FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
THRESHOLDS——16-040-9005
HUMAN RIGHTS AUTHORITY- South Suburban Region

[Case Summary— The Authority made corrective recommendations that were accepted by the service provider. The public record on this case is recorded below; the provider requested that its response should be included as part of the public record.]

INTRODUCTION

The Human Rights Authority (HRA) has completed its investigation into allegations concerning Thresholds. The complaint alleged that the agency failed: 1) to provide the guardian with copies of services plans upon her requests, 2) to provide incidents reports and especially those involving serious behaviors in a timely manner, and, 3) to secure the guardian's informed consent prior to administering psychotropic medication in the absence of an emergency. If substantiated, these allegations would be violations of the Illinois Administrative Code (CILA Rules, 59 Ill. Admin. Code 115.100 et seq.), the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/4), the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/100 et seq.) and the Illinois Probate Act (755 ILCS 5/11a-17 and 5/11a-23).

According to its website, Thresholds offers 30 innovative programs at more than 100 locations throughout the Chicagoland area, the adjacent suburbs, and nine surrounding counties. Services include assertive outreach, housing, employment, psychiatry, education, primary care, case management, substance abuse treatment and research. For 2015, the agency served more than 9500 adults and youths with mental illness, with 75% of services delivered in the community, representing more than 500,000 hours of care.

METHODOLOGY

To pursue the investigation, the complaint was discussed with Threshold's Director of Quality Assurance, the Quality Manager, the Attending Psychiatrist, the Program Director, the Team Leader and three Community Support Staff. The complaint was discussed with the resident's guardian. Sections of the adult resident's record and a copy of his Guardianship Order, dated January 23rd, 2006, were reviewed. This order appoints the guardian over his personal care and finances. Relevant policies were also reviewed.

Thresholds provided the HRA with emails that were not part of the record reviewed.

COMPLAINTS #1 and 2 Record Access and Incident Reports

The complaint stated that the resident's guardian has been requesting services plans for about three years. It was reported that the program staff had a meeting with the guardian as requested by the agency's Quality Assurance Department in September of 2015 and that then

copies of services plans were provided. The complaint stated that the guardian was not provided with incidents reports and especially those involving serious behaviors in a timely manner. It was reported that the guardian had recently learned that the resident might be discharged from his housing program due to three serious behavioral incidents.

FINDINGS

Information from the record, interviews and program policies

The HRA determined that the resident has been a client of Thresholds for about three years and that he lives in a Community Integrated Living Arrangement (CILA) managed by the agency. His home is supervised by clinical staff during the day and desk staff at night. His record contained two housing violation notices indicating that he might be discharged because of non-compliancy with the smoking rules in this home. The first notice dated October 29th, 2014 documented that the staff had found cigarette butts in the resident's room during a weekly room inspection. The resident signed the notice stating that he had agreed to stop smoking in his room. Also, it documented that the resident's tenancy would be evaluated after his probationary status ended on January 29th, 2015. The second housing violation notice documented that the resident was observed entering his home from the designated outside smoking area with a lit cigarette in his hand on January 23rd, 2015. According to the notice, all cigarettes must be extinguished and placed in the cigarette receptor before entering the home. On February 11th, 2015, the resident signed the notice stating that during his 60-day probationary period he had agreed to meet with the Team Leader and/or to attend group sessions on safe smoking. Also, it documented that the resident might be given a 30-day notice to vacate the home if he received another 60-day probation notice and did not make any improvements. The resident's record lacked any indication that the guardian was informed about the housing violations above.

The resident's services plan dated March 24th, 2015 reflected that he needed to work on appropriate boundaries with female staff and peers. He had acknowledged drinking alcoholic beverages and smoking marijuana during the past six months. He was observed panhandling in the community. He attends the agency's psychosocial rehabilitation program and has unsupervised time in the community. He had received a second housing violation notice for smoking in his home. His inappropriate behaviors had increased during the past six months and his prognosis was poor to fair. His services plan documented that he did not want family or significant others to attend his treatment staffing. It stated that the member's and/or guardian's signature would confirm their participation in the treatment planning process, consent, and agreement with services. Also, this would indicate that the member's rights were reviewed and that a copy of his services plan and the agency's rights statement were provided. The resident reportedly signed a "paper" copy of his services plan. However, there was no indication of the guardian's input in the treatment planning process or that she signed the services plan.

