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Egyptian Regional Human Rights Authority
Report of Findings
15-110-9015
Mulberry Center

The Egyptian Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegations concerning Mulberry Center in Harrisburg, Illinois:

1. **The facility failed to communicate with a Recipient's legal guardian regarding care and treatment and administered medications without consent.**

2. **A Recipient received inadequate care and treatment.**

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102, 107), Public Health Regulations (410 ILCS 50 et al), and Hospital Regulations (77 IL ADC 250 et al. and 42 CFR 482.13) as well as facility policies.

Mulberry Center is an acute in-patient psychiatric unit which is attached to the local hospital. The unit is divided into two wings; the first is a general adult unit with 21 licensed beds, housing individuals with psychiatric disorders which do not involve dementia. The second wing is a geriatric psychiatric unit with 10 beds. This unit is for treatment of individuals whose psychiatric condition is complicated by Alzheimer's and/or dementia.

The complaint alleged that Mulberry Center failed to communicate with this Recipient's legal guardian regarding care and treatment and failed to obtain consent from the guardian before adding and administering medications. The second allegation involved inadequate care and treatment due to the Recipient gaining 142 pounds in approximately 3½ weeks. To investigate the allegations, the HRA interviewed the recipient's guardian, treating psychiatrist at Mulberry Center, the nursing staff and the Administrator as well as the CILA (community integrated living arrangement) home staff. Records were also reviewed with consent, and pertinent policies and mandates were examined.

I. Interviews:

A. Legal Guardian: The legal guardian is a court appointed plenary guardian of the person for the recipient and therefore has authority to consent to medication, treatment and

placement of the recipient who has been deemed legally incompetent. The Recipient had been discharged from a state operated facility to the CILA home after 6 months of improving behavior while being free of psychotropic medications. The treatment team at the CILA home had been addressing his maladaptive behaviors with applied behavioral analysis (ABA) treatment rather than medication. The treatment team, including the guardian, were all of the opinion that the Recipient's issues were behavioral and not the result of psychosis. This was evidenced by no marked improvement while on psychotropic medication and his positive response to ABA. The Behavior Analyst (BA) had been tracking at least 16 behaviors including elopement, dependency, refusing medications and suicidal ideation. The guardian stated that the BA had invested "something like 1700 hours" on this recipient. The guardian explained that this recipient has had several placements at all levels of care and all have failed. He had been in this CILA home for approximately 13 months at the time of our interview but had recently been discharged back to the state operated facility due to increasingly aggressive and destructive behaviors at the CILA home including aggressing toward peers and property destruction such as throwing kitchen appliances, ripping out the toilet and knocking holes in the wall with his head. The recipient had periods of both good and maladaptive behavior but overall, the guardian was of the opinion that this CILA home was a good placement for him. He explained that the recipient had enjoyed the work he was doing at the day training workshop and at his previous placement he was refusing to work or participate in much of anything.

The guardian explained that the recipient was taken to the emergency room (ER) due to medication refusal along with refusing food and drinks for 3 days. At the time, the only medication he was on was for health related issues along with an antidepressant. The ER discharged him to Mulberry Center for psychiatric treatment and stabilization. While at Mulberry Center, 3 psychotropic medications were prescribed at the maximum dosage along with a blood thinner. The guardian stated that he was never contacted by Mulberry Center to discuss these changes or to obtain consent, as required by the Mental Health Code regulations. The guardian stated that he called frequently to check on the recipient and spoke to the nurses when he called, therefore, he did not think it was necessary to visit him in person since these types of admissions are usually short term for stabilization and the facility typically keeps the guardian updated and then notifies the guardian when the recipient is ready for discharge to discuss the discharge arrangements. The guardian did speak with the Psychiatrist at Mulberry Center just before the recipient was discharged. He inquired as to when the recipient would be discharged as the guardian felt he had been there too long. The Psychiatrist advised that he was ready and would be discharged soon. The guardian was not aware that new medications were prescribed or that the recipient had gained an excessive amount of weight until the CILA home staff notified him upon his return to the home. The CILA home was upset about the medications being added without consent and told the guardian that they had called frequently and were never told that medication had been added or that he had gained weight. The guardian saw the recipient right after discharge from Mulberry Center and stated that he was alert but had gained approximately 142 pounds in approximately 3½ weeks. The guardian spoke with the recipient's primary care physician about decreasing the medications that had been added while at Mulberry Center, however the physician

saw him as unstable upon discharge from Mulberry Center and would not agree to decrease the psychotropic medication. Therefore, the guardian "had to consent by no choice." The guardian explained that the recipient's weight was under control now and that he had lost all of the weight he gained while at Mulberry Center.

B. Administrator: The Administrator has been employed with the agency for approximately 9 years, 2 of which have been in his current role as Administrator. The facility provides medical stabilization for psychiatric issues. The social workers provide educational groups, recreational therapy such as card games, stress and relaxation techniques, coping skills and some arts and crafts. The social workers are case managers for the recipients but also run the groups. Most days, the census is 30 out of 30, but that drops occasionally to 25-29 out of 30. The facility has 1 full time psychiatrist on contract and 1 medical doctor. The facility also employs 3 psychiatric physician's assistants (PA), 1 medical PA and 3 nurse practitioners. The physicians make daily rounds to see the recipients. The average length of stay at the facility ranges from 1 day to 9 days.

The Administrator explained that at the time of this recipient's admission, all recipients' weights were checked upon admission, on Wednesdays and Saturdays. However, he had since learned that some staff were checking weights the night before rather than weighing the following morning as ordered by the physician. That issue has been addressed with the staff and it was clarified that weights must be checked on the same day and times the physician's order states. The weight check policy has also been revised to include checking a recipient's weight upon discharge in addition to the previous requirements of admission, Wednesdays and Saturdays. The new policy also requires that weight upon discharge be added to the discharge summary to depict a more accurate picture. At the time of the recipient's admission, the facility had floor scales with a dial-type weight measure. The facility has since switched to digital scales that also have weight measurements in the tenths so that weight checks will be more accurate. These changes were made following a public health inspection involving some of the same allegations that the HRA was investigating. Another change that was made following the public health inspection was how the body mass index (BMI) is checked. Previously, the dietician was only monitoring BMI below 19 to assess if a recipient was below their ideal body weight. Since the public health inspection, the dietician now monitors BMI over 40 as well to assess if a recipient is above their ideal body weight to ensure that diets are more closely monitored and adjustments can be made when necessary.

