitalized for about three weeks, and even though they can only hold beds for ten days, they do what they can to keep them reserved; only if someone else needs it will the bed actually be released. This resident did come back but they had to send her a second time involuntarily after she refused to go for medical emergencies. Their medical director completed a petition before she was taken and she eventually agreed to go. No one has been "dumped" at a hospital as per staff report.

A sample twelve month discharge plan was provided for our review. The plan outlines monthly steps of achievement potential toward discharge in areas of general living like grooming, housekeeping, attending appointments and activities, seeking employment, medication management, and banking. According to the care plan, Resident A was working toward discharge to a non-nursing home level of care and continued connection with the mental health clinic and was being guided by all disciplines: medical, nursing and psychosocial. Resident B had two hospital visits for a medial issue during the three month sample period. In both instances the resident returned to Royal Oaks after the issues were resolved. Much of the discharge plan's goals, primarily functioning in the community while working toward a move to apartments managed by the mental health clinic, were achieved and the resident was discharged to that program before our visit.

CONCLUSION

CMS requirements state that facilities must provide a safe environment (42 C.F.R. 483.15). Each resident must receive necessary care and services to attain or maintain the highest physical, mental and psychosocial wellbeing according to their assessments and plans of care (42 C.F.R. 483.25). If a facility does not employ a qualified professional to furnish a specific service to be provided, it must have that service furnished by an outside person or agency (42 C.F.R. 483.75).

Under state laws all facilities must develop and implement comprehensive care plans for residents that include measurable objectives to meet medical, mental and psychosocial needs as assessed (210 ILCS 45/3-202.2a). Interdisciplinary teams shall be established that include psychiatrists for residents with serious mental illness diagnoses (77 Ill. Admin. Code 300.4010). Their treatment plans are to be based on assessed functioning levels and include structured group or individual psychiatric services and substance abuse management as appropriate (77 Ill. Admin. Code 300.4030). Involuntary discharges may occur when it is necessary for medical reasons or for the physical safety of a resident or others (210 ILCS 45/3-401). Discharge plans are otherwise considered by interdisciplinary teams as components of comprehensive care plans (77 Ill. Admin. Code 300.4060).

Written policies and procedures must be established to implement the responsibilities and rights provided in the Nursing Home Care Act (210 ILCS 45/2-210).

At question is whether Royal Oaks has inadequate safety precautions, treatment and discharge planning in place. Regarding safety from illegal drug use specifically, managers handled an isolated situation with safety and protection in mind: they sought medical evaluation when the resident began acting out, searched the premises, counseled the resident when there was indication of drug use, and notified authorities and a guardian. Ultimately, the facility's licensing body found no violations in their inspection of care. Our own observations left no concerns either. Treatment planning and extended psychosocial services whether in or out of the facility are evident, complete with assessed goals and available psychiatrists, based on management's description and support from resident records. There is also no implication based on the same that residents are being discharged without appropriate planning, so the complaints are not substantiated violations of facility responsibilities or resident rights. But, we asked repeatedly for care, treatment and discharging planning polices and received nothing, and since these are required to be in place for implementation but were not produced, a violation of that requirement is substantiated.

RECOMMENDATION

Produce policies/procedures on care, treatment and discharge planning.