For July of 2015, the progress notes indicated that the resident had received a third housing violation notice. According to a progress note, the resident seemed intoxicated and threatened two housemates on the 23rd. The incident reportedly happened when the staff person went to get some medication for another resident at a nearby store. He told one housemate "I'm gonna kill you and your momma; I'm gonna [expletive] you up." Then, he told a second housemate "come and drink some of this with me … I'm gonna [expletive] you up." He reportedly denied threatening his housemates and said to the staff person that "I'm gonna [expletive] you up". He continued to make threatening statements but was later able to follow redirections. According to the progress note, the Program Director and the guardian were

notified on the incident day. The plan was to fax a copy of the incident report to the Housing Specialist on that next morning. The housing department would provide the resident with a copy of the housing violation notice. Another progress note stated that the staff met with the resident concerning the incident on that next day. On July 27th, the Team Leader was informed that the guardian was notified that the resident was very intoxicated on the incident day above. Once notified, she told the staff person to tell the resident to call her so that she could follow up with him. Also, she said that she would like for him to attend sobriety classes. There was no mention that the guardian was given a copy of the housing violation notice nor was a copy of the notice found in the resident's record.

For September, it was recorded that the Qualified Mental Health Professional (QMHP) had a meeting with the agency's Vice President of Clinical Operations and the Program Director concerning an incident that had occurred on the 5th. According to the QMHP's note, the resident was intoxicated and would not come inside of the home as requested. His guardian was reportedly called and picked him up for a home visit on that same day. She told the staff that they were not helping the resident when she arrived at the home. However, the QMHP wrote that the staff had tried to assist him, although they were off duty sometimes. His housemates and the staff were afraid because of his recent threats and behaviors when intoxicated. He had been observed making inappropriate gestures toward females in the community, and harassing employees at the gas stations and asking strangers for money when intoxicated. A meeting was scheduled with his guardian to discuss the staffs' concerns about the resident's increasingly threatening and inappropriate behaviors on the 14th. The meeting was rescheduled for the following week so that all necessary staff could be present. There was no more documentation concerning the meeting found in the resident's record.

The resident's services plan dated September 24th, 2015 stated that he had increased difficulty with maintaining sobriety during the past six months. He told the staff that he wanted to stop drinking alcoholic beverages because he did not want to get in trouble. His services plan documented that family or significant others attended his treatment staffing. However, the guardian did not sign the services plan. On that next month, an addendum to the resident's services plan stated that he said that his psychosocial program was helpful. A plan was developed to help him to attend as many therapy groups as possible instead of spending time in the community. This was signed by the guardian on November 10th, 2015.

When the complaint was discussed with Thresholds' staff, the Program Director said that she became the contact person because the Team Leader and the guardian had a disagreement some time ago. She said that she called the guardian concerning care planning meetings scheduled in 2015. The Team Leader said that the guardian told her what she expects in regard to notification about incident reports. Then, she said that the Program Director told her that the guardian only wanted to be notified about serious incidents. The guardian told the HRA that the agency did not provide her with incidents reports as requested. She said that the agency that subsidizes Thresholds' housing program provided her with copies of incidents reports after she was informed that the resident might be discharged for violating his leasing agreement three times. In the first incident, the guardian said that a staff person told her that cigarettes were observed in an ash tray in the resident's room. She said that the resident was asked to sign a violation notice. She was not given a copy of the notice but was informed that Thresholds' housing funding source had been notified about the violation. In the second incident, the guardian said that the staff alleged that resident had lit a cigarette in his home. However, she believes that the resident might have been trying to extinguish the cigarette upon entering the

home. In the third incident, the guardian said that the resident allegedly lashed out at his peer on or around the time that he had been given an injection.

The HRA found no documentation during the record review that the guardian had requested access to records. However, the agency's Quality Manager said that the guardian did request records in 2015. She provided an email from Thresholds' Medical Records Department documenting that the guardian had picked up copies of services plans at the agency's south suburban office. Also, the guardian was reportedly provided with 619 pages of progress notes including psychiatry notes on August 27th, 2015. According to the email, the guardian's record request only included the notes above. The Authority was informed that records are usually provided about a week after they are requested. Guardians can get copies of incidents reports.