This recipient was also a diabetic, but the nurse had placed him on a regular diet in error. The HRA inquired if this recipient was prescribed a diuretic medication for fluid retention and were informed that he was, however the Administrator stated that he had refused that medication during the last portion of his stay. He also explained that recipients have the right to refuse medication and when this occurs, the facility staff educates the recipient on the importance of medication compliance and if the recipient still refuses, the physician is contacted. Occasionally, when the physician explains the medication to the recipient and informs the recipient that he or she needs it, they will take it. The Administrator stated that he has never had to file a Petition with the Court for enforced medication and was not sure if they had authority to do so or not.

C. Nurses: The nurses at the facility work 12 hour shifts and the charge nurse delegates recipients to the nurses. Therefore, it is possible that the recipient would not have the same nurse every day or week. The HRA questioned three nurses about this recipient's weight gain. The first nurse stated that she did not notice any excessive weight gain and did not notice any significant difference in how his clothing was fitting him. The second nurse stated that she noticed that he may have gained some weight, but it did not seem excessive as he was still able to wear the same clothing. The third nurse stated that she noticed his clothes were fitting "snugger" but did not think much of it because he was still wearing the same clothing.

D. Psychiatrist: The Psychiatrist informed the HRA that the recipient was admitted for hallucinations and suicidal ideation and also due to refusing food and medication. The recipient told the Psychiatrist that he "wanted to get out of that place" referring to his CILA home. The recipient had diagnoses of schizoaffective disorder and deep vein thrombosis (DVT). However, despite these diagnoses the recipient was not on an antipsychotic medication or an anticoagulant. They ran a Doppler test and confirmed DVT and then started the recipient on an anticoagulant. He also prescribed an antipsychotic medication for his diagnosis of schizoaffective disorder. When asked if he discussed this with or obtained consent from the legal guardian for the recipient, his response was that the nurses typically contact the guardians for consent. He was aware that the recipient had a legal guardian from the documentation sent to them from the hospital prior to his admission to Mulberry Center. He stated that the nurses can obtain telephone consent with a witness but he did not know if there was any documentation showing if verbal consent was obtained. When the Psychiatrist was questioned on the dosage the medication was prescribed, he stated that the recipient was on 9 mg of Invega and 80 mg of Prozac upon discharge. When asked about typical dosage ranges for those medications, he explained that he started at a lower dosage and tapered the medications up. He stated that he has, in the past for others, "gone higher" than 80 mg on Prozac but has not gone above 12 mg for Invega. The Psychiatrist stated that he was not contacted by the nurses stating that the guardian refused to consent to the medications and he never heard from the guardian directly with the exception of a telephone conversation when the recipient was being discharged. He stated that the guardian did not visit the recipient while he was at their facility. When it was time to discharge the recipient, the Psychiatrist and the guardian "played phone tag" for a while until the guardian provided him with a cell phone number on which he was eventually able to reach the guardian. The Psychiatrist stated that he did not document every attempted contact, so he could not be certain as to how many times he attempted to reach the guardian, but he did document the one and only time he was able to speak with the guardian was when they discussed discharge planning. During that conversation, the Psychiatrist stated that the guardian did not voice any concerns regarding the medication he was prescribed but did state that he believed the recipient's issues are more behavioral than medical. The guardian explained that he typically "self-sabotages." The Psychiatrist discussed with the guardian the recipient's request to be placed somewhere new rather than returning to the CILA home. The guardian agreed to meet with the recipient at his group home and explore alternative placements at that time, but requested that the recipient be returned to the CILA home

upon discharge from Mulberry Center because the guardian could not come to Mulberry Center due to inclement weather at that time. The Psychiatrist stated that the recipient's discharge was delayed by a day due to inclement weather.

The HRA also questioned the Psychiatrist about the weight gain of the recipient during his admission. The Psychiatrist explained that he does not complete physical examinations on the recipients that would be the medical doctor's responsibility. He only talks to the recipient and treats the psychiatric issues. Therefore, he did not notice the recipient's weight gain during his daily rounds other than "some weight gain in his limbs." He stated that this recipient did drink a lot of water and soda and explained that he was taking his diuretic medication. The chart did show some weight gain but the Psychiatrist was not sure how accurate that would be because it is possible that the nurses took the weight from the hospital records and did not actually weigh him on the scales at Mulberry Center upon admission.

CILA Home Staff: The HRA interviewed the House Manager and the Qualified Intellectual Disabilities Professional (QIDP). They explained that the recipient was taken to the emergency room due to his primary care doctor's protocol. The protocol stated that if the recipient refused medication or food and drinks for 3 days, then he should be taken to the emergency room (ER) for an evaluation. Upon examination, it was discovered that the recipient also had fresh scratches to his leg due to self-injurious behavior (SIB). Therefore, the ER doctor referred him to Mulberry Center for psychiatric treatment. The staff explained that the nurse at workshop checks daily for SIB which is how they knew these were "fresh" scratches. The staff did not know if he was weighed at the hospital ER, but stated that he had an appointment with the primary care doctor the week prior and was weighed at that appointment. The staff explained that when clients are in the hospital they usually visit daily, however they did not visit this recipient while he was at Mulberry Center because the behavior analyst felt like that would reinforce his attention-seeking behaviors. The treatment team had been focusing on behavior analysis as his primary treatment rather than medications and the staff explained that he had been in their CILA home for a year and they had seen improvement with this type of approach. The team had even requested that the community case coordination agency cease visits temporarily due to the visits reinforcing his attention seeking behaviors. The team was of the opinion that the recipient's maladaptive behaviors were for both attention and avoidance. The BA was tracking approximately 16 different maladaptive behaviors. They explained that the recipient had a history of seeing medication advertisements on television and then asking his doctor to prescribe them, with success at times. They stated that daily he would ask for an increase in his medications.