The staff interviewed said that the guardian had left a phone message regarding her concerns on the agency's complaint department phone on September 8th, 2015. They reported that the guardian's concerns included: 1) inaccurate information in the resident's record, 2) the lack of notification involving signing care plans, 3) informed consent for medication, and, 4) and she believed that the resident was being treated unfairly. The Quality Manager explained that the staff held a special meeting with the guardian to address her concerns on September 24th, 2015. The guardian was given a copy of the resident's services plan at the meeting. According to the guardian, she was given some services plans at the meeting, and the staff told her that the resident needed to be placed in a nursing home. However, she disagreed and the recommendation was rescinded at the meeting. The agency provided emails concerning communication with the guardian in 2016. One of them stated that the guardian was informed about the care plan meeting held in March. At the site visit, the staff reported that a copy of the resident's services plan was left for the guardian at his home in March. Another email stated that the guardian was notified that pills were found in the resident's room on April 22nd.

The agency's "Coordinated and Integrated Services" policy state that the member, guardian, family and all appropriate staff will be invited to care planning meetings. It states that the agency's Individual Care Plan and service notes are to be used to document all services and treatment involving a member.

The agency's rights policy states that: 1) members are entitled to a copy of his or her care plan, and, 2) access to his or her record.

COMPLAINT #3 Medication

The complaint stated that Depakote and Latuda were added to the resident's medication regimen without informed consent and that Risperdone was discontinued without notice.

Information from the record, interviews and program policies

For 2015, the psychiatry notes documented that the resident was seen by the Attending Psychiatrist or assigned physician monthly with the exception of August, September and December. On January 12th, the Attending psychiatrist wrote that the resident reported that he was experiencing auditory hallucination sometimes. Medication education was done. An attempt to titrate Depakote from 500 mg twice daily to 500 mg and 750 mg at night would be done. Risperidone 3 mg orally twice daily and Latuda 120 mg at night was continued. He was encouraged to attend sobriety groups. For July, the Attending Psychiatrist wrote that the first loading dose of Invega Sustenna 234 mg intramuscularly IM was administered on the 24th. The second loading dose of Invega Sustenna 156 mg IM was given seven days later. The psychiatrist wrote that the medication would be administered monthly. Risperidone was discontinued and there were no other medication changes made.

According to the Medication Administration Records (MARs), Depakote and Latuda were administered in December of 2014 through December of 2015, and Risperidone was given until July. The resident's record lacked informed consent for Risperidone. A medication form documented that the guardian gave consent for the administration of Depakote, Latuda and Invega Sustenna, on August 5th, 2015, which was months after the medications were initially ordered. There was no consent for Risperidone. The Attending Psychiatrist told the HRA that she accepted the resident's consent for medication before she realized that he had a legal guardian. She said that she met with the guardian after Invega Sustenna IM was added to his medication regimen. This was confirmed by the guardian.

Thresholds' Informed Consent-Rights/Health Insurance Portability and Accountability Act policy states that informed consent forms are given to program members or guardians if applicable for signature at intake. They are filed in the member's permanent file. Its "Medication Use Practices" policy state that the agency's contracted Medical Consultant is available 24 hours a day and seven days a week. A recovery-based approach to using psychiatric medications is a person-centered approach. Each person has different beliefs and ideas about using medication. All members who require medication related services will have access to such services through a psychiatrist employed by the agency. All members will be offered choices and continuity of all medication related services.

According to the agency's "Medication Monitoring" policy, the purpose of the policy is to ensure that members served are empowered to actively participate in the decision making process concerning the use of medication for each individual recovery purpose.

Thresholds' "Psychiatric Consultation's Medication Review" policy states that the contracted psychiatrist or advanced nurse practitioner is responsible for completing documentation concerning services and review of medication. This includes but is not limited to a review of past medication effectiveness, side effects, current medication and confirmation of informed consent. According to the policy, the documentation of informed consent and possible side effects will be discussed with all members seen by a Threshold's psychiatrist or a consulting psychiatrist.