The House Manager stated that although they did not visit the recipient at Mulberry Center, she called daily except for a week when she was on vacation. When she called, she spoke with the recipient's Social Worker at Mulberry Center. She would ask how he was doing, when he would be coming home and ask if they needed anything. The Social Worker would say he was doing fine and would be coming home in a couple more days, but then the recipient would speak with the Physician's Assistant (PA) and would say things that would keep him there. The House Manager stated that the Social Worker

never mentioned that medications were added or that he had gained weight during their telephone conversations. When the staff from the CILA home picked him up from Mulberry Center to bring him home, they were shocked at the amount of weight he had gained which was approximately 142 pounds in 3½ weeks. They stated that due to his weight gain, they could not get his regular shoes on his feet and he had to wear house shoes home that day. He had difficulty getting into the van because he could not lift his leg high enough to get inside. He was wearing his same clothing, which was described as fleece type pants, however, they stated that the clothing was skin tight and "stretched to the max." When they questioned the nurse about the weight gain she laughed and stated that "he likes his food". When they discussed it with the recipient, he stated that he was "forced to eat seconds and ice cream and soda." The CILA home staff were concerned because he also has a history of water loading. Upon arrival at the CILA home, he was weighed on their scale which went up to 300 pounds and stated that he "broke the scale."

The day after he returned to the CILA home, he was taken to his regular primary care physician where he was weighed at 315 pounds. The physician was not happy about the weight gain or psychiatric medications being added, but stated he would leave him on them for the time being and just monitor him. He was placed on a heart healthy diet and was also placed on water limitations. He had lost 100 pounds in approximately 3 months since returning to the home. The staff explained that they have not noticed any difference in his behavior on the medications than when he was off of them, except he is more destructive now. They stated that he was going through a destructive phase trying to get himself readmitted to the hospital in order to avoid the structure of the home and the dietary restrictions he had been placed on. When questioned on whether or not the recipient had voiced dissatisfaction or complaints about his current placement in the CILA home, the staff explained that he "bosses everyone and wants to be in control" but had not stated that he was unhappy there. He has requested several times to be moved to the Chicago area where there are "prettier nurses." They stated that he "always wants what he doesn't have." They also explained that he likes the staff at his day training workshop and is proud of the work he does there. Staff at his workshop brags on him and say that he is a good worker. He also does house chores at his home such as cleaning his room and doing laundry.

II. Clinical Chart Review

A. Admission Notes for Mulberry Center: The Admission note dated 1/24/15 documented the reason for admission as recurrent suicidal ideation, refusal of psychotropic medication which led to a visit to the emergency room where he was seen and transferred to Mulberry Center. His past medical history was listed as DVT [deep vein thrombosis], chronic lymphedema, hypogonadism, noninsulin-dependent diabetes mellitus and hypertension. In the personal history section, it was noted that the recipient is not legally competent and has a guardian. His Diagnoses were listed as: Axis I Schizoaffective Disorder Depressed, Chronic with acute exacerbation and Anxiety Disorder, not otherwise specified; Axis II Mental Retardation, unspecified; Axis III Multiple Health Issues; Axis IV Limited Coping Skills; and Axis V GAF (global assessment of functioning) 20. The estimated length of stay is listed as "about five to seven days." The

criteria for discharge is listed as "the patient will show improvement in his psychiatric symptoms and will no longer report suicidal ideation." The plan was to monitor for sleep, appetite, mood and thought process and the doctor was going to order "Dopplers for his leg swelling." The medication reconciliation upon admission showed the recipient on the following medications: Docusate 100 mg [stool softener]; Levothyroxine .05 mg [thyroid]; Lexapro 20 mg daily [antidepressant]; Metformin 500 mg BID [twice daily for diabetes]; Tylenol PRN [as needed] Mylanta PRN; Imodium PRN, Milk of Magnesia PRN; and sliding scale glucose 1 stick daily and 10 mg Ambien [sedative for insomnia] at bedtime. His weight was listed on the medication reconciliation at 177 pounds upon admission. There was an order for his weight to be taken on admission then every Wednesday and Saturday.

B. Discharge Summary Report from Mulberry Center: The discharge summary, prepared and signed by the Psychiatrist, also noted that the patient was incompetent and had a legal guardian. The reason for admission was again summarized and it was also noted that the recipient had reported that he did not like his group home and "has been trying to get out of the place so he can move somewhere up north." It was documented that the recipient was maintained on Levothyroxine .05 mg at bedtime [thyroid medication]; Hydrochlorothiazide 25 mg daily [water pill]; Metformin 500 mg twice daily [diabetic medication] and Pradaxa 75 mg twice daily [anti-coagulant]. The recipient had a Doppler on his legs which confirmed DVT. It was also noted that the recipient was started on Invega 3 mg and the dose was increased to 6 mg [antipsychotic]. He was prescribed Temazepam 30 mg [benzodiazepine for insomnia] at bedtime to help him sleep and started on Prozac 20 mg [antidepressant] and the dose was gradually increased to 80 mg. It was also noted that the recipient was "presenting symptoms to delay his discharge." The Psychiatrist also noted that he had an "extensive discussion regarding this situation with his guardian. The guardian was asking me to discharge him back to the group home and he would follow up regarding the different placement options." It was also documented that the recipient was seen that day and was not exhibiting any dangerous behavior, therefore the psychiatrist "decided to discharge him." The group home was going to pick him up either that day or the next, depending on the weather situation. The diagnoses were listed as the same as the Admission Notes indicated with the exception of Axis V which had changed to GAF 50-60. The medication reconciliation lists the following medications: Hydrochlorothiazide 25 mg BID [water pill]; Levothyroxine .05 mg [thyroid]; Prozac 80 mg [antidepressant]; Metformin 500 mg [diabetes]; Pradaxa [anti-coagulant]; Docusate 200 mg [stool softener]; Magnesium Oxide 400 mg [supplement]; Invega 6 mg [antipsychotic]; Temazepam 30 mg [benzodiazepine for insomnia]. The weight was listed at 310 pounds upon discharge.

The HRA looked up the above medication dosages on drugs.com and the following dosage ranges were listed: Invega's recommended dosage is 6 mg per day with a maximum dosage allowed being 12 mg daily, noting that "*it has not been systematically established that doses above 6 mg have additional benefit.*" Temazepam's typical dosage ranges from 7.5 to 30 mg daily and Prozac's typical dosage ranges from 20-80 mg per day.

C. Medication Consents from Mulberry Center: The HRA viewed medication consent forms and searched the medications on WebMD. The following medications were being given at Mulberry Center: Ambien (sedative prescribed for insomnia), Lexapro (antidepressant prescribed for depression and anxiety), Invega (antipsychotic medication prescribed to treat mental/mood disorders), Prozac (antidepressant used to treat depression, obsessive compulsive disorder, and panic attacks), Restoril (used to treat insomnia) and Visteril (used to treat anxiousness, skin irritations due to allergies, additional medication for calming). No dosage amounts were listed on the forms, just the name of the medications. The consent forms were all signed by the recipient, the guardian's signature was nowhere on the forms and there was no note indicating that the guardian had been contacted or that he had given verbal consent for the medications. The HRA contacted the Administrator to follow up on the medication consent procedure and was told that typically, in the event that a power of attorney or guardian is not present to give consent, the nursing staff should open a telephone consent form, but upon further review, the Administrator did not see where that had been done in this particular case. He was only able to find documentation of discussions with the guardian in the discharge summary with the Psychiatrist and a couple of times with the social worker during the course of the stay.

D. Progress Notes from Mulberry Center: The progress notes showed an admission date of 1/24/15 and a discharge date of 2/17/15. On 1/30/15 a Social Worker note indicated she had informed the recipient that the group home and his guardian had called to check on him. There was a registered nurse (RN) case note which documented that the patient had stated that he wanted a new place to live and does not like his guardian. A Social Worker note dated 2/6/15 documented that the recipient stated he is not any better but he and the doctor were working on getting his medications straightened out and noted that per staff the recipient "keeps seeking new and increased medications" and had stated that he would like another place to live. The Social Worker informed him that he would have to go through his guardian. On 2/11/15 the Social Worker documented that she had contacted the guardian and the group home to notify them of an expected discharge date of 2/12/15. On 2/13/15 a Social Worker case note documented that she had met with the patient who had stated that he was doing ok just a little depressed. It was also documented that a phone call was made to the group home and a case manager to inform them that the patient would not be discharged on that day. Another progress note signed by the Psychiatrist and an Advanced Practice Nurse (APN) that same date documented that a discharge was planned for 2/16/15 and noted that "we are attempting to get a hold of his guardian to make discharge plans." On 2/17/15 the Social Worker documented that the patient was discharged and transported by the group home staff.

E. Medical Records from the Community: The HRA reviewed summary sheets from the recipient's Primary Care Provider and Gastroenterologist in the community. The Gastroenterologist appointment was dated 1/20/15, prior to his admission at Mulberry Center. The recipient's weight, dressed with shoes, was listed at 176 pounds with a BMI of 24.55. On 2/18/15, the day following discharge from Mulberry Center, the recipient's weight at his Primary Care Provider was listed at 315 pounds with a BMI of 43.93. The

physician's notes stated that the recipient gained 130 pounds in one month at Mulberry Center due to being given double and triple portions of food and sodas.

F. Public Health Report: The HRA reviewed the report issued by the Department of Public Health following their investigation of Mulberry Center dated 3/12/15. The Department found that the Hospital was not in compliance with standards involving RN supervision of nursing care based on evidence that 7 out of 10 patients were not weighed on admission then every Wednesday and Saturday as per physician order. The case reference that involved this recipient stated that his weight was documented as 177 pounds on admission and the discharge showed his weight at 310 pounds. The report stated that *"there is no documentation to indicate nursing staff notified the physician of the patient's change in condition. There is also no documentation to indicate the physician detected the patient's change in medical condition or responded with interventions, updated or revised the patient's plan of care. All documentation indicated the staff focused on the patient's needs related to the primary diagnosis (psychiatric) and no interventions were initiated for the patients weight gain."*

III...Facility Policies:

A. Admission Orders: This policy states "*it is the policy of the hospital that when a patient is admitted to the program the Physician's Orders will be complete and include all of the required elements."* Item G under the procedure heading states *"Dietary consults shall be considered by the physicians and ordered if indicated."* Item H states *"frequency of vital signs and weights is specified in the Order."*

B. Informed Consent, Medications/Psychoactive: This policy outlines the following procedures for obtaining consent for medication.
"A. The physician will discuss use of medications, reason for treatment, target symptoms, justification, risk of not using medication, and possible alternatives to medication with patient and/or guardian, or POA if applicable. If this cannot be done in person, it will be done by phone with a witness in attendance. The patient/guardian will be provided with an Information Sheet explaining their right to refuse.