The agency's rights policy includes as follows: 1) to have as much information about one's treatment and choices as needed to make a good decision about one's care, 2) to express choice either by consent or refusal of services, and, 3) to file a grievance about services with advocacy and governmental agencies.

CONCLUSION

According to Section 110/2 of the Mental Health and Developmental Disabilities Confidentiality Act,

> Record means all records and communications, except for the therapist's personal notes, kept by an agency in the course of providing mental health or developmental disabilities service to a recipient and the services provided.

Section 110/4 states that,

> The parent or guardian shall be entitled, upon request, to inspect and copy a recipient's record. Whenever access or modification is

> requested, the request and any other action taken thereon shall be noted in the recipient's record.

Section 115.230 (k) of the Administrative Code states that the individual or guardian shall be given a copy of the services plan.

Section 115.250 (a) (1) of the Administrative Code states that "The individual's rights are protected in accordance with the Code, except that the use of seclusion shall not be permitted."

According to Section 5/2-102 (a) of the Mental Health Code,

> 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 resident to the extent feasible and the resident's guardian, if appropriate.
> (a-5) If the services include the administration of electroconvulsive therapy or psychotropic medication, the physician or the physician's designee shall advise the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment, to the extent such advice is consistent with 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 designee shall provide to the recipient's substitute decision maker, if any, the same written information that is required to be presented to the recipient in writing. If the recipient lacks the capacity to make a reasoned decision about the treatment, the treatment may be administered only [i] pursuant to Section 5/2-107 ….

The Illinois Probate Act Section 5/11a-17 states that the personal guardian shall make provision for the ward's support, care, comfort, health, education and maintenance.

Section 5/11a-23 states that,

> Every health care provider and other person (reliant) has the right to rely on any decision or direction made by the guardian … to the same extent and with the same effect as though the decision or direction had been made or given by the ward.

Complaint #1 stated that the agency failed to provide the guardian with copies of services plans upon her requests. The guardian told the HRA that she has been requesting copies of services plans and incident reports for about three years. However, the agency's Quality Manager said that the guardian did not request records until 2015 and that copies of services plans were provided. An email from the agency's medical records department indicated that the guardian was provided with progress notes as requested. There was written no documentation of

the guardian's specific record request found in the resident's record. Although the Authority cannot substantiate the complaint as presented above, the agency violates Section 115.230 (k) of the Administrative Code stating the guardian shall be given a copy of the services plan. The agency's rights policy states the same. The Administrative Code Section above and the agency's rights statement do not require that the guardian must ask for a copy of the plan. Also, the agency violates Section 110/4 of the Mental Health and Developmental Disabilities Confidentiality Act because there was no documentation of the guardian's record request found in the resident's record.

Complaint #2 stated that the agency failed to provide the resident's guardian with incidents reports and especially those involving serious behaviors in a timely manner is substantiated. The resident's record contained many documented behavioral episodes from October 29th, 2014 to September 5th, 2015 including three housing violations incidents. However, it lacked any indication that the guardian was informed about the first two housing violations incidents or that copies of the notices were provided. Also, there was no mention that she was given copies of incidents reports. Although the agency's policies reviewed do not clearly indicate that guardians should be given copies of incidents reports, especially eviction/termination notices and related information without having to requests them, best practice indicates this. Also, the Illinois Probate Act Sections 5/11a-17 and 5/11a-23 directs the staff to include the guardian in all aspects of the resident's life and to rely on any decision or direction made by the guardian. However, this would be impossible without adequate and timely notification.

Complaint #3 stating that the agency failed to secure the guardian's informed consent prior to administering psychotropic medication in the absence of an emergency is substantiated. Thresholds violates the Sections 5/2-102 (a) (a-5) of the Code, the Illinois Probate Act Section 5/11a-23 and program policy, which directs the staff to include the guardian in the resident's personal care and to obtain signed informed consent for medication and services. The agency's rights policy further guarantees residents or guardians the right to refuse treatment.

RECOMMENDATIONS

1. Thresholds shall follow Section 115.230 (k) of the Administrative Code and rights policy stating the guardian shall be given a copy of the services plan.

2. Follow Section 110/4 of the Mental Health and Developmental Disabilities Confidentiality Act and document requests concerning records.