B. The RN will document in progress notes that the above was completed and will sign the Informed Consent Sheet.

C. The nurse will list the medication on the Flow Sheet for Informed Consent form.

D. The patient and guardian will sign and date next to each medication to be given.

E. The nurse may start medication regime according to Physician Order once the Informed Consent is obtained and the form is placed in the Medical Record." There was a note at the bottom of this same policy that stated *"classes of medications requiring consent when utilized in psychiatry are: antidepressants, anxiolytics, sedatives, hypnotics and antipsychotics as well as Monamine Oxidase Inhibitors, mood stabilizers, and stimulants."*

C. Documentation of Consent for Psychiatric Treatment: The policy requires that *"either a signed consent for treatment will be obtained for each patient or documentation regarding the refusal to give consent will be recorded in patient's chart…According to the hospital policy, psychiatric patients will sign required hospital consent forms…A legal guardian and/or DPOA may sign for the patient when the state statute will allow…Consent forms and other legal forms will become part of the patient's medical record regardless of their legal status."*

D. Patient and Family Involvement in Care and Treatment Decisions: This policy states that *"patients, their families, and significant others will be encouraged to participate in and/or provide input into treatment and care decisions after patient consent is obtained."* The procedure outlined states as follows: "on admission, the patient, family, legal guardian, or significant other will be encouraged to participate in the development of the treatment plan and to acknowledge understanding of treatment objectives. The plan will be written in terms understandable to the patient and others as appropriate….A copy of the treatment plan will be printed and given to the patient and significant others. ATH [sic] their request after the patient or guardian signs the plan…The patient and family participation and agreement with the plan of treatment will be documented by the nurse or case manager in the patient's medical record…should the patient be unable to sign, or refuse to sign, this and an explanation will be documented in the medical record and a copy of the plan will be given to the patient…"

E. Patient Food Service: The Administrator provided the HRA with an updated Food Service policy, revised on 3/10/15. The prior policy had just focused on monitoring and modifications based on low BMI or significant weight loss. The revised policy includes a section in the protocol for nutrition care plans that addresses weight gain as well. It states as follows: *"All BMIs over 40 will be documented in the medical chart. The care plan will involve looking at the patient's current diet prescription, intake at meals, labs and medical history all in an effort to determine if current diet order is appropriate for the patient. If the clinical assistant and/or dietician determine the patient will benefit from a change in the diet order, the nursing staff will be contacted and made aware of this recommendation. All communication with nursing will be documented in the Nutrition Services flow chart and staff communication tab. Education will be based on the current diet prescription and a consult must be ordered by the physician before is provided."* This policy further states that *"the dietician has the authority to prescribe nutritional supplements to patients who have been identified to be at nutritional risk. The dietician will also have the authority to make any diet revisions as needed…documentation shall be made in the medical chart that the patient is receiving a supplement or has had a change in diet prescription."*

F. Memo Regarding New Scales and Weight Reporting Guidance: The HRA reviewed a memo dated 4/28/15 from the Administrator to all staff. This memo advised that two new digital scales had been purchased. One is on the adult unit and is a floor scale and the other is on the geriatric unit and is a chair scale. The following guidelines regarding weighing patients were also listed in the memo: *"each patient MUST be weighed on our*

scale at the time of admission. We CANNOT use weights listed on paperwork from other departments or hospitals NOR can we ask the patient what they weigh. If a patient refuses to be weighed you must document the refusal in the Nurses Notes…The Charge Nurses should include in their report an admission weight and a current weight. If there is a gain or loss of greater than 10 pounds in a week the Charge Nurse needs to discuss it in Treatment Team. In the event a patient is here longer than a week and the weight exceeds a gain or loss of more than 10 pounds that needs to be discussed in Treatment team as well. In those cases in which a weight variance is reported to the Physician the nurse reporting it must document the specifics of what was reported at that time."

Statutes

The Mental Health and Developmental Disabilities Code (405 ILCS 5/1-114) defines Mental health facility as *any licensed private hospital, institution, or facility or section thereof, and any facility, or section thereof, operated by the State or a political subdivision thereof for the treatment of persons with mental illness and includes all hospitals, institutions, clinics, evaluation facilities, and mental health centers which provide treatment for such persons*

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) also states *"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."*

Under section (a-5) of the Code, *"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 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. If the recipient is under guardianship and the guardian is authorized to consent to the administration 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.*

The Code (405 ILCS 5/2-107) provides that *"(a) An adult recipient of services or the recipient's guardian, if the recipient is under guardianship, and the recipient's substitute decision maker, if any, must be informed of the recipient's right to refuse medication or electroconvulsive therapy. The recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication or electroconvulsive therapy. If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available. The facility director shall inform a recipient, guardian, or substitute decision maker, if any, who refuses such services of alternate services available and the risks of such alternate services, as well as the possible consequences to the recipient of refusal of such services. (b) Psychotropic medication or electroconvulsive therapy may be administered 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 Probate Act (755 ILCS 5/11d) ensures that *"A guardian acting as a surrogate decision maker under the Health Care Surrogate Act shall have all the rights of a surrogate under that Act without court order including the right to make medical treatment decisions such as decisions to forgo or withdraw life-sustaining treatment…"*

Public Health Regulations (410 ILCS 50/3) guarantees "*The right of each patient to care consistent with sound nursing and medical practices, to be informed of the name of the physician responsible for coordinating his or her care, to receive information concerning his or her condition and proposed treatment, to refuse any treatment to the extent permitted by law, and to privacy and confidentiality of records except as otherwise provided by law"*

Hospital Regulations (77 IL ADC 250.1640) require that *"All diets shall be ordered by the patient's attending physician and/or a registered dietitian with the attending physician's confirmation. Diet orders shall be recorded in the patient's medical chart. b) All diet orders shall be sent to the dietetic service department in writing. Each diet order shall have sufficient pertinent information to enable the dietetic service to serve the diet as prescribed by the physician. c) Appropriate records for patients shall be maintained in the dietetic service department. These records shall contain pertinent information that will be helpful to the patient's nutritional care."*

Hospital Regulations (77 IL ADC 250.2290) state that *"Progress notes must be recorded by the physician, clinical psychologist, nurse, social worker and by others significantly involved in active treatment modalities. The notes must contain recommendations for revisions in the treatment plan as indicated as well as precise assessment of the patient's progress in accordance with the original or revised treatment plan."*

According to the Medicare/Medicaid Conditions of Participation for Hospitals pursuant to 42 C.F.R. 482.13, *"(a)(1) A hospital must protect and promote each patient's rights. The hospital must inform each patient, or when appropriate, the patient's representative (as allowed under State law), of the patient's rights, in advance of furnishing or discontinuing patient care whenever possible. (b)(1-2) the patient has the right to participate in the development and*

implementation of his or her plan of care. The patient or his representative has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. (c)(3) The patient has the right to be free from all forms of abuse or harassment. (e) Standard: Restraint or seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time."

Conclusion

The first allegation was that the facility failed to communicate with a Recipient's legal guardian regarding care and treatment and administered medications without consent. Upon review, the only consent forms the HRA found in the chart were forms that were signed by the recipient however, the legal guardian's signature was not on any of these forms. The Psychiatrist informed the HRA that he was aware that the recipient had a legal guardian, but the nurses have the responsibility of contacting the guardian and obtaining consent before carrying out his orders. The CILA home staff and the guardian all informed the HRA that they checked on the recipient regularly via telephone communication with the nurses and/or social workers at Mulberry Center but were never informed of any medications being prescribed or excessive weight gain. The HRA found documentation from the social worker that there was communication with the CILA home staff and guardian on 1/30/15 and 2/11/15 however, it was not documented what specifically was discussed. There were no case notes or formal consent forms documenting that the nurses obtained verbal consent from the guardian for any medication or treatment and no documented evidence of providing the guardian with the required written education materials for the drugs prescribed. Therefore, the allegation is **substantiated** and the following **recommendations** are made:

1. **The HRA recommends that the hospital follow the Mental Health and Developmental Disabilities Code, Medicaid/Medicare mandates and the Illinois Probate Act and ensure guardian involvement in treatment. Physicians, nursing staff and Social Workers should be retrained on facility policies: *Informed Consent, Documentation of Consent for Psychiatric Treatment* and *Patient and Family Involvement in Care and Treatment Decisions* and also on the Mental Health Code requirements (405 ILCS 5/2-102a-5 and 2-107) for obtaining guardian consent prior to treatment and the right to refuse.**
2. **The Code (405 ILCS 5/2-102, a-5) requires that the physician advise a guardian, who is authorized to consent to medication, in writing of the side effects and risks of the treatment, alternatives to the proposed treatment, and the risks and benefits of the treatment. However, the Psychiatrist stated that it was the nurses who contact the guardians to obtain consent for medication and treatment. Mulberry Center should revise policies and procedures to comply with the Mental Health Code requirements.**

3. **If psychotropic medications are being offered and ultimately accepted then a physician must make written decisional capacity determinations and drug information must be provided (405 ILCS 5/2-102 a-5). Familiarizing key staff with the Code's processes seems imperative since mental health treatment does occur at Mulberry Center (405 ILCS 5/1-114).**

4. **Guardians should be notified of treatment plan meetings and be allowed the opportunity to participate by telephone or in person and the guardian should also be provided a copy of the treatment plan for review and approval as per the Mental Health Code requirements (405 ILCS 5/2-102).**

The following **suggestion** is also offered:

1. This hospital has an electronic record keeping system which allows caregivers to accurately record the care of their patients. Typically an electronic system might alert a caregiver that an individual has allergies, their blood type and when the last medication was given etc… The HRA also suggests that this same system be used to alert staff that a patient has a guardian to make his or her medical decisions and that this same system be used to state what the contact preferences are for both the guardian and care provider/CILA home when, in specific situations like this, they are two different people. This would ensure that important information is passed along from one nurse and/or shift to the next and would prevent miscommunication among the nursing staff and ensure guardian involvement in treatment. The patient has the right to have guardian participation for health services and notification for rights restrictions. This electronic record keeping system might facilitate the protection of patient's rights by reminding the staff to work with the patient's guardian and/or care provider and have them available to help formulate the plan for these services, which might also help the hospital staff provide the best quality of care for the individual.

The final allegation was that the Recipient received inadequate care and treatment due to his weight gain of approximately 140 pounds in approximately 3½ weeks. The HRA verified this weight gain through weight records at both Mulberry Center and the recipient's community physicians. There was no documentation that this weight gain was ever noticed by staff at Mulberry Center or that the treatment plan was ever revised to address the weight gain. Therefore this allegation is **substantiated**. The HRA does recognize that since the initiation of the HRA complaint and investigation, steps have been taken to improve the process for weight checks and documentation of same. Some examples include purchasing new scales to obtain more accurate weights and revising its dietary policy to include monitoring of BMI over 40 not just under 40 as previously. The following **recommendations** are made:

1. **Mulberry Center Administration should provide the HRA with training records documenting that staff have been retrained on the proper procedures for obtaining weight upon admission and on Wednesdays and Saturdays and as ordered by the physicians.**

2. **Oversight should be provided and documented ensuring that facility policies regarding weight checks are being followed.**

3. **In the future, guardians should be contacted with significant changes in a patient's condition, including significant weight gain or loss.**

The following **suggestion** is also offered:

1. Although the Psychiatrist and Medical Physician both make regular rounds as do nursing staff, this recipient's excessive weight gain went seemingly unnoticed. A policy should be put in place to clarify what responsibilities each treatment member has (Physician, Psychiatrist, Nurses, Dietary etc…) how that will be communicated between the treatment team members and what oversight the facility will have of that process. This will ensure that a medical or psychiatric condition is not being overlooked and ensure proper care of patients.

The HRA commends the facility for its cooperation and assistance throughout the course of its investigation.

RESPONSE

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

Harrisburg medical center

12/18/2015

Response to Report of Findings

Case 15-110-9015

Mulberry Center

The first allegation was that the facility failed to communicate with a Recipient's legal guardian regarding care and treatment and administered medications without consent.