3. Be sure to provide guardians with incidents reports so that they can make appropriate and timely decisions about the ward's care, etc.

4. Thresholds shall obtain guardians' consent prior to administering scheduled and non-emergent psychotropic medications pursuant to Section 5/2-102 of the Code, the Illinois Probate Act, Section 5/11a-23, and program policy.

5. Ensure discussions regarding medication changes and treatment include guardians.

SUGGESTIONS

1. Document all communications with guardians, funding sources, etc. in the resident's record.
2. Document what level of involvement/notification the guardian wants concerning the resident's care in the record and in the treatment plan.
3. Ensure that all physicians are aware when a resident has a guardian.

RESPONSE

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

December 23, 2017

Judith Rauls, Chairperson
Regional Human Rights Authority
West Suburbs Regional Office
PO Box 7009
Hines, IL 60612

VIA US MAIL

Re: **HRA No. 16-040-9005**

Dear Ms. Rauls:

Below is our response to the recommendations regarding communication in HRA No. 16-040-9005:

Thresholds continually assesses our policies and procedures to meet programming needs and requirements and works to provide quality services and to ensure the safety of members in our care. All employees are held to Thresholds Service Standards, which includes a commitment to communication with members, guardians, external partners and funders. Once it comes to the attention of Thresholds leadership that a staff person may not be meeting agency and/or program standards, there is an immediate response.

The details surrounding the complaint of this case are unique because the guardian is also an employee of Thresholds. The Program Director had ongoing communication with the guardian via phone and Thresholds email regarding the care of the member. The guardian advised that she did not want to be made aware of certain incidents and there were medical appointments for which she asked the Program Director to stand in her stead. Once the guardian advised the Quality Department of her concerns regarding the communication of the team, it was addressed with the program.

Thresholds understands the importance of effectively communicating with guardians and will continually train staff around the related administrative codes and standards. We have responded to the recommendations of your office accordingly:

1. Thresholds shall follow section 115.230 of the Administrative Code and rights policy stating the guardian shall be given a copy of the services plan.
    - Guardians are asked to be a part of drafting, sign and are provided a copy of service plans
    - This is outlined in Thresholds "Confidentiality Privacy and Disclosing PHI of Persons Served" and Authorized Signatures Policies
    - Compliance with this code is reinforced in Team Leader Orientation, team meetings and individual staff supervisions
2. Follow Section 11/04 of the Mental Health and Developmental Disabilities Confidentiality Act and document requests concerning records.

- This is outlined in Thresholds "Confidentiality Privacy and Disclosing PHI of Persons Served" and "Informed Consent- Rights/HIPAA" Policies
- Record requests are responded to in a timely manner

3. Be sure to provide guardians with incident reports so that they can make appropriate and timely decisions about the ward's care, etc.
    - There is ongoing communication with guardians regarding any concerns with ward's care, behavior, health, etc.
    - Incident reports are provided to guardians. This is especially important and executed in residential programs, in which incidents can impact members' housing
4. Thresholds shall obtain guardians' consent prior to administering scheduled and non-emergent psychotropic medications pursuant to Section 5/2-102 of the Code, the Illinois Probate Act, Section 5/11a-23 and program policy
    - This is addressed in Thresholds "Medication Monitoring" and "Psychiatric Consultation's Medication Review" policies
    - Compliance with this code is reinforced by Thresholds Medical Director and onboarding of Psychiatric Consultants
5. Ensure discussions regarding medication changes and treatment include guardians
    - Guardians are welcome to attend all psychiatric appointments
    - This is addressed in Thresholds "Medication Monitoring" and "Psychiatric Consultation's Medication Review" policies
    - This is reinforced by Thresholds Medical Director and onboarding of Psychiatric Consultants

As outlined in your report, Thresholds serves nearly 10,000 adults and youth with mental illness and [illegible] communicate with not only those we serve, but guardians, family members, community supports and partners. This was Thresholds first complaint with the HRA and we have worked diligently to address the outlined concerns. We will continue to work with our staff to ensure that the standards outlined in your recommendations are met.

If you have any questions, please follow up with me directly at 773.432.6298.

Sincerely,

Joyce Weston
Director, Quality
Joyce.Weston@thresholds.org