1. The HRA recommends that the hospital follow the Mental Health and Developmental Disabilities Code, Medicaid/Medicare mandates and the Illinois Probate Act and ensure guardian involvement in treatment. Physicians, nursing staff and Social Workers should be retrained on facility policies: Informed Consent, Documentation of Consent for Psychiatric Treatment and Patient and Family Involvement in Care and Treatment Decisions and also on the Mental Health Code requirements (405 ILCS 5/2-102a-5 and 2-107) for obtaining guardian consent prior to treatment and the right to refuse.

In response to the first allegation recommendation 1: We have recently assigned the following via HMC's education software, Healthstream ; Informed Consent policy 08.003, Documentation of Consent for Psychiatric Treatment and Patient policy 02.207, and Family Involvement in Care and Treatment Decisions policy 04.010. We also assigned the Mental Health Code requirements (405 ILCS 5/2-102a-5 and 2-107) for obtaining guardian consent prior to treatment and the right to refuse to our Physicians, nursing staff and Social Workers.

2. The Code (405 ILCS 5/2-102, a-5) requires that the physician advise a guardian, who is authorized to consent to medication, in writing of the side effects and risks of the treatment, alternatives to the proposed treatment, and the risks and benefits of the treatment. However, the Psychiatrist stated that it was the nurses who contact the guardians to obtain consent for medication and treatment. Mulberry Center should revise policies and procedures to comply with the Mental Health Code requirements.

In response to the first allegation recommendation 2: The nursing staff have been assigned code 405 ILCS 5/2-102 and Dr. was provided with a copy of the HRA Report of Findings including the recommendations and statutes on 12/02/2015. These practices will be incorporated into our Policies and Procedures.

3. If psychotropic medications are being offered and ultimately accepted then a physician must make written decisional capacity determinations and drug information must be provided (405 ILCS 5/2-102 a-5). Familiarizing key staff with the Code's processes seems imperative since mental health treatment does occur at Mulberry Center (405 ILCS 5/1-114).

In response to the first allegation recommendation 3: The Physician, Social Workers, and nursing staff have been assigned code 405 ILCS 5/2-102.

4. Guardians should be notified of treatment plan meetings and be allowed the opportunity to participate by telephone or in person and the guardian should also be provided a copy of the treatment plan for review and approval as per the Mental Health Code requirements (405 ILCS 5/2-102).

In response to the first allegation recommendation 4: The Physician, Social Workers, and nursing staff have been assigned code 405 ILCS 5/2-102.

The final allegation was that the Recipient received inadequate care and treatment due to his weight gain of approximately 140 pounds in approximately 3 ½ weeks.

1. Mulberry Center Administration should provide the HRA with training records documenting that staff have been retrained on the proper procedures for obtaining weight upon admission and on Wednesdays and Saturdays and as ordered by the physicians.

In response to the final allegation recommendation 1: Please see the attached training records. The most current weight procedure will be a part of our unit orientation processes.

2. Oversight should be provided and documented ensuring that facility policies regarding weight checks are being followed.

In response to the final allegation recommendation 2: Starting in September 2015 we added "Weights performed as ordered" to our monthly Quality Assurance monitoring. We query 10% of the discharged accounts for the previous month to ensure that the weights are being done on Admission, Wednesdays, Saturdays, and at Discharge. Please see the attached worksheet. It is the responsibility of the Charge nurse to monitor weight documentation and report adverse findings to the physician on a weekly basis.

3. In the future, guardians should be contacted with significant changes in a patient's condition, including significant weight gain or loss.

In response to the final allegation recommendation 3: We will work with the Information Systems department to incorporate a specific area for reporting significant changes in a patient's condition to the Guardian (when applicable).

Respectfully,

Director of Behavioral Health
Mulberry Center at Harrisburg Medical Center

HARRISBURG MEDICAL CENTER **Policy/Procedure**

SUBJECT	Documentation of Consent for Psychiatric Treatment	Page 1 of 1	Policy No.
		EFFECTIVE DATE 07/21/98	02.207
DEPARTMENT	BEHAVIORAL HEALTH UNIT ADULT / GERIATRIC	REVISED 11/15/12	

1.0 PURPOSE

To provide a mechanism to obtain consent for treatment.

2.0 POLICY

Either a signed consent for treatment will be obtained for each patient or documentation regarding the refusal to give consent will be recorded in patient's chart .

3.0 PROCEDURE

1. According to the hospital policy, psychiatric patients will sign required hospital consent forms.

2. In addition, patients will also sign a specific consent for psychiatric treatment. The form specified in state statutes will be utilized for this purpose. A legal guardian and/or DPOA may sign for the patient when the state statute will allow.

3. Consent forms and other legal forms (e.g., copy of DPOA's appointment) will become part of the patient's medical record regardless of their legal status.

APPROVALS			ORIGINATING DEPT
COMMITTEE	CHAIRPERSON	DATE	
			DISTRIBUTION

HARRISBURG MEDICAL CENTER **Policy/Procedure**

SUBJECT	Patient and Family Involvement in Care and Treatment Decisions	Page 1 of 1	Policy No.
		EFFECTIVE DATE 07/21/98	04.010
DEPARTMENT	BEHAVIORAL HEALTH UNIT ADULT / GERIATRIC	REVISED 11/15/12	

1.0 POLICY

Patients, their families, and significant others will be encouraged to participate in and/or provide input into treatment and care decisions after patient consent is obtained.

2.0 PROCEDURE

A. On Admission, the patient, family, legal guardian, or significant other will be encouraged to participate in the development of the treatment plan and to acknowledge understanding of the treatment objectives. The plan will be written in terms understandable to the patient and others as appropriate.

B. A copy of the treatment plan will be printed and given to the patient and significant others ATH their request after the patient or guardian signs the plan. Significant others may have copies when appropriate releases have been signed.

C. With the patient's consent, family or significant others may participate in the treatment planning and review processes. The patient and family participation and agreement with the plan of treatment will be documented by the nurse or case manager in the patient's medical record.

D. Should the patient be unable to sign, or refuse to sign, this and an explanation will be documented in the medical record and a copy of the plan will be given to the patient.

E. Patient and family participation will be encouraged through this initial process as well as in the process of reassessment and further development of the patient's treatment program up to and including the development of the plan for continuing care following discharge from the program.

APPROVALS			ORIGINATING DEPT
COMMITTEE	CHAIRPERSON	DATE	
			DISTRIBUTION

STAFF TRAINING REPORTS

Course Completion Report - Drill Through

REPORT GENERATED: Jan 28, 2016, 10:55 am ET

HealthStream

Harrisburg Medical Center

Summary

Completion Range: Jan 29, 2015 through Jan 28, 2016

Data as of: Jan 28, 2016, 1:00 am ET

Report Generated: Jan 28, 2016, 10:55 am ET

Student Groups Selected: 2

Departments: 1

COURSE COMPLETION SUMMARY

COMPLETIONS BY DEPARTMENT	UNIQUE STUDENTS SELECTED	COMPLETED STUDENTS	TOTAL COMPLETIONS	COMPLETE
BEHAVIORAL HEALTH UNIT	**34**			**85.29%**
Documentation of Consent for Psychiatric Treatment Policy		29	29	85.29%
Totals	**34**	**29**	**29**	**85.29%**

LEGEND = Course

Build 13.01.28.895.256 | O:HLCWEB15

Course Completion Report - Drill Through

REPORT GENERATED: Jan 28, 2016, 10:56 am ET

HealthStream

Harrisburg Medical Center

Summary

Completion Range: Jan 29, 2015 through Jan 28, 2016

Data as of: Jan 28, 2016, 1:00 am ET

Report Generated: Jan 28, 2016, 10:56 am ET

Student Groups Selected: 2

Departments: 1

COURSE COMPLETION SUMMARY

COMPLETIONS BY DEPARTMENT	UNIQUE STUDENTS SELECTED	COMPLETED STUDENTS	TOTAL COMPLETIONS	COMPLETE
BEHAVIORAL HEALTH UNIT	**34**			**85.29%**
Patient and Family Involvement in Care and Treatment Decisions Policy		29	29	85.29%
Totals	**34**	**29**	**29**	**85.29%**

LEGEND = Course

Build 13.01.28.895.256 | O:HLCWEB15

Course Completion Report - Drill Through

REPORT GENERATED: Jan 28, 2016, 10:55 am ET

HealthStream

Harrisburg Medical Center

Summary

Completion Range: Jan 29, 2015 through Jan 28, 2016

Data as of: Jan 28, 2016, 1:00 am ET

Report Generated: Jan 28, 2016, 10:55 am ET

Student Groups Selected: 1

Departments: 1

COURSE COMPLETION SUMMARY

COMPLETIONS BY DEPARTMENT	UNIQUE STUDENTS SELECTED	COMPLETED STUDENTS	TOTAL COMPLETIONS	COMPLETE
BEHAVIORAL HEALTH UNIT	**78**			**89.74%**
New Digital Scales and Weight Reporting Guidance Memo		70	70	89.74%
Totals	**78**	**70**	**70**	**89.74%**

LEGEND = Course

Build 13.01.28.895.256 | O:HLCWEB15

Course Completion Report - Drill Through

REPORT GENERATED: Jan 28, 2016, 10:54 am ET

HealthStream

Harrisburg Medical Center

Summary

Completion Range: Jan 29, 2015 through Jan 28, 2016

Data as of: Jan 28, 2016, 1:00 am ET

Report Generated: Jan 28, 2016, 10:54 am ET

Student Groups Selected: 2

Departments: 1

COURSE COMPLETION SUMMARY

COMPLETIONS BY DEPARTMENT	UNIQUE STUDENTS SELECTED	COMPLETED STUDENTS	TOTAL COMPLETIONS	COMPLETE
BEHAVIORAL HEALTH UNIT	**34**			**85.29%**
Illinois Mental Health Code (405 ILCS 5 2 107)		29	29	85.29%
Totals	**34**	**29**	**29**	**85.29%**

LEGEND = Course

Build 13.01.28.895.256 | O:HLCWEB15

Course Completion Report - Drill Through

REPORT GENERATED: Jan 28, 2016, 10:53 am ET

HealthStream

Harrisburg Medical Center

Summary

Completion Range: Jan 29, 2015 through Jan 28, 2016

Data as of: Jan 28, 2016, 1:00 am ET

Report Generated: Jan 28, 2016, 10:53 am ET

Student Groups Selected: 2

Departments: 1

COURSE COMPLETION SUMMARY

COMPLETIONS BY DEPARTMENT	UNIQUE STUDENTS SELECTED	COMPLETED STUDENTS	TOTAL COMPLETIONS	COMPLETE
BEHAVIORAL HEALTH UNIT	**34**			**85.29%**
Illinois Mental Health Code 405 ICLS 5/2-102		29	29	85.29%
Totals	**34**	**29**	**29**	**85.29%**

LEGEND = Course

Build 13.01.28.895.256 | O:HLCWEB15

Course Completion Report - Drill Through

REPORT GENERATED: Jan 28, 2016, 10:50 am ET

HealthStream

Harrisburg Medical Center

Summary

Completion Range: Jan 29, 2015 through Jan 28, 2016

Data as of: Jan 28, 2016, 1:00 am ET

Report Generated: Jan 28, 2016, 10:50 am ET

Student Groups Selected: 2

Departments: 1

COURSE COMPLETION SUMMARY

COMPLETIONS BY DEPARTMENT	UNIQUE STUDENTS SELECTED	COMPLETED STUDENTS	TOTAL COMPLETIONS	COMPLETE
BEHAVIORAL HEALTH UNIT	**34**			**85.29%**
Informed Consent Medications/Psychoactive		29	29	85.29%
Totals	**34**	**29**	**29**	**85.29%**

LEGEND = Course

Build 13.01.28.895.256 | O:HLCWEB10